

SETTLEMENT OF COMPLEX LIABILITY COVERAGE DISPUTES

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I. INTRODUCTION

For all the number of complex liability-insurance coverage disputes pending in our nation's courts, few are tried to a jury in their entirety. Usually, some or all parts of complex coverage cases are resolved consensually.

Complex coverage disputes are marked by the size of the dollars at stake as well as their uncertainty, because at issue in most instances is some element of future dollars or future claims. These disputes often involve liability problems that are national in scope, as in the case of products liability, or involving multiple states, as in environmental liabilities scattered among a number of sites. Complex disputes ordinarily involve multiple insurers that have issued insurance policies potentially applicable to indemnify the insured for loss. Complex coverage disputes are marked particularly by legal and factual uncertainty. There is legal uncertainty as to the manner the insurance policies may apply to the particular loss,¹ and often there is factual uncertainty as to, for example, the nature of the underlying problem, whether the product in question actually causes injury, the ultimate scope of the liability problem, and the culpability of the insured's conduct leading to the claims of liability in the first place.

Consequently, high-stakes coverage cases are difficult and expensive to litigate and are uncertain in outcome. These attributes, however, provide the incentive

1. Although the key terms of insurance policies are more or less uniform, the legal meaning of that uniform language is determined under state law, and the state-law rule can vary 100 percent from state to state, though in many states the case law has not developed to the point that there is any governing rule at all. The absence of governing legal standards combined with the discontinuities in outcomes from state to state combine to create tremendous legal instability, thereby creating in turn the incentive to file suit preemptively so as to manipulate choice of law.

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to achieve some form of resolution other than a litigated one.² This article addresses the mechanics of resolving complex coverage disputes consensually.

II. A PRIMER ON COVERAGE

A. Overview

Insurance policies are legal instruments,³ and to assess how much an insurer should pay, one must understand the coverage afforded under the particular instruments at issue. As Roger Fisher and his colleagues have long urged, one can adequately evaluate negotiated resolutions only if one considers the best alternative, which—in this context—is an adversarial trial.⁴ Although business relationships and market concerns may affect settlement, a settlement takes place in substantial part against the backdrop of a litigated resolution. As a result, the parties will evaluate their respective settlement positions based on their predictions as to how the court or jury will rule on the substance of their dispute. Settlement is also guided by the insurer's own assessment of its "fair share"—a calculus that takes into account its contract obligations, the likelihood of the policyholder's prevailing at trial and for how much, and the relative burden being shouldered by other carriers. This section reviews key background concepts to assess the obligations under any given insurance policy.⁵

B. Primary and Excess Insurance Policies

Within a given type of insurance, there are two types of insurance policies: primary and excess. A primary policy applies at "first dollar," that is to say, for any given loss it is the first policy the insured will look to for performance. An excess policy, in contrast, generally will pay only after the underlying primary policy has paid or had its obligation discharged.

In addition to the difference in dollar attachment points between primary and excess policies, perhaps the most salient difference between the two types of policies is that, in addition to a duty to indemnify the insured for judgments against it or settlements it enters, a primary policy typically imposes a duty on the insurer to defend the insured, i.e., the obligation to pay for the cost of defending liability claims against the insured. The duty to defend in primary policies is particularly valuable in two different ways. First, in most states, a primary insurer's duty to

2. For a guide to litigating such cases, see Marc Mayerson, *Managing Complex Insurance Coverage Disputes*, 32 *TORT & INS. L.J.* 53 (1996).

3. Perhaps more accurately, insurance is a product whose form is that of a legal instrument. This formulation better captures the notions underlying interpretative doctrines such as the reasonable expectations of the insured and bad-faith concepts requiring a carrier to make payment when its liability is "reasonably clear" (or alternate formulations).

4. ROGER FISHER, WILLIAM URY, AND BRUCE PATTON, *GETTING TO YES* (2d ed. 1992).

5. The points expressed here appear in summary fashion, and the author has not tried to catalogue each of the issues or coverage provisions that may have implications on the monetization of particular insurance policies.

defend the insured is considerably broader than is its duty to indemnify, and the insurer can be held to pay, on an ongoing basis, the costs of defending the insured in a case in which the carrier ultimately will not be required to pay the resulting judgment.⁶ Second, monies a primary carrier pays for the defense are usually paid on top of the policy limits; in other words, the dollar limits in a policy typically do not apply to the defense obligation, which as a result is unlimited.⁷ In contrast to primary carriers, the defense obligations of excess carriers are less uniform and typically are more circumscribed: they may have no defense obligation at all, may pay defense costs only after the underlying case is over, may pay defense costs subject to policy limits, or may pay defense costs only for claims covered by the policy's duty to indemnify.

As a consequence of how the insurance programs of most companies are put together, a company likely will have several policies of excess insurance, each applying once successively higher levels of loss are reached. This "layering" of insurance is significant in evaluating settlement because each successively higher excess layer generally has no obligation to perform until the underlying policies have performed. Layering is also significant because it is common for a number of insurers concurrently to issue policies that together fill a single layer. Put differently, at a specific dollar of coverage, say, ten million dollars in excess of the first two million dollars of loss, a number of insurers each may have issued policies under which each agreed to pay a relative "quota share" of losses penetrating the particular layer. Each quota-share policy, however, is liable only for its percentage, and policies within a quota-share layer are applied concurrently in shares rather than sequentially (as if each quota-share policy were a separate layer within the dollar layer in question).⁸

In many instances, a number of years of the policyholder's coverage may be implicated. Consequently, the coverage in the different applicable years may (or may not, depending on the state) need to be coordinated and applied. The legal doctrines that govern the allocation of loss to policies across time and layers are the trigger of coverage, the scope of coverage, and ordering of exhaustion.

Though these interrelated issues are complex—and are the subject of divergent and inadequately considered judicial decisions—most insurers and insureds as a practical matter operate by general rules of thumb that are adequate guides for identification of positions and negotiation. The question of trigger is generally what event must occur during the policy period for the policy to apply (subject to its

6. For a comprehensive review of the defense obligation under primary policies, see Marc Mayerson, *Insurance Recovery of Litigation Costs: A Primer for Policyholders and Their Counsel*, 30 TORT & INS. L.J. 997, 999-1000 (1995).

7. *Id.* at 1001.

8. See generally *American Marine Underwriters, Inc. v. Holloway*, 826 F.2d 1454 (5th Cir. 1987); but cf. *Harding Assocs. Inc. v. London Agency*, 1993 U.S. Dist. LEXIS 3546 (N.D. Cal. 1993) (holding that co-subscribers to a policy, though "each for his own part and not one for the other," were jointly and severally liable to perform resulting in solvent subscribers paying the shares of the insolvent KWELM companies).

terms and conditions). As a practical matter, in most environmental or product liability matters in which the process of injury or the etiology of the disease takes place over time, insurers and insureds will assume that policies are triggered across the continuum of the injurious process.⁹ Trigger also raises the question of after what time are policies no longer included for purposes of allocation, and whether this end point is based on, for example, the application of policy exclusions, the unavailability of coverage due to the introduction of standard exclusions, the termination of the process of injury, the date of claim against the insured, or the date of the insured's notice to the insurer. The question of scope of coverage is how should the insured's costs and liability be mapped onto the triggered policies. Do the policies pay based on their full policy limits, a time factor alone (e.g., the percentage of time each policy provided coverage relative to all the triggered policies), the relative dollar limits of the triggered policies, or the quantum of damage or injury taking place during the policy period.¹⁰ Particularly in the settlement context the parties may decide to allocate the loss only across years of applicable coverage even though that block or band is not coextensive with the period of injury.

Crucial to the determination of how much a policy is to pay is the ordering of payment among the policies that are triggered. This is the question of exhaustion. There are two principles of exhaustion: horizontal and vertical. Under horizontal exhaustion, coverage is allocated first to the primary layer policies across time before any excess policy applies.¹¹ Under vertical exhaustion, all policies, both primary and excess, in any given year are called upon to pay, and dollars are allocated upwards. The case law in some states now appears to embrace or permit allocation schema that combine elements of both horizontal and vertical exhaustion.¹²

Another crucial background element to the negotiation of complex coverage disputes is the applicability of policy limits. The allocation issues discussed above address the mapping of the liability onto the coverage generally. The applicability of policy limits concerns how the money in a specific policy applies with respect to the stated policy limits. Here, there are three points that should be considered. First, as indicated above, primary policies that pay defense costs usually do so in addition to the policy limits. As a result, to the extent a particular carrier is called upon or agrees to pay defense, those payments do not reduce the availability of coverage under the policy. Second, most policies pay their indemnity limits in

9. There may be exceptions, of course, depending on the nature and the means of injury. For example, in certain medical device liability cases, triggering policies at the time of their implantation only may be more consonant with the facts and the governing case law.

10. A related question is whether a different rule applies when the insured seeks performance versus when one insurer that has paid the insured seeks contribution against other insurers whose policies also apply to a loss but have not paid the insured. Compare *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993) with *American Cas. Co. v. PHICO Ins. Co.*, 702 A.2d 1050 (Pa. 1997).

11. Courts that have embraced horizontal exhaustion have not provided much guidance as to how layers of excess policies should be exhausted horizontally.

12. See, e.g., *Chemical Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co.*, 978 F. Supp. 589 (D.N.J. 1997).

terms of dollars "per occurrence." This raises the question of the number of "occurrences," for the number of occurrences determines how many policy limits may be called upon to satisfy the insured's obligations. In the environmental context, it is conventional to apply one per-occurrence set of limits for each environmental site. In the products context, there are two governing theories: either each claimant is said to constitute a separate occurrence or all of the related products liability claims are considered to be a single occurrence.

The third related policy limits issue concerns the applicability of aggregate limits. Most policies specify an overall total maximum dollar amount the policy will pay. This is the aggregate limit, which is a number equal to or greater than the per-occurrence limit. Under most liability policies, the aggregate limits apply based on the "hazard" generating the loss. A hazard is a particular type of risk exposure, and conventionally the categorization of hazards includes, among others, the (1) products/completed-operations hazard and (2) the premises/operations hazard.¹³ Typically, there are separate pools of money for occurrences arising from each hazard. Thus, if a policy pays \$100,000 per occurrence and provides for an aggregate of \$200,000 applicable separately to two hazards, the total amount of coverage available under the policy is \$400,000, even though the maximum the policy would pay for any one occurrence is \$100,000, and the maximum the policy will pay for occurrences stemming from either hazard is \$200,000. Some hazards have aggregate limits, and some do not.

Depending on the nature of the claim and whether there is an aggregate, the settlement dynamic is very different. For hazards like product liability with an aggregate, if the insured's anticipated loss is large enough such that the aggregate limit ultimately will be exhausted, the driving force of the settlement may be to discount the carrier's ultimate anticipated payout to present value, with the carrier paying a lump sum today in exchange for a release of its future obligations. For hazards like the premises operations hazard, within which most environmental claims fall, there is usually *no aggregate limit*.¹⁴ This means that, subject to the per-occurrence limit only, the policy will pay for covered occurrences within that hazard repeatedly. In such circumstances, the carrier will be concerned that claims will arise in the future within the hazard, and it may be interested in buying out the hazard completely, buying out all claims of a certain type within the hazard, or creating a negotiated cap on the hazard to limit its upside risk.

The question of exhaustion of policy limits—both per-occurrence and aggregate—is important not only to monetize the particular policy, but also to access overlying

13. See generally *Frontier Insulation Contractors Inc. v. Merchants Mut. Ins. Co.*, 690 N.E.2d 866 (N.Y. 1997).

14. In many primary layer policies, according to the standard policy language, whether an aggregate applies to property damage claims within the premises operations hazard depends on how the particular policy is rated (priced); the policy language usually does not impose an aggregate limit for bodily injury claims except for those arising from the products hazard. Most excess policies impose aggregates only for products and occupational disease claims.

excess coverage, because an excess policy applies upon the exhaustion of the applicable limits of the underlying policy. An excess policy will pay after the underlying policy pays its maximum applicable per-occurrence limit. If the underlying policy is not obligated to pay the full stated per-occurrence limit due to the prior exhaustion of the applicable aggregate, the excess policy will pay upon the payment of the maximum available under the policy.¹⁵ If the insured has released an underlying carrier from paying its full per-occurrence limits or its full aggregate limit, or if the insured has capped a carrier's unlimited (i.e., no aggregate) obligation through the creation of an aggregate limit post hoc via settlement, the insured may be called upon to "self-insure" the difference between the original contract policy limits of the underlying insurer and what it received in settlement. The excess carrier will not be excused from performance, but the excess carrier will seek to have the integrity of the underlying buffer of coverage respected.¹⁶

Finally, together with the question of coverage allocation, when the insured has policies that impose deductibles or retrospectively rated premium adjustments (retros), the parties must consider how the deductibles or retros are to apply.¹⁷ Some of the issues concerning deductibles and retros are addressed below in Part V.

To sum up, the monetization of the coverage depends on a number of interrelated issues: trigger, scope, allocation, exhaustion, number of occurrences, application of aggregates, and application of deductibles or the like. These issues must be resolved *assuming there is coverage*. Though the parties may—or will—negotiate over the manner the insured may draw upon its coverage, these issues are all separate from the question whether there is coverage or not, such as whether an exclusion applies or whether the insured breached a condition to coverage. For the latter issues, depending on the policy language, the governing law, and the particular facts, the parties will likely figure litigation discounts in the settlement matrix.

III. EXOGENOUS FACTORS, MOTIVATIONS, AND DYNAMICS

The prior section sketched several legal questions that bear on the valuation or monetization of the applicable insurance policies. As in all disputes, additional factors come into play that bear upon both the willingness of a party to negotiate

15. For an unusual application of this rule where the insured was in bankruptcy, see *UNR Indus., Inc. v. Continental Cas. Co.*, 942 F.2d 1101 (7th Cir. 1991).

16. The courts have held for seventy-five years or more that partial payment by underlying coverage does not preclude the overlying excess carrier's obligation to perform. *Zeig v. Massachusetts Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928) (A. Hand, J.); *Koppers Co. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440, 1454 (3d Cir. 1996); *E.R. Squibb & Sons, Inc. v. Accident and Cas. Ins. Co.*, 853 F. Supp. 98, 101 (S.D.N.Y. 1994) (requiring excess insurers to "pay amounts due the insured which are unpaid for any reason, including a compromise reached by a first-tier carrier through an arm's length settlement").

17. Insureds may likewise have agreements that are the functional equivalent of a deductible or a retro such as a side indemnity agreement or a captive reinsurance arrangement under which the insured agrees to pay the insurer some amount for each loss under the policy.

and the form that any settlement will take. Several of the more salient factors influencing the shape of settlement are addressed in this section.

Perhaps the dominant motivation to settle a complex coverage case is each party's desire for certainty and peace. The desire for certainty cuts in a number of directions from the differing perspectives of the policyholder and its insurers. From the policyholder's perspective, the desire for certainty may lead it to accept a cash-out of its coverage (for the claim, for the type of hazard, etc.) because the particular carrier had already breached its contract and obtaining money from the carrier in the future could require another lawsuit. On the other hand, in any cash-out deal, the policyholder accepts the transfer back from the insurer of the risk the policyholder paid premiums for the insurer to accept in the first place. From the perspective of the insurer, the transfer back to the policyholder of uncertain upside risk is very attractive. The carrier may desire to rid itself of the policyholder more generally and avoid future claims against it by buying out the hazard, etc., completely. From the policyholder's perspective, however, any type of buyout means that it is accepting the upside risk of not obtaining an adequate amount from the insurer in the settlement.

Financial considerations may dictate the desire by one side or the other for a lump sum payment or a series of future payments from the insurer. A lump sum payment eliminates the risk that the carrier may become insolvent and no longer be able to perform. On the other hand, a lump sum payment may have adverse tax consequences for the insured.¹⁸ The insurer may prefer a series of payments instead of a lump sum to permit it to continue to earn investment return on the amounts owing to the insured.¹⁹

A related, nonmonetary factor that similarly bears on the structure of any settlement is whether the parties as a practical matter are willing to remain married or want a divorce. In buyouts, the parties go their separate ways (at least for the type of claim settled). Under other types of settlements such as a "coverage in place" arrangement under which the insurer pays a percentage of future costs as they are incurred, the policyholder and the insurer are required to continue working with one another against the backdrop of their dispute. In any type of continuing relationship, there likely will be ongoing friction between the insured and insurer on who, what, when, and how much should be paid. On the other hand, staying married permits the parties to develop a *modus vivendi* and to develop a relationship of trust and mutual credibility. When the parties enter into an interim agreement (discussed further below), that is, one that temporarily resolves their dispute or resolves a subset of their disputes, working together may permit the parties to

18. See William Paul and Bruce McGovern, *Tax Aspects of Environmental Liabilities and Related Insurance Recoveries*, 7 MEALEY'S LITIG. REP.: INS. (Apr. 20, 1993).

19. Even where there is an actual or imputed interest rate applied to such streams of payments, the insurer may believe that it can earn a greater return on the money than what it will be paying the insured for the privilege of holding onto the money, and the delta (less administrative and transaction costs) thus represents pure profit.

develop the confidence to reach a final, comprehensive resolution. An interim agreement also permits the parties to defer resolution, or final resolution, of the more contentious issues dividing them, until such time as the underlying liability becomes more certain, the relevant law becomes more clear, or the parties become more comfortable working together.

Both sides will also be concerned about the precedential value of the settlement. Where the settlement between the policyholder and the insurer resolves only a subset of recurring claims and coverage for future similar claims is preserved, the settlement may establish baselines between the parties for the resolution of the future claims. Insurers (rightly or wrongly) do not want their settlement with one policyholder to establish their obligation to pay another policyholder or the level of payment appropriate for another policyholder. An insured is also concerned about the precedential value of a given settlement with respect to its other carriers. An insured that settles early in a case with one insurer will likely give that insurer some sort of discount for settling early, and the insured will naturally resist a later-settling carrier's effort to obtain similar favorable treatment.

An important, and sometimes driving, factor from an insurance company's perspective is the availability of reinsurance. Reinsurance has three main influences on the perspective of insurance companies. First, the ability of the insurance company to tap its own reinsurance means that the ultimate "loss" to the insurance company is limited. This may increase the insurance company's receptiveness to settlement. Second, where there is a possibility of reinsurance recovery, the insurance company will wish to ensure that, by settling with the policyholder (and not litigating), the insurance company has not somehow prejudiced its ability to tap its reinsurance policies. As a practical matter, if the insurance company settles instead of litigates with the insured, the reinsurers may have a marginally enhanced ability to challenge certain aspects of the settlement with the insured that the reinsurer would not have had were the payment to the policyholder the consequence of a jury verdict. Although most reinsurance contracts expressly contain a "follow the settlements" clause limiting the reinsurer's ability to second-guess the (ceding) insurance company's decision to settle with the insured, reinsurers on occasion have succeeded in refusing to pay all or part of a settlement with an insured.²⁰ Accordingly, the

20. See, e.g., *Commercial Union Assurance Co. v. NRG Victory Reinsurance Ltd.*, 1996 Folio No. 1350 (English App. Mar. 16, 1998), reprinted in 8 MEALEY'S LITIG. REP.: REINS. § B (Mar. 25, 1998). Under a follow-the-settlements clause, the settlement with the insured is deemed to have been within the coverage of the insurance policy, unless the settlement has been entered into collusively or fraudulently; if the insurance company makes payment to the insured but was never obligated to do so under its insurance policy and there was no possibility that the court would find coverage, the payment is considered to be "ex gratia" and the reinsurer has no obligation to cover the loss. See generally William Hoffman, *On the Use and Abuse of Custom and Usage in Reinsurance Contracts*, 33 TORT & INS. L.J. 1, 60-78 (1997); *Commercial Union Assurance Co. PLC v. NRG Victory Reinsurance Ltd.*, 1996 Folio No. 1350 (Q.B. 1997), reprinted in 8 MEALEY'S LITIG. REP.: REINS. § A (Nov. 12, 1997). The follow-the-settlements clause thus circumscribes, but does not eliminate, the bases that a reinsurer has to challenge the settlement with the insured. Compare *International Surplus Lines Ins. Co. v. Certain Underwriters at Lloyd's of London*, 868 F. Supp. 917 (S.D. Ohio 1994) with *Hiscox v. Outhwaite*, 1990 Folio No. 2491 (O.B. 1990).

presence of reinsurance may influence the insurance company's decision *away* from settlement, because by settling it naturally increases to some extent the reinsurer's ability to challenge the payment.²¹

Third, the presence of reinsurance may influence the insurance company's desire to allocate portions of the settlement amount to either (1) particular policies or (2) defense versus indemnity costs, so as to increase the insurance company's reinsurance recovery. Although the policyholder owes no duty to the reinsurer to prevent the settling insurance company from manipulating the allocation of the settlement to suit the (ceding) insurance company's own reinsurance needs, insurance companies that manipulate their payments have been denied recovery under their reinsurance policies on this ground.²² In any event, the policyholder may resist such manipulation on the basis that the allocation may adversely affect the policyholder's ability to tap its other coverage.

IV. NEGOTIATING PARTNERS AND TYPES OF AGREEMENTS

In approaching settlement of a complex coverage claim in which more than one insurance carrier issued applicable coverage, the policyholder needs to make the strategic decision to negotiate collectively with all its affected carriers or to negotiate with each carrier individually. The dynamic and issues for each alternative are different. The parties also need to determine whether to seek a final resolution or an interim one, and each side's interest in seeking a final or an interim agreement may vary over the course of the negotiations.

A. *Bilateral and Multilateral Agreements*

As indicated above, most complex coverage claims involve multiple insurers. The insurers may be from different layers of coverage, primary and excess, may represent portions of a given layer, as with quota share layers, or may have issued policies in different years. A policyholder facing such an array of targets needs to determine whether to seek a resolution with all the insurers concurrently, a subset of the insurers concurrently, or individual insurers *seriatim* or concurrently.

A policyholder may be inclined to proceed multilaterally because (1) transaction costs are reduced and (2) the policyholder can achieve certainty of result, including reducing the risk that an aggregation of individual settlements would result in a lower recovery. In addition to being unwieldy, multilateral negotiations suffer from the "lowest common denominator" problem. Multilateral negotiations tend to

21. Other aspects of the reinsurance contract may cut in favor of a settlement, such as where the reinsurance policy limits could be exceeded if an adverse verdict against the ceding insurer were rendered.

22. *Insurance Co. of the State of Pennsylvania v. Grand Union Ins. Co.*, [1990] LLOYD'S L. REP. 208 (Hong Kong); *American Marine Ins. Group v. Neptune Ins. Co.*, 775 F. Supp. 703, 708-09 (S.D.N.Y. 1991) *aff'd*, 961 F.2d 372 (2d Cir. 1992); *see also* *United States v. Brennan*, 938 F. Supp. 1111, 1123 (E.D.N.Y. 1996) (mail fraud conviction); *cf. Kaiser Found. Hosp. v. North Star Reinsurance Corp.*, 153 Cal. Rptr. 678 (Cal. App. 1979); *Span, Inc. v. Associated Int'l Ins. Co.*, 277 Cal. Rptr. 828 (Cal. App. 1991); *Hartford Acc. & Indem. Co. v. Michigan Mut. Ins. Co.*, 463 N.E. 2d 608 (N.Y. 1984).

create a dynamic where the party most hawkish on a particular issue tends to drive the other parties towards its position. The phenomenon often intensifies as the number of insurers increases as no one insurer is a hawk on every issue, but the group as a whole may include members with individual positions that taken together are hawkish on a number of the significant issues. Multilateral negotiations can also become bogged down where one or more of the parties are "holdouts" about some matter, when the others are more or less prepared to reach final agreement.

A bilateral negotiation—or a series of concurrent or *seriatim* bilateral negotiations—avoids the lowest-common-denominator and holdout problems and may be advantageous to the policyholder if only because individual negotiation provides the policyholder with baselines for comparison as the policyholder goes from insurer to insurer. Each individual settlement indicates what is possible given the facts, thus providing an important counterpoint to subsequent insurers' effort to take certain issues or approaches off the table entirely. In this model, the insured uses each individual settlement as a building block to achieving a global resolution.

As a practical matter, the policyholder is likely to embrace both approaches: multilateral and bilateral. It is well-nigh impossible to get all one's insurers to the table simultaneously or—perhaps more accurately—to keep them all at the table simultaneously. A settlement, even if conceived as a comprehensive, multilateral negotiation, is more likely than not to be only partial, with some insurers refusing to engage in meaningful settlement dialogue.

Even when the insured negotiates with a subset of its carriers, such as with all or most of the primary carriers, the insured should consider involving to some degree absent carriers in the negotiations, at least with respect to those issues where the proposed settlement will impact the absent carriers' obligations; in other words, where the absent carriers' obligations to the insured are dependent in part on the resolution with the settling carriers, the insured may wish to seek agreement, or at least acquiescence, to the methodologies being employed in the main settlement. Thus, if the insured and the primaries are settling premised on the particular claim situation being considered to be one occurrence, the insured may want the excess carriers to sign off on that assumption, rather than face later litigating or disputing with the excess carriers whether there were multiple occurrences (that would have the result, subject to the applicability of aggregate limits, of further deferring the excess carriers' obligations to perform). A similar primary/excess split occurs with respect to the allocation of costs to defense versus indemnity buckets. Though the ideal result might be to have the absent carriers agree to the particular methodological assumption, the insured should at least try to put the excess carrier in the position of being estopped from taking a different position.

On the question of bilateral versus multilateral negotiations more generally, it is worth noting that, with respect to London market coverage, there will likely be a coalition of interests on the insurer side, representing, among others, the Lloyd's of London interests and interests in the London "companies" market outside of Lloyd's that may have underwritten part of the risk. As part of the

Lloyd's Reconstruction and Renewal effort, a runoff reinsurer EQUITAS was formed to handle virtually all pre-1993 Lloyd's exposure; as a result, the pre-1993 Lloyd's interests now are being represented by the EQUITAS Claim Unit. Prior to EQUITAS, negotiations would take place with the "leaders" on the slip, who would in turn try to sign up the "following" market, which they usually were able to do; however, some types of claims, such as environmental and asbestos, were handled in a more centralized fashion by Lloyd's even before the establishment of EQUITAS. The London companies have always been separately represented from the Lloyd's qua Lloyd's interests, and that practice continues today. As with Lloyd's, there has been increasing centralization of claims responsibility on the companies' side, which facilitates and streamlines the negotiations to some degree. As a practical matter, most negotiations with the London market will take place jointly or separately with one representative of Lloyd's and one representative of the London companies market, each having some authority with respect to their respective constituencies.

B. Interim and Final Agreements

Final agreements resolve the parties' dispute, and a final agreement in effect substitutes for the insurance policy as applied to the particular matter. An interim agreement, in contrast, resolves the matter partially, i.e., in terms of governing time period, dollars, issues, or the like. Whether the agreement is final or not, the parties also must decide what type of settlement they want—a "buyout" or a coverage-in-place arrangement.

The overwhelming uncertainties that imbue complex coverage cases may as a practical matter preclude the sides from achieving finality, though some more limited arrangement may be sensible or appropriate. An agreement can be "interim" as marked by its time period. Thus, an agreement among one or more insurers may involve payment of all past costs and a commitment for one year, automatically renewable, concerning payment of future costs. Alternately, an interim agreement may impose dollar caps instead of time limits, so that the agreement automatically terminates once a level of payout is reached.

An interim agreement stabilizes the relationship among the policyholder and its carriers. Often an interim agreement will avoid the need for litigation or suspend, narrow, or defer existing litigation. An interim agreement permits the parties to build trust as they work together during its course.²³ An interim agreement also permits the parties to defer resolution of divisive issues. As an example, the parties may establish procedures to resolve difficult questions, such as which defense costs are to be covered, via arbitration or other alternative dispute resolution mechanisms.

23. During its term, an interim agreement should specify how the insured is to comply with its obligations under the policy, such as providing notice and the like. See generally Marc Mayerson, *Perfecting and Pursuing Liability Insurance Coverage: A Primer for Policyholders on Complying with Notice Obligations*, 32 TORT & INS. L.J. 1002 (1997). The agreement should provide that the performance pursuant to the settlement substitutes for and discharges the obligations of the insured under the policy.

This deferral mechanism thus permits the parties to reach agreement without resolving particularly divisive issues, thereby bracketing the scope of the ongoing dispute.²⁴ Of course, an interim agreement may form the stepping stone for a final resolution.

In addition and often related to the question whether the settlement will be an interim or final one, the parties need to decide whether the settlement will take the form of a one-time payment by the insurer(s) or whether the settlement will call for ongoing relations between the insurer(s) and the policyholder in the management of the particular claim scenario. For ongoing matters, liquidating the claim in a lump sum settlement (usually referred to as a "buyout") results in the possibility that the insured will have guessed wrong about the size of its ultimate payout and thus may settle for too little. The opposite can happen too: the carrier may guess that the ultimate payout will be worse than it turns out to be. In a buyout the insured achieves the certainty provided by receiving cash and avoids any risk of insolvency on the part of the insurer; the carrier benefits by capping and liquidating its coverage obligation.²⁵

In a coverage-in-place arrangement, the insurer or insurers typically agree to make some lump sum payment for costs or losses incurred in the past and commit to fund at least a portion of the future losses. Under a coverage-in-place arrangement, the insured and the insurers continue to work together concerning the subject matter of their dispute.

In any coverage-in-place arrangement in which there are third-party claims against the insured that remain to be resolved at the time of settlement, the parties should reach agreement on control of claims handling, the selection and compensation rate of counsel and experts, processes by which the party not controlling the claims handling can object to a settlement or be deemed to acquiesce, and a process for resolving disputes arising in the course of the coverage-in-place arrangement. Depending on the nature of the anticipated disputes, the parties may agree to some form of alternate dispute resolution.²⁶

Finally, due to the complexity of the issues, whether the settlement is final or interim, a buyout or a coverage-in-place arrangement, a bilateral or multilateral negotiation, the process of negotiating and documenting the agreement is typically arduous.

24. An interim agreement can include irrevocable waivers by either side; a policyholder may waive bad faith claims, for example, and the insurer may waive certain coverage defenses, such as notice.

25. All is not lost if an insurer with continuing obligations becomes insolvent. There is an elaborate state-by-state system governing the operation, rehabilitation, or liquidation of insurance companies admitted to do business in particular states. There are quasi-bankruptcy proceedings, both domestic and international, as well as state-guaranty funds, that the insured can look to for recovery. See generally Francine Semaya and Lenore Marema, *An Overview of the State Insurance Receivership System*, 27 THE BRIEF 12 (Fall 1997).

26. Where the parties are operating under a mandatory interim agreement, the parties may wish to agree that all disputes that would otherwise be submitted to ADR under the agreement be aggregated until such time that the balance of the dollars in question reaches a specified level of materiality.

V. ELEMENTS AND PROVISIONS IN COMPLEX COVERAGE SETTLEMENTS

The previous sections highlighted some background and structural issues that influence the parties negotiating a resolution of complex insurance coverage disputes. The focus of this section is more microscopic. Discussed are the particular terms and elements that are addressed or could or should be addressed in the settlement negotiations and ultimately in the settlement document.

A. *Scope of the Agreement*

The parties naturally are required to determine what is to be contained and excluded in the agreement. Is the insured resolving a particular claim; a group of claims (if so, how is the group defined?); individual sites or locations; an entire hazard; a single type of claim within a hazard (such as all past and future environmental liability under the premises-operations hazard); or the policy as a whole (all hazards, aggregates or not)? It is probably a fair generalization to suggest that insurers want as broad a scope as practical and thus may prefer, for example, a complete buyout of a hazard.

B. *Defense Issues*

For liability policies, a number of defense issues crop up in the negotiations. Does the policy have any defense obligations? If so, does the obligation arise at the outset of the case (as is true generally with primary policies)? Does defense count against policy limits? Among the recurring issues is the determination of what constitutes a defense cost. Are remedial investigations and other environmental-contamination investigative costs treated as defense or indemnity costs?²⁷ Similarly, some carriers maintain that costs incurred in administrative-type proceedings are not covered by the defense obligation on the ground that such costs are not incurred in the context of a "suit" to which the duty to defend attaches.²⁸

Where the insured wants the carriers to make a "catch-up" payment for the past, the insurers will likely maintain that they will not pay costs incurred in the period before the claim notice was received, though the more recent "pre-tender" cases have rejected the insurers' position.²⁹ If there is a catch-up payment, the insured will demand interest, which some carriers (incorrectly) believe to be inappropriate where there is a good faith dispute.³⁰ When the settlement involves ongoing payments by the insurers, the parties should consider standards by which counsel

27. See Mayerson, *supra* note 6, at 1009-11.

28. *Id.* at 1008-09.

29. See *Sherwood Brands, Inc. v. Hartford Acc. & Indem. Co.*, 698 A.2d 1078 (Md. 1997); *TPLC, Inc. v. United Nat'l Ins. Co.*, 44 F.3d 1484, 1493 (10th Cir. 1995); cf. *Clarke v. Fidelity & Cas. Co.*, 285 N.Y.S.2d 503, 523 (Sup. Ct. 1967).

30. It is well established in contract cases that interest is not awarded as punishment but rather to compensate the nonbreaching party's making payment in lieu of the party that breached (here, the insurer).

are selected and paid, including their rates of compensation. On a related issue, the parties can reach agreement on the extent to which the costs of in-house resources of the insured will be reimbursed by the insurers, and any protocols (such as prior approval) necessary to ensure future payment by the insurers.³¹

C. Allocation Issues

As suggested above, there are a number of allocation issues for the parties to resolve in complex coverage disputes.

Some of the costs incurred by the insured addressing the particular problem may not be compensable under insurance policies or the insurers may dispute their compensability. In approaching settlement, therefore, the insured should identify the types of costs it has incurred and the likelihood of recovery in each category. Some categories of costs, however, may not be recoverable at all, and these amounts should or will be taken off the top of the potential insurance claim. For other costs, the question will be less clear, and the answer may depend on the circumstances leading to their incurrence.³² The recoverability of these costs therefore will themselves be part of the negotiation.

Related to the general question of covered versus uncovered costs is the categorization of covered costs, as appropriate, into defense and indemnity amounts.³³ There will likely be costs whose recoverability or categorization is somewhat ambiguous and thus subject to negotiation. Within indemnity costs, monies will need to be allocated to the particular hazard or hazards implicated (and thus to aggregate limits, if applicable). This will affect exhaustion of the policy, which the policyholder may or may not wish to occur depending on the nature of its other coverage and its other claims.³⁴ When multiple policies from an insurer are at issue—policies either across time or across layers—the parties may need to allocate amounts to particular policies.

These internal-to-the-policy allocation issues, though no doubt important, are generally secondary to the question of the allocation of the entirety of the insured's loss across its coverage program, an allocation that generates in the first instance the particular insurer's "fair share." As indicated above, this question is very complex and open-textured legally, and the parties will likely expend significant effort to resolve the manner by which the particular insurer's share is determined.

31. On the recoverability of in-house costs, see Mayerson, *supra* note 6, at 1006-07.

32. See generally Donald R. McMinn, *The Duty to Defend Following Buss and Domtar: Restrictions on Insurance Carriers' Ability to Avoid Defense Costs Through Allocation*, 11 MEALEY'S LITIG. REP.: INS. (Oct. 21, 1997).

33. See generally Mayerson, *supra* note 6, at 1009-11.

34. The insured may want the particular policies to become exhausted so it can tap overlying excess coverage. Similarly, the insured may have deductible obligations for one type of claim (or for one hazard), and thus the insured will want or not to allocate the loss in a particular manner because of the deductible.

D. Calculating the Settlement Amount

There is a fairly common methodology for determining the payment to be made by the insurance company in resolution of the policyholder's claim. To arrive at a figure, the parties first need to determine what might be called the policyholder's gross claim, that is, a calculation of the amount of money at issue, divided into past costs and projections of future costs.

In calculating the amount of costs, the insured should look at both hard and soft dollars. Insurers generally focus on hard dollars (out-of-pocket expenditures traceable to the insurance claim) but will and should pay for soft dollars when an adequate case can be made and adequate substantiation of the costs provided. Thus, in-house costs that were incurred in lieu of outside contractors (lawyers, engineers, and others) can be recovered if the insured can show that the incurred costs were attributable to defense or indemnity expenses and not for responsible business oversight of a matter, and the insured has a methodology for calculating these costs.³⁵ Whether the insured segments the past costs, both hard and soft dollars, precisely along the lines of cost categories in dispute is a practical and tactical question.

As to future costs, the insured and, indeed, the parties have a number of options. First, the parties can elect not to resolve future costs. Second, the insured could provide an estimate of its future exposure with whatever backup or documentation the insured possesses.³⁶ Third, one of the parties or the parties jointly could retain a consultant to help quantify the uncertain future exposure. Such analyses generally are predicated on a probabilistic model in which a total is calculated by summing the probability of each particular outcome multiplied by its associated dollars, or such factors as the anticipated rate of claims, defense-to-indemnity ratios, settlement values, and demographics of the potential plaintiff population.³⁷

In addition to quantifying the future costs, if the parties intend that a lump sum payment will extinguish the future liability, they need to determine the present value of these future costs. This requires an assessment of the number of years over which the ultimate payout will occur, the rate of that payout per annum, and an appropriate discount rate (usually linked in part to the policyholder's cost of capital and anticipated interest rate fluctuation over the period). A present-value analysis comes into play as well when one is settling a matter within an aggregate limit, such as for the products hazard. In such circumstance, once the question of coverage *vel non* has been determined, where the size of the policyholder's liability is sufficiently large, it can become clear that the policyholder will present claims

35. See generally Mayerson, *supra* note 6, at 1006-07.

36. Of course, in making estimates of its future expense, the insured need be mindful of its past and future disclosures on its financial statements.

37. See generally, FREDERICK DUNBART, DENISE MARTIN, AND PHOEBUS DHRYMES, ESTIMATING FUTURE CLAIMS: CASE STUDIES FROM MASS TORT AND PRODUCT LIABILITY LITIGATION (1996).

through the course of time that will exhaust the applicable aggregate. In such event, the policyholder may accept a lump sum payment that represents the present value of the coverage remaining in the applicable aggregate.³⁸

Having established the range of dollars at issue, a natural part of the negotiation is the application of litigation-risk discounts based on the state of the law or the facts, or both. Usually, this is an implicit process in which each party weighs its assessments privately, though in the first few volleys of the settlement shuttlecock, one or the other party may express a rationale to justify the particular offer. The parties can also utilize the litigation-discount methodology as the means of their settlement; the parties can elect not to swap bottom-line numbers but instead agree upon a generative methodology, based on negotiating the particular elements of the equation.

A final issue that drives the selection of a number is the extent to which the policy or policies in question provide for the payment of deductibles or retrospective premiums (retros). Whenever the allocation methodology or methodologies assesses shares to a number of policies across time, the insurers will no doubt contend that the policyholder pay the full value of any deductible or retro among the triggered policies. Such a result, however, may allocate a significant portion of the loss to the insured, one that is disproportionate to the relative risk assumption engaged in by the insured and the insurance companies in the first place.

For example, assume that the primary policies each provide \$1 million in policy limits, subject to a \$100,000 deductible, and five consecutive policies are triggered. Under the typical carrier view, the insured is obligated to pay the first \$500,000 of loss representing its cumulative deductible obligation. As a practical matter, the insurer has hiked the buffer between it and the insured's loss five times. The stacking of the deductibles across the bottom of a coverage program results in the insured's absorption of loss greater than what the insured apparently believed would be the proper loss-sensitive threshold and on which the premium was calculated. Inasmuch as the deductible amount is set on an annual basis, a company anticipating exposure for the first \$100,000 of loss is not going to like paying the first \$500,000. Obviously, if the total loss is less than the cumulated deductibles and if the insured is required to pay the deductibles under all triggered policies, the insured receives no insurance recovery.

One way of addressing this asymmetry is to pro rate the deductibles in some fashion. For example, a relative risk-assumption ratio can be established under which loss can be allocated to both the insurer and the policyholder based on their relative risk exposures. In the above example, the insured can be said to bear 10 percent of the loss per annum (\$100,000/\$1,000,000), and if the settlement methodology allocates particular dollars to particular policies, 10 percent of that amount can be allocated to represent the insured's deductible contribution. A

38. The parties may agree also on the postsettlement rate of exhaustion of the aggregate limit over time.

percentage approach avoids the cumulation of dollar amounts across the bottom while preserving the essence of the risk-assumption deal represented by the insurance policies. Other ways of addressing the problem include swapping the number of deductibles for the number of policy limits available or simply capping the insured's deductible obligation.

For policies containing retrospective premiums instead of deductibles, the issues are similar.³⁹ Retrospectively rated premiums usually are calculated by taking a figure called the "incurred loss" and multiplying that figure by various factors, generally a tax multiplier and a loss-conversion factor (LCF). As with deductibles, the insured should be concerned about the number or size of the incurred-loss input within a single policy and across all the policies. There are two other issues unique to retros that merit discussion at the negotiating table. First, the incurred loss input often is determined by both amounts paid and amounts set as reserves by the insurer for claims that have yet to be paid. Where reserves are figured into the retro, the insurance company bills the insured immediately, long before the third-party claimant receives any money from the insurer. In the context of settlement, depending on who bears the cash-flow burden and the size of the individual claims, the policyholder should request that the insurer not charge retros on reserved, as opposed to paid, claims. Second, most retro calculations include an LCF charge. The LCF is intended in theory to cover in whole or in part the insurer's overhead costs in handling the claims against the insured. If, because of the insurer's prior breach of contract or as a consequence of a settlement, the insured bears the administrative overhead of claims handling, the justification for the LCF charge is removed.

E. Release

The "release" is usually the section of the settlement document that specifies what claims the policyholder is relinquishing. Typically, settlements take the form of releases of individual cases or sites, or releases of entire categories of past and future loss, such as all bodily injury claims from use of a particular product (or even all products); all environmental claims; or all property damage.

Usually the policyholder will be called upon to waive all its contractual claims for the underlying matter being resolved.⁴⁰ If the insured is providing fairly general releases, the insured should be sure that language preserving other coverage is clear and, in the event of dispute, supercedes the general release language. For example, if all products liability coverage is going to be released, does the insured also intend

39. One should also be aware that deductible and retro issues typically involve parts of the insurance company different from the claims or law departments, and within many insurers, functional responsibility resides in the underwriting and collections departments. The involvement of these additional groups within the insurance company may alter the settlement dynamics or politics.

40. A related issue is on whose behalf the policyholder is releasing coverage. The settling policyholder need consider whether it has the authority to release claims by all insureds (named, additional, etc.) under the policy or confine the release accordingly. See generally *In re Forty-Eight Insulations, Inc.*, 133 B.R. 973 (Bankr. N.D. Ill. 1991).

to give up the similar hazard known as the "completed operations" hazard? If not, specific language may be needed to preserve completed-operations coverage because both products liability and completed-operations claims typically are subject to a single combined aggregate. Where the insured agrees to an environmental buyout, does the agreement include product liability claims where the insured's product is a chemical, even where the chemical product is not defective? Is the insured releasing general liability coverage? What about advertising or personal injury coverage that is usually separate but packaged together with the general liability coverage? Are both bodily injury and property damage being released, or only one? Is the insured releasing the settling insurer from any policies it issued, i.e., liability, property, directors' and officers', foreign, workers' compensation/employers' liability, and so forth?⁴¹ Is the insured releasing all policies issued by a related family of insurance companies, even those not present at the negotiating table? Each settlement resolves these issues differently. The insurer also typically will seek a release of noncontractual claims, such as for bad faith. If the insurer agrees to make payment, it typically wants to be sure that a tort lawsuit from the insured is not imminent.

Although the focus of the release discussion will be on what the policyholder is giving up, the policyholder should insist that the releases be bilateral. The carrier's release of the insured can include (1) comparative or reverse bad faith claims (that is, claims by the insurer that the insured breached the duty of good faith and fair dealing); (2) retro or deductible obligations; or (3) any and all claims of whatever nature as of the date of the agreement. In interim agreements, the policyholder should seek to obtain final releases of as many coverage defenses as possible. Defenses that should be considered candidates for a final release in an otherwise "interim" agreement include lack of notice, breach of cooperation, and fraudulent nondisclosure. The timing of the release must also be considered. Is it effective when the agreement is signed, thereby limiting the insured's remedies to breach of the settlement agreement, or where the insurer is to provide a series of payments over time, is the release effective only upon the receipt of the final payment?

F. Waivers Against Third Parties

The parties should address how the settlement affects, limits, transfers, or extinguishes rights as against third parties that were possessed by each of the settling parties independent of the settlement. For example, the policyholder may have contribution or equitable indemnification claims against cotortfeasors or other potentially responsible parties and may have direct contractual claims against other insurance companies. These claims can be waived, assigned, or preserved.

The settling insurer may have claims for contribution or equitable indemnification against other insurance companies in an allocation/other-insurance-clause fight be-

⁴¹ Are policies issued to other companies as to which the policyholder was added as an additional insured included?

tween and among the carriers that paid the insured. These claims can be transferred in the settlement agreement via an assignment to the insured of the choses in action possessed by the settling insurer relative to the settlement. An assignment vests in the insured control over those claims forming the basis of an independent action initiated by the settling insurer. Those choses in action could become valuable, for example, based on an unforeseen change in allocation law taking place after the policyholder settles or recovers from the other carrier(s).⁴² Alternatively, the insurer can waive its rights to claim against others either on a wholesale basis (waiving as against the world, including co-tortfeasors against whom the insurer might have a subrogation claim) or a retail one (waiving only as respects those carriers that provide a reciprocal waiver or only as against named entities).

In sum, the parties need to think about and document how the settlement affects claims possessed against third parties and whether as part of the consideration for the settlement those claims can or should be transferred or extinguished in whole or in part.

G. Indemnity

As part of the settlement, the insurers will typically seek a "complete indemnity" from the policyholder. Like "the usual stipulations" at a deposition, the phrase "complete indemnity" often is invoked as a talisman, yet it is important for the parties to determine exactly what they mean and negotiate over whether any indemnity will be provided and, if so, its precise contours and limitations.

Insurers typically seek an indemnification provision that protects them from the costs and expense of future claims against them within the scope of the release being provided by the insured. Of course, had the insurer simply performed, it would not be entitled to and would not have occasion to ask for an indemnity, inasmuch as seeking such a provision would be tantamount to renegotiating the parties' insurance contract at the point of claim. Yet, against the backdrop of coverage litigation, insurers typically seek such provisions. From the insurers' perspective, indemnities heighten the likelihood that the insurers' negotiated payment to its insured, usually in an amount less than the full applicable limit, will be the maximum the settling insurer will pay. For example, the settling insurer does not want to pay the insured a sum certain only to later be subject to a claim of contribution from another insurance company, which has made a subsequent payment to the insured and which argues the settlement payment by the first insurer was less than the first insurer's fair share of the loss, with the result that the subsequent-paying insurance company successfully recovers from the earlier settler

42. The insurer may also keep the choses but agree to pay to the insured any proceeds obtained by their pursuit. See generally *Mitchell, Silberberg & Knupp v. Yosemite Ins. Co.*, 67 Cal. Rptr. 2d 906 (Cal. App. 1997) (permitting excess insurer that acknowledged full coverage to bring contribution action against other insurers even where doing so would, if successful, deplete the aggregate limits in the other insurers' policies to the detriment of the insured).

some portion of its own payment to the insured.⁴³ From the policyholder's perspective, however, such indemnities do represent point-of-claim renegotiation of the policy and place at risk whatever proceeds the insured has collected from the settling insurer. As a result, insureds will often resist providing such indemnities, and settlements can fall apart over this issue.

To evaluate and negotiate an indemnity, it is important first to identify the potential plaintiffs that could bring a subsequent action against the settling insurer. There are tort claimants that in some states may bring direct actions against the insurers for coverage or bad faith,⁴⁴ other insurers claiming contribution or indemnity or bad faith,⁴⁵ and other insureds under the same policy seeking coverage or claiming bad faith.⁴⁶ It is important for the parties, and the insured in particular, to consider these various claimants when structuring an indemnity, and what may or may not stimulate such a claim.

There are a number of ways of structuring the indemnity, and each negotiation will yield a uniquely tailored result. There are essentially three approaches to consider. First, the parties may agree to dollar caps or collars on the indemnity, including

43. Some courts have refused to permit such claims to be brought mainly on the ground that equity, which largely governs such noncontractual intercarrier claims, need not intervene to reallocate the loss where the second insurer in fact is liable to the insured for the amount paid and in view of the strong public policy favoring settlements. See *Asbestos Ins. Coverage Cases*, Jud. Council Coord. Proc. No. 1072, Statement of Decision Concerning Phase IV Issues at 42-56 (Sup. Ct. City and Cty. San Francisco Jan. 24, 1990), reprinted in *MEALEY'S LITIG. REP.: INS. SPEC. SUPP.* (Feb. 1990); see also *E.R. Squibb & Sons, Inc. v. Accident and Cas. Ins. Co.*, 1997 U.S. Dist. LEXIS 6674 (S.D.N.Y. 1997) (holding that monies paid pursuant to settlement do not constitute "other insurance").

44. In direct action states the tort plaintiff may simply skip suing the insured/tortfeasor and sue the insurer directly seeking to establish concurrently the insured's liability and the extent of coverage. Insurance companies may owe duties to tort plaintiffs not to act in bad faith toward them and to resolve their claims promptly and fairly, obligations that may be based on a number of applicable statutory schemes.

45. As indicated above, insurers may bring actions against one another seeking to reallocate the loss among triggered policies on the ground that one policy, though legally obligated to pay relative to the insured, is bearing a disproportionate burden of the loss compared with other policies that also have legal obligations to pay. These contribution and indemnity claims are pursued at equity, usually with reference to other-insurance clauses. In addition, though clearly a minority, and quite likely aberrational, position, some courts have held that primary insurers owe duties directly to excess insurers, and thus the excess insurer may be able to maintain an action for direct breach of those duties as against the primary insurer. Compare *Twin City Fire Ins. Co. v. Country Mut. Ins. Co.*, 23 F.3d 1175, 1180-81 (7th Cir. 1994) (Posner, J.) with *Russo by Russo v. Rochford*, 472 N.Y.S.2d 954 (Sup. Ct. 1984). Note that in most circumstances, where an excess carrier brings an action against an underlying insurer it does so in equitable subrogation to the rights of the insured; because the settlement with the underlying insured will release the insured's rights, the insured no longer will possess a claim as to which the excess carrier could be equitably subrogated.

46. Other insureds may bring actions seeking coverage for wholly unrelated matters, for matters within the scope of the release, for matters within the same per-occurrence limit, or within the same aggregate limit. In the absence of policy language addressing the issue, it appears that one insured cannot accelerate exhaustion of policy limits through a consensual settlement to the detriment of another insured, and insurers may face claims of bad faith if they unreasonably pay one insured to the detriment of another insured with mature claims for coverage. See generally *Shell Oil Co. v. National Union Fire Ins. Co.*, 52 Cal. Rptr. 2d 580 (Cal. App. 1996); *Forty-Eight Insulations*, 133 B.R. 973.

deductible-like provisions in which the insurer bears the first dollars and the insured indemnifies thereafter. As with deductibles generally, the use of these provisions align the interests of the insurers with its indemnitor (in this case, its policyholder). The parties can agree on upper limits that can be any figure below, above, or equal to the settlement amount. A zeroing-out provision, in which the cap on the indemnity is equal to the settlement payment, is a rational maximum for the insured as it ensures that the insured is ultimately no worse off from having settled with the particular carrier than not having settled at all. Second, the parties may impose time limits on the indemnities and thus agree to a sunset provision whereby the indemnity expires after a fixed period. Third, and perhaps most important, the parties may agree to carve out from the indemnity various matters such as potential claimants and potential claims. The principal cleavage is between coverage claims and bad-faith/statutory claims. Furthermore, to the extent that the insurer owes direct duties to others, whether tort claimants or other insurers, and in particular, involving conduct over which the insured has no control, the insured may want to resist indemnifying the insurer.⁴⁷ The indemnity can also be structured to exclude certain kinds of damages, such as punitive or statutory damages.

In addition to the scope of the obligation to indemnify the insurer, the parties may negotiate over whether or the extent to which the insured will pay for the defense or undertake the defense of the settling insurer.⁴⁸ Here, again, the same issues of caps, collars, and carve-outs arise. Usually, major issues focus on the selection and control of counsel to represent the insurer (assuming the insured has agreed to defend). Does the insurer select counsel? With or without the policyholder's consent? Does the policyholder/indemnitor have an absolute right to settle claims instead of litigating? In defending the integrity of the settlement or resisting claims predicated upon the coverage afforded by the policy, who controls the interpretation of the policy and in whose name?⁴⁹ Moreover, as part of or in addition to its obligation to defend, does the insured have the obligation to pursue counterclaims and more generally pay for "offense" costs? Is payment of offense costs at the election of the insured, such as where the insurer has not waived or assigned to the insured its own choses in action on a wholesale basis to the insured,

47. Indemnities granted by policyholders should always carve out claims against the settling insurer brought by its own reinsurers (that have presettlement contracts with the insurer), unless some form of facultative reinsurance is involved and the policyholder is dealing with the reinsurer that provides a release, in which case, claims by retrocessionaires of the reinsurer should be carved out. Likewise, the insured (as indemnitor) should not be responsible for any claims by the insurance company's shareholders.

48. Notice-related questions are also most pointed in the defense context. Does late notice by the insurer void the defense and indemnity obligations? Does the insured have the obligation to pay for prenotice defense costs, or at least such costs incurred more than, say, thirty days before notice?

49. Both parties, however, should have an independent obligation to support the settlement and provide witnesses and the like to establish that the settlement represents a good-faith compromise of their respective positions or litigation outcomes.

and, if so, does the insured receive all or part of the proceeds as the *quid pro quo* for its payment of the offense costs?⁵⁰

H. Confidentiality Provisions

For the reasons explained in section III concerning the precedential effects of settlements, insurers especially are likely to insist on confidentiality provisions, though such provisions may also be in the interest of the insured, particularly if it is engaged in litigation with its other carriers.⁵¹ Assuming that such provisions will be respected, the parties need to address to whom the agreement may be disclosed and under what circumstances or conditions.

Generally, the fact of settlement is not itself confidential. Often a public filing is necessary where the parties have pending litigation. Of particular concern to the parties are the amount and the key terms of the agreement. Even so, some entities likely require access to the agreement for the needs of one party where the disclosure likely will not adversely affect the other party. Examples of such entities are auditors, regulators, and tax authorities. For insurers, their reinsurers typically have a right to inspect their claim files, and the insurer may need to offer proof of the settlement and its surrounding circumstances to perfect its own claim for reinsurance recovery. Disclosure thus may be necessary, though because reinsurers often are also direct writers (or have affiliates that directly write coverage in commercial markets), some form of pledge of confidentiality usually is requisite.

A more complex issue is presented concerning proof of exhaustion of per-occurrence limits or aggregate limits. Though settlement agreements routinely include a provision disaffirming that the settlement represents an interpretation of the insurance policy, insurers just as routinely allocate the settlement payment to particular policies (to facilitate reinsurance recovery and for other reasons). The policyholder has an interest in being able to prove the exhaustion of applicable policy limits where it seeks to collect from other insurers. Alternately, a policyholder may want to demonstrate to a second primary carrier that the first paid an appropriate portion for a particular matter or class of matters. Though neither the insured nor the insurer has an interest in providing the settlement agreement to other carriers in the first instance, the insured needs some mechanism by which it can prove to the other insurers what amounts the settling insurer paid to the extent

50. As is generally true in the subrogation context, the proceeds of such offense claims can be first applied to the costs of pursuing the claim before being divided between the parties. A related issue is whether the insurer has a duty to apprise the policyholder of the existence of such offense claims and how such a duty can be policed.

51. Somewhat surprisingly, the courts are divided on the discoverability of settlement agreements in this context. Though most courts appear to respect their confidentiality, *see UMC/Stamford, Inc. v. Allianz Underwriters Ins. Co.*, 647 A.2d 182, 190-91 (N.J. Super. Law Div. 1994); *Alco Indus. Inc. v. Liberty Mut. Ins. Co.*, No. L-905376, slip op. (N.J. Super., Apr. 18, 1996), *reprinted in* 10 *MEALEY'S LITIG. REP.: INS.* (June 11, 1996), other courts have not, largely on the ground that overlying carriers need to confirm that the underlying coverage has been properly exhausted. *See Home Ins. Co. v. Superior Court*, 54 Cal. Rptr. 2d 292 (Cal. App. 1996).

that the other insurers' obligations are dependent in part on the performance of the settling insurer. A copy of the settlement agreement may suffice, but it behooves the insured to establish an obligation on the part of the settling insurer to cooperate with the insured for the purpose of permitting the insured to access other coverage.

I. Recoupment/Reallocation

In interim agreements, the parties will often defer a significant dispute in the interest of establishing a *modus vivendi*. In such circumstances, however, the parties (or the recalcitrant party, as the case may be) may be reluctant to make an irrevocable commitment to a coverage methodology or even as to a coverage amount. Accordingly, the parties will provide some mechanism for the reallocation or recoupment of the payment by the insurer if certain events occur. Such an event can be keyed to the decision in a pending case before the state's highest court, for example, or a final decision in the parties' own coverage case. The parties will also need to consider whether their settlement agreement is intended to expand, restrict, or be agnostic as to any ability of the insurer otherwise to obtain recoupment and reallocation.⁵²

VI. CONCLUSION

It is truly the rarest of complex coverage cases that goes all the way to coercive execution of a judgment. Whether settlement occurs early or late or sometime in between, the parties and their lawyers will face the issues and difficulties addressed here. Settlement of these cases requires the simultaneous consideration of a host of difficult and often contentious issues, and it is only through sensitive and open dialogue among the parties about the issues, their interests, and their concerns can a settlement be reached and a settlement document hammered out.

52. On the issue of recoupment of defense costs, see generally McMinn, *supra* note 32.