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We inadvertently misspelled the name of Christopher A. Scifres, who was one of the contributors to “Recent Developments in Fidelity & Surety Law” in the 2017 survey issue (Volume 52-2). The editors regret the error.
RECURRING DISCOVERY ISSUES IN INSURANCE BAD FAITH LITIGATION

Douglas R. Richmond

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I. INTRODUCTION

It is widely known that the law implies a duty of good faith and fair dealing in all insurance policies, and that an insurer’s breach of this duty is generally actionable in tort. These are opposite sides of the same coin; an insurer’s duty to act in good faith and its liability for bad faith refer to the same obligation.1

Unreasonable conduct by an insurer is the essence of bad faith,2 but the standard for, or meaning of, unreasonableness in this context varies by jurisdiction. For an insurer to be found liable for bad faith in some jurisdictions, a plaintiff must establish that the insurer engaged in dishonest, malicious, or oppressive conduct in order to avoid an obligation to the insured.3 In other jurisdictions, a plaintiff must prove only that the insurer acted negligently in handling a claim to prevail in a bad faith case.4 Regardless of the standard to be applied, however, it is unquestionably true that bad faith liability is a significant economic or financial threat to insurers. Insurers that are found to have committed bad faith face po-

tentially significant compensatory damages, and, depending on the facts, may be found liable for punitive damages. 5

Given the stakes for everyone concerned, bad faith litigation is often contentious and it is frequently characterized by discovery disputes. To be sure, many civil cases spawn discovery disputes, and high stakes litigation of any sort is particularly likely to feature discovery battles. Insurance bad faith litigation, however, is characterized by a few recurring discovery issues. This Article examines those issues, beginning in Part II with the dis-

5. See, e.g., Jeff Sistrunk, Nationwide Stuck With $8M Bad Faith Award, 11th Circ. Says, LAW360 (July 10, 2017), https://www.law360.com/insurance/articles/942231/nationwide-stuck-with-8m-bad-faith-award-11th-circ-says (discussing the 11th Circuit’s succinct affirmation of an $8 million third-party bad faith award); Rick Archer, 9th Circ. Affirms $14M All-state Bad Faith Verdict, LAW360 (June 16, 2007), https://www.law360.com/insurance/articles/935290/9th-circ-affirms-14m-allstate-bad-faith-verdict (describing an unpublished opinion in which the court affirmed a $14 million bad faith judgment against Allstate for failing to settle the underlying motorcycle accident case within its policy limits); Michelle Cassady, Lloyd’s Hit With $41.6M Verdict In Offshore Rig Damage Row, LAW360 (May 15, 2017), https://www.law360.com/insurance/articles/923549/lloyd-s-hit-with-41-6m-verdict-in-offshore-rig-damage-row (reporting that a Texas jury awarded an insured $10.9 million on six findings of bad faith in connection with claims for hurricane damage to an oil drilling rig, and $27.3 million more after finding that five of the six instances of bad faith were knowing); Dan Packel, MSA Awarded $47M In Punitives Over Insurer’s Bad Faith, LAW360 (Feb. 15, 2017), https://www.law360.com/article/892593/print?section=insurance (describing a bad faith verdict in Allegheny County, Pennsylvania against North River Insurance Co. that included $30 million in punitive damages, $11.8 million in attorneys’ fees, and $5.1 million in pre-judgment interest); Michelle Cassady, Texas Jury Slaps USAA With $1.8M Verdict In Hailstorm Claim, LAW360 (Feb. 13, 2017), https://www.law360.com/articles/891308/print?section=insurance (noting a verdict in favor of a homeowner in a bad faith case arising out of USAA’s alleged under-valuation of a $76,500 hail damage claim); Sue Resinger, AIG Sub-sidaries Get Slammed With Punitives Following Contentious Trial, CORP. CONS. (Nov. 16, 2015), http://www.corpcounsel.com/printfriendly/id=1202742472251 (reporting that a California jury “slammed three AIG insurance subsidiaries with $55 million in breach of contract and bad faith damages—including $46 million in punitives”); P.J. D’Annunzio, $22 Mil. Settlement Reached in Allstate Bad-Faith Case, LEGAL INTELLIGENCER (Sept. 30, 2014), http://www.thelegalintelligencer.com/id=1202671713602/22-Mil-Settlement-Reached-in-Allstate-BadFaith-Case (reporting a $22 million settlement following a $19.1 million verdict for the insurer’s bad faith failure to settle within a $250,000 policy limit); Justin Rebello, Nevada Man Wins $60 Million in Bad Faith Retrial, LAW. USA, Jan. 19, 2009, at 9 (describing a $60 million first-party bad faith verdict against a disability insurer that the trial court reduced to $50 million); Charles Emeric, Allstate Appeals $16M Verdict, Questions Bad Faith Claims, MO. LAW. Wkly., Nov. 3, 2008, at 5 (reporting a $16 million bad faith verdict in Missouri and the insurer’s appeal); Laurie Mason, Insurer to Pay $20M in DUI Crash, BUCKS Cty. COURIER TIMES, June 29, 2007, available at http://www.phillyburbs.com/phdyn/news (reporting a $20 million bad faith verdict based on insurer’s refusal to settle within policy limits); $20 Million Allstate Ruling, CHL. TRIB., Oct. 14, 2006, § 2, at 2 (stating that an Indiana jury returned a $20 million bad faith verdict against Allstate, including $18 million in punitive damages); Natalie White, Insurer Held Liable for Refusing to Pay Claim for Lawyer’s Diabetes, LAW. USA, Apr. 24, 2006, at 10 (detailing a $4.7 million verdict in an Ohio first-party bad faith case); Insurer Told To Pay $36M For Not Honoring Policy, NAT’L J., Feb. 27, 2006, at 17 (reporting a Mississippi verdict in a first-party bad faith case); $55.2M Award to Firm Insurer Failed to Defend, NAT’L J., Dec. 26, 2005, at 19 (highlighting a Minnesota third-party bad faith verdict); Bad Faith Claim Nets $10 Million, MO. LAW. Wkly., Aug. 29, 2005, at 9 (noting a $10 million California third-party bad faith verdict).
covery of insurers’ claims manuals and guidelines. Part III discusses the discovery of insurance companies’ reserves, sometimes described as loss reserves, and related information. Part IV explores the discovery of insurers’ reinsurance agreements and their communications with reinsurers. Part V addresses the discovery of insurance company employees’ personnel files. Finally, Part VI analyzes plaintiffs’ attempted discovery of information concerning claims “similar” to theirs, other bad faith claims or complaints against the insurer, and other bad faith litigation involving the insurer.

Before exploring these areas, a brief summary of four related points is in order. First, this Article focuses primarily—although not exclusively—on the relevance of the types of information sought. Insurers may assert other valid case-specific discovery objections, such as particular requests being overly broad or unduly burdensome, or not being proportional to the needs of the case. Second, many of the bad faith cases in which discovery is contested are federal district court decisions. While federal district court decisions may be persuasive or influential, they are neither authoritative nor precedential. There are few state court appellate decisions on several key discovery issues. So, in many jurisdictions, insureds and insurers alike may advocate their positions unconstrained by precedent. The result overall is inconsistency and potential confusion. Third, and related to the second point, because state trial court decisions generally go unreported, it is difficult to know how those courts are resolving the types of disputes discussed here. Fourth, a court’s determination that information is discoverable does not mean that the court will allow the information to be admitted into evidence at trial. Evidence obtained in discovery may turn out to be irrelevant and therefore inadmissible at trial, may be excluded at trial because its probative value is outweighed by its unfairly


7. See, e.g., Moore v. GEICO Gen. Ins. Co., Case No. 8:13-cv-1569-T-24 AEP, 2016 WL 5719474, at *5–6 (M.D. Fla. Sept. 30, 2016) (excluding evidence at trial of GEICO’s claims manuals, code of conduct, and training materials as being irrelevant because GEICO structured its policies and procedures to exceed Florida law requirements); see also Dogra v. Liberty Mut. Fire Ins. Co., No. 2:14-cv-01841-GMN-GWF, 2015 WL 5086434, at *3 (D. Nev. Aug. 25, 2015) (“Given the broad scope of relevancy for purposes of discovery, this [c]ourt will follow those courts which hold that reserve information is relevant and discoverable. This does not mean, however, that reserve information will necessarily be admissible at trial. The insurer may be able to show that the reserves had no actual relationship to its determination of actual claim value and therefore should not be admitted into evidence.”).
II. DISCOVERY OF INSURANCE COMPANY CLAIMS MANUALS AND GUIDELINES

A. Overview

In an effort to ensure that their employees act reasonably in resolving claims, and with a goal of achieving consistency and reliability in the claims adjustment process, insurance companies often develop claims manuals and guidelines. In some instances, they may do so to satisfy state administrative regulations and unfair claims practices acts that require them to adopt and implement reasonable standards for the prompt investigation and settlement of claims under their policies.\(^9\) Insurance company claims manuals and guidelines may outline procedures and processes for verifying coverage, communicating with insureds, investigating losses, identifying potentially applicable insurance policies, identifying other parties who may share fault for an occurrence, assessing damages, communicating with claimants and their counsel, setting reserves, negotiating settlements, initiating fraud investigations, retaining defense and coverage counsel, and more. Sometimes insurers distribute “best practices” manuals that cover these topics. Regardless of how they are styled, insurance company claims manuals and guidelines often contain hortatory statements such as, “Our overriding goal is to do the right thing when handling a claim,” or “Remember, we are fiduciaries to our policyholders when handling claims.”\(^11\)


\(^9\) See Miller v. Kenny, 325 P.3d 278, 298 (Wash. Ct. App. 2014) (“As a general policy, it is preferable that loss reserves not be admitted into evidence, because when an insurer sets loss reserves it should be solely concerned with the purpose of ensuring the company’s financial stability and should not be tempted to ‘manipulate its reserves’ to be consistent with the insurer’s settlement position.” (quoting Stephen S. Ashley, Bad Faith Actions: Liability and Damages § 10.31 (1997))).

\(^10\) Absent specific language in a particular state statute or administrative regulation, there is no requirement that an insurance company’s standards for promptly investigating and settling claims under its policies be in writing. See, e.g., Cromer v. Bristol W. Ins. Grp., No. 63385, 2015 WL 4611934, at *1 (Nev. July 31, 2015) (“A Coast [National Insurance Co.] employee testified that Coast followed Nevada insurance regulations, and [the plaintiff] offers no support for his contention that [standards for promptly investigating and processing insurance claims] must be written.”).

It is easy to see how insurance company claims manuals and guidelines may play a critical role in bad faith litigation, and therefore why their discovery is contested as frequently and vigorously as any other issue. For example, a plaintiff may seek to discover an insurer’s claims manual in an effort to establish that the insurer did not adhere to its own procedures when resolving a claim and thereby acted unreasonably. Similarly, a plaintiff may allege that an insurer’s guidelines or procedures set a standard of care for handling claims, such that conduct falling below that standard establishes the insurer’s bad faith. If an insurer defends a first-party bad faith claim on the basis that its obligations to the insured were fairly debatable, the insured may try to use the insurer’s claims manual to establish that the insurer’s urged interpretation of the policy in litigation is inconsistent with its own understanding of its policy terms. At the very least, a plaintiff’s lawyer may invoke admonitions to claims professionals to “do the right thing,” or to conduct themselves as fiduciaries toward policyholders, to try to control or shame claims professionals during depositions, to impeach their testimony, or to try to create a genuine issue of material fact that will preclude summary judgment for the insurer.

Occasionally, insurers’ claims guidelines or manuals are alleged to encourage unfair practices. If these allegations are true, the claims manuals or guidelines can be damning evidence at trial. In Bonenberger v. Nationwide Mutual Insurance Co., for example, the trial court described Nationwide’s “overall philosophy” as expressed in its “Pennsylvania Best Claims Practice Manual” as encouraging unethical and unprofessional practices by adjusters. In affirming the judgment for the plaintiff, who alleged that Nationwide acted in bad faith by inadequately evaluating his injuries

12. See, e.g., Miel v. State Farm Mut. Auto. Ins. Co., 912 P.2d 1333, 1337 (Ariz. Ct. App. 1995) (“The articles [from a State Farm internal newsletter] were relevant because they addressed the company’s approved policies and procedures for handling such claims—policies and procedures which the claims representative admits she did not follow. The [claims] manual, like the articles, notes that the failure to keep an insured informed of settlement offers can constitute bad faith.”); Cont’l Ins. Co. v. Tollman-Hundley Hotels Corp., 636 N.Y.S.2d 319, 320 (App. Div. 1996) (noting that the trial court properly permitted claims handling instructions to be admitted into evidence “so that defendant could argue that plaintiff’s alleged departures from the instructions evinced a failure to act reasonably”).

13. See, e.g., Moore v. Am. United Life Ins. Co., 197 Cal. Rptr. 878, 896 (Ct. App. 1984) (discussing punitive damages and the insurer’s knowledge that its claims procedures misstated California law); Berg v. Nationwide Mut. Ins. Co., 44 A.3d 1164, 1177 (Pa. Super. Ct. 2012) (“The Bergs contend that Nationwide implemented a litigation strategy that called for aggressive tactics designed to deter the filing of small claims. . . . They further contend that Nationwide documented this litigation strategy in a claims processing manual (‘Best Claims Practices’), and that as a result, the trial court erred in refusing to permit testimony regarding the amounts paid by Nationwide to its attorneys in this case. . . . [W]e agree and conclude that on retrial the Bergs should be permitted . . . to introduce evidence regarding Nationwide’s alleged litigation strategy in an effort to establish bad faith conduct. . . .”).


15. Id. at 380.
and consequently discounting his underinsured motorists (UIM) claim, the appellate court concluded that several passages in the manual supported the trial court’s finding of bad faith. As the Bonenberger court explained:

We also find the [trial] court properly considered the contents of Nationwide’s Pennsylvania Best Claims Practice Manual. The [trial] court found that the manual was . . . used by Nationwide’s employees as their primary guide in evaluating, valuing and negotiating claims. The [trial] court further found that the employees involved in this particular matter utilized the procedures and guidelines of the manual. The court cited portions of the manual which set forth the company’s philosophy, which was to reduce the average claim payment to a level first consistent with then lower than major competitors, and to be a “defense-minded” carrier in the minds of the legal community. The court reference[d] the manual statements, which called for “aggressive use of IME’s,” attempts at catching claimants “off guard,” and assigning cases to defense counsel who fully follow the adjuster’s orders and who refrain from exercising independent judgment. . . . We agree with the trial court that this philosophy does not encourage reasonable case-by-case evaluation. The manual was relevant evidence and offers support for the court’s ultimate finding of bad faith.

Happily, the Bonenberger situation is the exception rather than the rule. In the usual case in which an insurer promulgates guidelines or establishes procedures that are intended to ensure reasonable claims handling practices, claims representatives’ deviation from those guidelines or procedures alone does not establish bad faith. Insurance company claims manuals and guidelines should not be held to establish standards of care or standards of conduct for bad faith purposes. Rather, an insurer’s liability for bad faith must be determined according to the law of the jurisdiction. More broadly, an insurer’s actions in response to a particular claim are a far better indicator of the company’s reasonableness than is its compliance with generalized standards or guidelines of variable application and importance.

Certainly, insurance company best practices standards or goals do not establish a measure for evaluating or assessing bad faith liability. In insur-

16. Id. at 381–82.
17. Id. (citation to the record omitted).
20. See MICHAEL R. NELSON ET AL., EXTRA-CONTRACTUAL LITIGATION AGAINST INSURERS § 8.02[2], at 8-6 (2009 & Supp. 2012) (stating that in comparison to an insurer’s claims practices and procedures, “[t]he insurer’s actions in response to a particular claim are a better indicator of an insurer’s liability for bad faith”).
ance as elsewhere, “best practices” are aspirational ideals; they do not constitute standards of care, and a failure to meet or to comply with them is no basis for imposing liability.21

B. Essential Concerns in the Discovery of Claims Manuals and Guidelines

Insurers often resist the discovery of claims guidelines and manuals on the basis that they are irrelevant given the facts of the case. There is case law support for the position that claims manuals and guidelines should not be discoverable on the basis that they are not relevant because the violation of standards or policies expressed in them “does not establish bad faith on the part of the [insurer] in handling [a] plaintiff’s loss.”22 But while a claims representative’s violation of her company’s guidelines or policies does not alone establish bad faith, a prohibition of related discovery appears to be a minority view. The obvious reason for this is the liberal scope of discovery in civil litigation.23 Under Rule 26(b)(1) of the Federal Rules of Civil Procedure, for example, a party may obtain discovery regarding any non-privileged matter that is relevant to another party’s claim or defense and proportional to the needs of the case.24 Relevance for discovery purposes is broader than the evidentiary relevance required for admissibility at trial.25 Indeed, Rule 26(b)(1) specifically states that information within the scope of discovery “need not be admissible in evi-


dence to be discoverable.” Under state rules of civil procedure analogous to earlier versions of Federal Rule 26, information need not be admissible at trial if the discovery request appears to be reasonably calculated to lead to the discovery of admissible evidence.

Not surprisingly, courts have regularly found that insurers’ claims manuals are relevant to plaintiffs’ bad faith claims and are thus discoverable. Some courts have held that insurers’ claims manuals or guidelines may also be relevant to policyholders’ breach of contract claims, although that position is nowhere near unanimous.


27. Although under both the current and prior versions of Federal Rule of Civil Procedure 26(b)(1) evidence need not be admissible at trial to be discoverable, it is important to remember that following the 2015 amendments to Rule 26(b)(1), the test for discovery is “whether evidence is ‘relevant to any party’s claim or defense,’ not whether it is ‘reasonably calculated to lead to admissible evidence.’” In re Bard IVC Filters Prods. Liab. Litig., 317 F.R.D. 562, 564 (D. Ariz. 2016).


29. Compare McCalla v. Royal Maccabees Life Ins. Co., 14 F. App’x 840, 845 (9th Cir. 2001) (finding that evidence of the insurer’s claims handling practices was germane to the insured’s breach of contract claim, but offering no rationale for that conclusion), and Glenfed Dev. Corp. v. Super. Ct., 62 Cal. Rptr. 2d 195, 197–99 (Cal. App. 1997) (permitting the discovery of an excess insurer’s claims manual in coverage litigation), with Columbian Chems. Co. v. AIG Specialty Ins. Co., Civ. A. No.: 5:14-cv-166, 2015 WL 12755711, at *4 (N.D. W. Va. Sept. 18, 2015) (observing in a breach of contract action that “absent a bad faith claim or perhaps an alleged ambiguity in the terms of the policy, an insurer’s claims manuals, procedures, and internal guidelines are not reasonably calculated to lead to admissible evidence”), and Idaho Tr. Bank v. Bankinsure, Inc., Case No. 1:12-CV-032-REB, 2013 WL 12156409, at *2 (D. Idaho Jan. 18, 2013) (refusing discovery in a declaratory judgment and breach of contract action), and Royal Bahamian Ass’n, Inc. v. QBE Ins. Corp., 745 F. Supp. 2d 1380, 1381 (S.D. Fla. 2010) (“[E]vidence of an insurance company’s claims handling procedures is irrelevant to the determination of coverage and damages. . . . These procedures are only relevant to a claim of bad faith.”).
Insurers may be able to argue that a plaintiff must demonstrate a connection between requested claims manuals or guidelines and the claim at issue for discovery to be allowed. If there is no connection, the court should deny discovery.30 Naturally, if the plaintiff is able to show a connection between the guidelines or manual and the insurer’s alleged bad faith conduct, the court will likely determine that the manual is relevant evidence.31 Absent other valid objections, the court in such a case will permit reasonable related discovery. The result may differ, however, if a claims manual or guidelines establish requirements for the insurer’s claims staff that exceed the duties or requirements imposed by state law.32 In that case, a claims professional’s deviation from the guidelines or manual cannot be evidence of bad faith, and the documents are therefore irrelevant.33 Discovery into irrelevant matters should not be permitted.

In some cases, insurers may be able to persuade a court that depositions of the claims handlers involved is all that should be required, such that they need not produce claims manuals or guidelines.34 After all, it is the conduct of those employees in the context of the particular claim on which the plaintiff’s bad faith case pivots. Unless the employees acted as they did because they were following the company’s manual or guidelines, producing those materials serves no purpose.

In a case in which the discovery request is simply overbroad, the court should narrow it to make the materials sought potentially relevant to the plaintiff’s claim.35 For example, the court in Adams v. Allstate Insurance

30. See, e.g., MI Windows & Doors, LLC v. Liberty Mut. Fire Ins. Co., Case No.: 8:14-cv-3139-T-23MAP, 2016 WL 7213270, at *6 (M.D. Fla. Oct. 20, 2016) (agreeing with the insurer’s refusal to produce claims manuals in effect during a time when no claims were pending on the basis that manuals then in effect were irrelevant); Striegel v. Am. Family Mut. Ins. Co., No. 2:13-cv-1338-GMN-VCF, 2014 WL 6473597, at *3 (D. Nev. Nov. 18, 2014) (refusing to allow discovery of claims manuals and similar materials that were unrelated to the plaintiff’s theory of bad faith, and criticizing the plaintiff’s discovery requests as “a fishing expedition”).


33. Id.

34. See, e.g., Garvey v. Nat’l Grange Mut. Ins. Co., 167 F.R.D. 391, 396 (E.D. Pa. 1996) (explaining that “the fact that the [insurer] may have strayed from its internal procedures does not establish bad faith . . . in handling the plaintiff’s loss. As previously mentioned, the plaintiff has had the opportunity to depose the defendant’s employees that were actually involved with the claim.” (emphasis added)).

Co. held that only those portions of Allstate’s claims manuals that were “relevant to processing the claim in question” were discoverable. In Kaufman v. Nationwide Mutual Insurance Co., the court required Nationwide to produce only those parts of its claims manuals and internal newsletters that contained claims handling instructions, and only then such parts “which were sent to the employees who directly handled [the] plaintiff’s claims.” While an insurer may make its claim manual or guidelines available electronically, as by posting them on an intranet site, that display does not necessarily mean it sent them to the claims personnel whose conduct is under scrutiny. In any event, not all courts are as conservative as the Adams and Kaufman courts when evaluating alleged links between insurers’ claims manuals or guidelines and conduct by claims representatives said to constitute bad faith. Courts in this latter category reason


37. Id. at 332.
39. Id. at *2; see also Platt v. Fireman’s Fund Ins. Co., Civ. A. No. 11–4067, 2011 WL 5598359, at *2 (E.D. Pa. Nov. 16, 2011) (limiting the scope of discovery to material which was given to the adjusters who worked on the plaintiff’s claim); Safeco Ins. Co. of Am. v. M.E.S., Inc., No. 09-CV-3312 (ARR)(ALC), 2011 WL 6102014, at *8 (E.D.N.Y. Dec. 7, 2011) (permitting discovery where claims procedures were tied to a particular claim).
40. See, e.g., Scott-Warren, 2016 WL 3876660, at *8 (refusing to permit discovery of “materials that were merely available to, but not utilized by, the claims unit in processing [the] plaintiff’s claim”).
that an insurer’s mere creation of a claims manual or guidelines evidences its knowledge of reasonable or unreasonable claims practices, thus connecting the manual or guidelines and the subject claim.\(^{41}\) As a result, the employees involved in the case need not have reviewed or relied upon the manual or guidelines.\(^{42}\)

Claims manuals or guidelines are almost certainly discoverable where a plaintiff alleges that the insurer’s own policies or procedures, as described in the guidelines or manuals, “embody or encourage bad faith practices.”\(^{43}\) When faced with such an accusation, an insurer’s best opposition strategy may be to request \textit{in camera} review of the manual or guidelines before production to the plaintiff in an effort to show that the allegations do not match the facts.

C. Claims Manuals and Guidelines as Trade Secrets

Moving beyond relevance, a common subject of discovery disputes is whether claims manuals and guidelines represent the insurer’s trade secrets. Not all confidential business information is considered a trade secret.\(^{44}\) Rather, a trade secret is information that:

\begin{itemize}
  \item [(i)] derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use, and
  \item [(ii)] is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.\(^{45}\)
\end{itemize}

In short, a trade secret is information that (1) is of independent economic value due to its confidential nature; (2) would be economically advantageous to competitors if disclosed; and (3) is reasonably kept secret by its owner.\(^{46}\)

On the right facts, insurance company claims manuals and guidelines may be held to constitute trade secrets.\(^{47}\) \textit{Hamilton v. State Farm Mutual...}
Automobile Insurance Co.\footnote{48} leads this line of cases. The plaintiff there, Linda Hamilton, was injured in a rear-end crash. She was insured under a State Farm auto policy that covered medical payments. Hamilton alleged that during the time she was being treated for her injuries, State Farm wrongfully denied coverage for some of her medical bills and unreasonably delayed the payment of others.\footnote{49} She sued State Farm for bad faith, breach of contract, and intentional infliction of emotional distress.

Hamilton served State Farm with discovery requests seeking information concerning the company’s claims handling policies, practices, and procedures.\footnote{50} State Farm sought a protective order on the basis that the requests encompassed confidential and proprietary business information.\footnote{51} State Farm offered to produce the requested materials if Hamilton would promise not to share them with third-parties; State Farm was concerned about competing insurers obtaining the information.\footnote{52} Hamilton objected to the scope of State Farm’s proposed protective order, and argued that “any rights to privacy [were] outweighed by the public’s right to access the information.”\footnote{53}

The Hamilton court concluded that State Farm was entitled to a protective order because the information Hamilton sought constituted trade secrets.\footnote{54} The court based its ruling on State Farm’s demonstration that:

1. the claims handling procedures and materials were developed with considerable time, effort, and expense, [and] thus possess[ed] economic value;
2. the materials were developed, created, and maintained for business use and considered confidential and proprietary; (3) the documents contain[ed] claims handling philosophies and strategies unique to State Farm; (4) access of the materials by a competitor would result in economic value to the com-

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\footnote{48}{204 F.R.D. 420 (S.D. Ind. 2001).}
\footnote{49}{Id. at 421.}
\footnote{50}{Id.}
\footnote{51}{Id.}
\footnote{52}{Id.}
\footnote{53}{Id.}
\footnote{54}{Hamilton, 204 F.R.D. at 423–24.}
petitor and place it in a competitive advantage; and (5) the materials are in locking file cabinets and/or in areas not open to the public.\textsuperscript{55}

In holding that State Farm had met its burden of establishing that its claims handling policies and procedures were trade secrets,\textsuperscript{56} the court observed that State Farm’s need to protect its confidential information “outweigh[ed] any legitimate interest one may possess in obtaining these documents.”\textsuperscript{57} In doing so, the court drained Hamilton’s shallow argument that the public had a right to the information. The court went on to enter a protective order that was narrower than the one proposed by State Farm, but which was nonetheless reasonable.\textsuperscript{58}

Trade secret determinations are case-specific.\textsuperscript{59} A party may struggle to establish that information constitutes a trade secret; conclusory assertions of trade secret status are not sufficient.\textsuperscript{60} As a result, an insurer is just as likely to lose an argument that its claims manual or guidelines contain trade secrets as it is to win it.\textsuperscript{61} In \textit{McCallum v. Allstate Property & Casualty Insurance Co.},\textsuperscript{62} for example, the insurer lost its trade secret argument because it could not demonstrate (1) how its claims handling procedures or strategies were materially different from those of its competitors; and (2) that it devoted considerable time, resources, and expense to developing the materials.\textsuperscript{63} The fact that in many instances claims manuals and guidelines are not novel and unique is a common hurdle to obtaining trade secret protection. Trade secret protection will not attach if an insur-
er’s claims manual “simply set[s] out good claim practices and philosophies that would be obvious to any insurance company setting out to prepare a claims manual.”

Even if an insurer establishes that its claims manual qualifies as a trade secret, that determination does not make the manual absolutely privileged against disclosure. Rather, it typically means that the court will order its production under a protective order. That is still a victory for the insurer, because it protects against the insurer’s loss of its intellectual capital to competitors. Additionally, any reasonable protective order will prevent the plaintiff from sharing the manual with lawyers or parties in other cases, and will otherwise prevent distribution of the manual in ways that are disadvantageous to the insurer.

Importantly, the discovery of an insurer’s claims manuals or guidelines in other cases, or adversaries’ general awareness of guidelines’ or manuals’ existence or contents, will not defeat trade secret protection. The key for insurers is to habitually seek protective orders to maintain the confidentiality of their claims manuals and guidelines.

Finally, trade secret considerations aside, insurers should seek protective orders or confidentiality agreements when producing their claims manuals or guidelines in discovery. The fact that claims manuals and guidelines may not qualify as trade secrets does not mean they are without economic value. As a rule, there is no good reason for opposing lawyers to resist reasonable confidentiality agreements or protective orders. There is no public right of access to insurers’ claims manuals or guidelines. The usefulness of these materials in other cases should be of no concern or interest to the discovering party or to the court. Indeed, a court should limit a party’s use of claims manuals or guidelines to the case in which their dis-
covery is sought. A court should not permit a plaintiff to discover claims manuals or guidelines for use in other cases. If a plaintiff balks at the entry of a confidentiality agreement or protective order, the insurer should be prepared to address the issue with the court if it cannot reasonably resolve any differences with the plaintiff through negotiation.

D. Recommendations for Insurers

Insurers should assume that their claims manuals and guidelines will be discovered in bad faith litigation and that plaintiffs will try to use these documents to their advantage at every opportunity. With this in mind, insurers should proactively evaluate claims practices, policies and procedures with an eye toward potential bad faith litigation. This is actually a two-step process, which has to consider first whether claims professionals might understand guidelines or policies to require them to act in unreasonable or unfair ways, and second whether courts or jurors might interpret guidelines or policies as promoting bad faith conduct. Within that general framework, a number of straightforward questions for responsible insurance company executives come easily to mind: How will courts or jurors perceive a policy? Can a policy be easily misconstrued, whether by claims staff or by a court or jurors? Does a guideline suggest that the insurer is favoring its financial interests over those of its insureds? Can the acronym for a process or program be exploited by a plaintiff? To the extent these questions are answered in ways that suggest an insurer’s potential vulnerability to allegations of bad faith, what corrections are required? Should materials be rewritten? Should explanations or qualifiers be added? Should internal titles for procedures or programs be changed? Do claims representatives require training to ensure that they uphold the insurer’s duty of good faith and fair dealing? Insurers should in all cases be wary of analogies, metaphors, and attempted levity in materials intended for internal use to which litigants or courts may assign different intent or meaning. Hind-sight often casts a harsh light on decisions, events, and language.

Insurers should make clear in their claims manuals or guidelines that claims must be handled on a case-by-case basis; every claim rests on its own facts. In other words, guidelines are just that. Different losses of the same general kind or class may need to be handled differently based on their respective facts or circumstances. Insurers should review and update their manuals or guidelines as appropriate. They should not establish

70. See Oppenheimer Fund, Inc. v. Sanders, 437 U.S. 340, 353 n.17 (1978) (stating that “when the purpose of a discovery request is to gather information for use in proceedings other than the pending suit, discovery is properly denied”).
standards in their manuals that claims professionals cannot regularly achieve.

Insurers may also wish to consider whether they can draft claims guidelines and manuals so that their requirements for their staff exceed any state law standards for good faith claims handling, thereby eliminating these documents’ evidentiary value. The challenge in adopting this approach is finding a balance between setting standards high enough to exceed related state law requirements while concurrently implementing procedures or policies that are reasonable and achievable as a practical matter. Some insurers have succeeded in doing this so it certainly is possible, but that does not mean the task is easy (or even that it is desirable from a particular insurer’s perspective).

A final point to consider in connection with the drafting and revising of claims manuals and guidelines is that a court may determine these documents to be relevant in coverage litigation as well as bad faith litigation. For instance, if resort to extrinsic evidence is necessary to resolve an ambiguity in an insurance policy, a court may decide that information in the insurer’s claims manual or guidelines may furnish such evidence. Thus, insurers should interpret their policies consistently with definitions, interpretations, or instructions contained in their claims manuals or guidelines.

If an insurer believes that its claims manual or guidelines embody trade secrets, it should take reasonable precautions to safeguard them as such, and it must be prepared to demonstrate why they are trade secrets when their discovery is sought in litigation. Even if it is not positioned to assert a trade secret claim, an insurer should insist on a confidentiality agreement or protective order when producing its claims manual or guidelines in discovery. Courts are usually willing to enter such orders


75. Confidential commercial information that does not qualify as a trade secret may still be the subject of a protective order requiring that it “not be revealed or be revealed only in a specified way.” Fed. R. Civ. P. 26(e)(1)(G).
or require such agreements, and with good reason. After all, confidential information that does not qualify as a trade secret still has commercial value that may be compromised, diminished, or exploited if not protected.

III. DISCOVERY OF INSURANCE COMPANY RESERVES

A. Introduction

Like the discovery of claims manuals and guidelines, plaintiffs’ attempted discovery of reserves set by the insurer in the underlying case or in connection with the disputed claim is a leading source of friction in bad faith litigation.76 Reserves, which are sometimes described as loss reserves, are funds held by an insurer to pay claims for losses that have occurred but have not been resolved.77 Reserves assigned to individual claims may be described as case reserves.78 Reserves “are liabilities in the accounting sense because they are shown on an insurer’s financial statements as sums that the insurer owes to others. They represent an estimate of the amount of claim payments the insurer will make in the future.”79 Insurers are required by state statutes and administrative regulations to maintain adequate reserves.80 Some states, however, do not require insurers to maintain case reserves; they require only that insurers maintain aggregate reserves.81

Methods of establishing reserves may vary significantly among insurers.82 For example, reserve amounts may be calculated based on the maximum possible exposure without regard for the strength of liability de-

76. Reserves set by the insurer in the bad faith case are irrelevant and therefore are not discoverable. G & S Metal Consultants, Inc. v. Cont’l Cas. Co., Cause No. 3:09-CV-493-JD-PRC, 2014 WL 5431223, at *4 (N.D. Ind. Oct. 24, 2014). That information may further be shielded from discovery by work product immunity, the attorney-client privilege, or both.


78. Id. at 6.24.

79. Id.

80. See, e.g., Cal. Ins. Code § 923.5 (2015) (“Each insurer transacting business in this state shall at all times maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims for which the insurer may be liable, and to provide for the expense of adjustment or settlement of losses and claims. . . . The reserves shall be computed in accordance with regulations made from time to time by the commissioner.”); N.Y. Ins. L. § 1303 (2015) (“Every insurer shall, except as provided in [§ 1304] of this article and subject to specific provisions of this chapter, maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims incurred on or prior to the date of statement, whether reported or unreported, which are unpaid as of such date and for which such insurer may be liable, and also reserves in an amount estimated to provide for the expenses of adjustment or settlement of such losses or claims.”).


fenses or coverage defenses, they may or may not include claim expenses and attorneys’ fees, and they may or may not be adjusted for inflation over the expected time until payout. A reserve figure may not be based on a thorough factual or legal analysis of a case or claim. An insurer may calculate a reserve based on data determined by its actuaries from multi-year studies and limited claim profile information, without analyzing the claim’s factual and legal merit. Insurers typically increase or decrease reserve amounts over the life of a case or claim, but those adjustments may be made at predetermined intervals or only with the concurrence of more than one person, in either instance meaning that a reserve amount may not truly reflect the insurer’s view of the case or claim at a given time. In some instances, an insurer may reserve a case or claim at a particular amount for ministerial reasons. For example, an insurer may initially reserve all claims at $X dollars, subject to subsequent adjustment or development. Alternatively, a reserve of $Y dollars may be posted on a claim because a reserve of at least that amount is required to assign a claim to a particular unit within the insurer’s claims operation, or a reserve set at that amount may automatically transfer responsibility for the claim from one unit to another.

Again, plaintiffs in bad faith cases routinely seek to discover reserves set by the insurer in connection with the underlying claim. In a third-party bad faith case predicated on the insurer’s failure to settle within policy limits, the plaintiff may assert that the reserve amount evidenced the insurer’s recognition of the insured’s liability or reflected the settlement value of the case from the insurer’s perspective. If the reserve is set at the liability limit of the subject policy, the plaintiff may argue that the reserve amount evidenced the insurer’s recognition of the potential for an excess verdict, and thus that the insurer’s refusal to settle within policy limits was an act of bad faith.

In a first-party bad faith case, the plaintiff may allege that the reserve either reflected the insurer’s valuation of the claim or showcases the insurer’s unreasonable claims handling. Thus, if the insurer sets a high reserve and denies the claim or offers a sum materially less than the reserve amount in payment of the loss, the plaintiff will argue that the inconsistency is evidence of bad faith. On the other hand, if the insurer sets a low reserve in connection with a claim involving substantial property

85. Luthardt & Wiening, supra note 77, at 6.25.
86. Barker & Kent, supra note 83, § 16.03[12], at 16–49.
damage or significant bodily injury, the plaintiff will argue that the insurer ignored the evidence in the hope of avoiding its full obligations under its policy.

Reserves are measured by the same relevancy standard for discovery as other information or material. Their relevancy—and thus their discoverability in the absence of other objections—turns on the facts of the case. In weighing the relevancy of reserve information during discovery, a court should take into account the nature of the case, the purpose for which the information is sought, and the insurer’s reserving methods or practices.

B. Reserves Should Not Be Held to Constitute Evidence of Coverage, Fault, Liability, or the Value of a Case

Although the relevancy of reserve information requires case-specific inquiry, the majority rule holds that reserves do not evidence an admission of coverage, fault, or liability by the insurer. It is also the majority rule

89. Mazzone, 625 S.E.2d at 360.
that reserves are not evidence of settlement authority, or of the settlement or verdict value of a case.\textsuperscript{91} In fact, as the \textit{In re Couch}\textsuperscript{92} court explained, “[t]he legislature and Insurance Commissioner establish reserve policy. For this reason alone, a reserve cannot accurately or fairly be equated with an admission of liability or the value of any particular claim.”\textsuperscript{93}

While these positions reflect majority rules, there is a relentless tide of contrary case law.\textsuperscript{94} Accordingly, insurers that intend to resist the discov-

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\textsuperscript{91} See, e.g., \textit{McKeen}, 2016 WL 4256948, at *4 (agreeing with other courts that reserves should not be equated with valuation by an insurer); CR Operating Co. v. Great Am. Ins. Co. of N.Y., No. CIV-12-00715-HE, 2013 WL 12091068, at *8 (W.D. Okla. Sept. 27, 2013) (“Plaintiffs argue that defendant unreasonably failed to settle—or ‘low balled’ the plaintiffs by not settling with them for the amounts which Great American ‘reserved’ in connection with this claim. Plaintiffs’ argument tries to turn the insurer’s ‘reserve’ determination into something it is not. . . . Here, the insurers [sic] calculations were not an amount assigned to the claim for purposes of settlement, but rather were a reserve determination. . . . The evidence as to defendants’ reserve determinations does not support an inference of bad faith.” (citation omitted)); \textit{Cummins}, 2011 WL 130158, at *12; \textit{LeBlanc v. Travelers Home & Marine Ins. Co.}, No. CIV-10-00503-HH, 2011 WL 2748616, at *4 (W.D. Okla. July 13, 2011) (“[Reserves] do not represent the insurer’s judgment as to what a plaintiff should recover....A s such . . . the evidence as to the difference between defendant’s reserve for this claim and its payments on the claim does not support an inference of an bad faith.”); Liberty Mut. Fire Ins. Co. v. APAC-Southeast, Inc., Civ. A. No. 1:07-CV-1516-JEC, at *11 (N.D. Ga. May 16, 2008) (explaining that reserves are not relevant to the settlement value of a case); \textit{Lipton}, 56 Cal. Rptr. 2d at 349 (quoting a treatise); \textit{Sunahara}, 280 P.3d at 656; \textit{Hoechst Celanese}, 623 A.2d at 1109–10; \textit{Schierenberg}, 571 N.E.2d at 337; \textit{Gaspard v. S. Farm Bureau Cas. Ins. Co.}, 155 So. 3d 24, 31 (La. Ct. App. 2014) (concluding that a reserve amount does not establish a reasonable payment value for purposes of determining whether an insurer should face penalties); Miller v. Kenny, 325 P.3d 278, 298 (Wash. Ct. App. 2014) (stating that a reserve “cannot be equated with settlement authority”); see also Steven Plitt & John K. Wittwer, \textit{The Discoverability of Reserve Information in Bad Faith Cases}, 31 INS. LITIG. REP. 81, 81 (2009) (“Claim reserves are not a reflection of the value of a case.” (footnote omitted)).

\textsuperscript{92} 80 B.R. 512 (S.D. Cal. 1987).

\textsuperscript{93} Id. at 517 (citing Union Carbide Corp. v. Travelers Indem. Co., 61 F.R.D. 411, 413 (W.D. Pa. 1973)).

\textsuperscript{94} See, e.g., \textit{Kirchoff v. Am. Cas. Co.}, 997 F.2d 401, 405 (8th Cir. 1993) (“Clearly, if [the claims representative] valued Kirchoff’s claim at $300,000 . . . but offered only $8000 to settle Kirchoff’s claim, evidence of that valuation was relevant to . . . whether CNA’s settlement offers were made in good faith.”); \textit{Hidden Cove Park & Marina v. Lexington Ins. Co.}, Civ. A. No. 4:17-CV-00193, 2017 WL 2448582, at *2 (E.D. Tex. June 6, 2017) (“The loss reserve
ery of reserves on the basis that they are not relevant to coverage, fault, liability, or settlement or verdict value should be prepared to demonstrate why that is so. For example, it may be that the insurer sets reserves by formula, so that any reserve is divorced from the merits of the claim. Or, an insurer may set a case reserve without regard for possible liability or coverage defenses, again making reserve information irrelevant to coverage, fault, liability, or case or claim value. Finally, an insurer may not set case reserves and instead only set aggregate reserves, which clearly have no relevance to any individual case or claim. Regardless of the particular issue or precise argument, an insurer cannot simply assume that a court will hold that reserves are irrelevant to these issues and thus are not discoverable.

information is relevant because it could show that [the] [d]efendant knew or should have known its liability was reasonably clear, yet still denied [the] [p]laintiffs' claim.”); Everest Nat'l Ins. Co. v. Santa Cruz Cty. Bank, Case No. 15-cv-02085-BLF (HRL), 2016 WL 6311876, at *2 (N.D. Cal. Oct. 28, 2016) (“Whether Everest kept loss reserves for the Bridges claim is probative of whether it thought it had any potential liability.”); Dogra v. Liberty Mut. Fire Ins. Co., No. 2:14-cv-01841-GMN-GWF, 2015 WL 5086434, at *3 (D. Nev. Aug. 25, 2015) (permitting discovery on the theory that reserves may be relevant to claim value); Park-Ohio Holdings Corp. v. Liberty Mut. Fire Ins. Co., No. 1:15-CV-943, 2015 WL 5055947, at *4 (N.D. Ohio Aug. 25, 2015) (“Information about the levels of reserve . . . is relevant as information about [the] [d]efendant’s valuation of the claims and could demonstrate a lack of good faith regarding settling the claim.” (footnote omitted)); Paul Johnson Drywall, Inc. v. Phoenix Ins. Co., Civ. No. 13-8124-PCT-PGR, 2014 WL 1764126, at *3 (D. Ariz. May 5, 2014) (permitting discovery because the “record show[ed] that the reserve was adjusted based on Traveler’s assessment of the merits of [the] [p]laintiffs’ claims”); Larson v. One Beacon Ins. Co., Civ. A. No. 12-cv-03150-MSK-KLM, 2013 WL 2477150, at *4 (D. Colo. June 10, 2013) (concluding that reserves were likely to lead to the discovery of admissible evidence regarding the insurer’s assessment of the settlement value of the case against the insured); Fireman’s Fund Ins. Co. v. Great Am. Ins. Co. of N.Y., 284 F.R.D. 132, 139 (S.D.N.Y. 2012) (reasoning that reserve information might be relevant to whether the insurers failed to settle the plaintiff’s claims in good faith, and might reflect their belief about their coverage or liability); St. Paul Fire & Marine Ins. Co. v. Drummond Co., Case No.: 2:11-cv-02695-JEO, 2012 WL 12897960, at *6 (N.D. Ala. May 1, 2012) (reasoning that although mandated, reserves bear some relationship to the calculation of the insurer’s potential liability); U.S. Fire Ins. Co. v. Bunge N. Am., Inc., 244 F.R.D. 638, 643–44 (D. Kan. 2007) (determining that the insurers’ reserves and the timing of their establishment could be relevant to the insurers’ positions on liability, their investigations, and coverage); Bernstein v. Travelers Ins. Co., 447 F. Supp. 2d 1100, 1115–16 (N.D. Cal. 2006) (reasoning that reserve information was relevant in light of the plaintiff’s claim that Travelers resisted and delayed payments in a calculated effort to induce him to accept a modest settlement offer); Grange Mut. Ins. Co. v. Trude, 151 S.W.3d 803, 813 (Ky. 2004) (“Evidence of Grange’s reserve setting procedures would help show whether Grange is following the statutory and regulatory requirements and whether the specific system for setting reserves is aimed at achieving unfairly low values. We find that this evidence is relevant to the bad faith claim.”); see also Auto-Owners Ins. Co. v. C & J Real Estate, Inc., 996 N.E.2d 803, 806–08 (Ind. Ct. App. 2013) (deciding that reserve information was relevant to the plaintiff’s third-party bad faith claim, but not explaining why it was relevant).
C. The Relevance of Reserves to Issues Other Than Coverage, Fault, Liability, or Case Value

Although reserves may not be relevant to coverage, fault, liability, settlement authority, or case value, they may be relevant to other issues in a bad faith case, and may be discoverable on those grounds. See, e.g., McKeen v. USAA Cas. Ins. Co., Case No. 2:14-cv-396-DN-PMW, 2016 WL 4256948, at *4 & n.32 (D. Utah Aug. 11, 2016) (concluding that reserves were relevant in connection with the insured’s bad faith claim, apparently because they bore on the insurer’s state of mind); PCS Phosphate Co. v. Am. Home Assur. Co., No. 5:14-CV-99-D, 2015 WL 8490976, at *4 (E.D.N.C. Dec. 10, 2015) (“The timing and any changes in reserve amounts is relevant here because it is probative of whether American Home engaged in unreasonable delay in making a coverage determination.”); Keefer v. Erie Ins. Exch., Civ. No. 1:13-CV-1938, 2014 WL 901123, at *3 (M.D. Pa. Mar. 7, 2014) (“Since Plaintiff claims that Defendant acted in bad faith during its investigation of Plaintiff’s claim, a comparison between the reserve value of the claim and Defendant’s actions in processing Plaintiff’s claim could shed light on Defendant’s liability under the bad faith statute. The reserve amount is, therefore, relevant or could potentially lead to relevant information, and the court will order disclosure of such information.” (footnote omitted)); Nat’l Union Fire Ins. Co. v. Donaldson Co., No. 10–4948 (JRT/JJG), 2014 WL 2865900, at *4 (D. Minn. June 24, 2014) (“[T]he Magistrate Judge did not err in concluding that reserve information is relevant, particularly as evidence of Plaintiffs’ estimation of how it would apply coverage under the policies at any given point in time, which could bear on Donaldson’s claim for breach of the duty of good faith and fair dealing.” (footnote omitted)); First Tenn. Bank N.A. v. Republic Mortg. Ins. Co., 276 F.R.D. 215, 222 (W.D. Tenn. 2011) (concluding that reserves were discoverable because they were relevant to the plaintiff’s bad faith claims that the insurer “did not properly evaluate its risks and, following the economic downturn, operated in a manner that placed its interests above its insured”); Prof’l Sols. Ins. Co. v. Mohrlang, No. Civ. A07CV02481REBKLM, 2008 WL 4079290, at *4 (D. Colo. Aug. 28, 2008) (finding that reserve information was discoverable to show that the insurer recognized that were multiple claims against the insured and thus multiple liability limits were in play; the plaintiff argued that under the insurer’s claims guidelines, reserves would have to be posted for each claim, so that multiple reserves necessarily reflected the insurer’s acknowledgment of multiple claims); Miller v. Kenny, 325 P.3d 278, 298 (Wash. Ct. App. 2014) (explaining that reserves were relevant in a third-party bad faith case in which the insurer refused to settle within policy limits despite knowing “almost from day one that its insured was exposed to much greater liability”).

Lipton v. Superior Court is a leading case on this subject. In Lipton, a discovery referee ruled that the insured, Howard Lipton, was not entitled to discover the reserves set by the insurer, LMIC, in the underlying tort action because they were unlikely to lead to the discovery of admissible evidence. The trial court adopted the referee’s report and Lipton appealed. Reversing the trial court, the Lipton court reasoned that reserve information might reasonably lead to the discovery of admissible evidence concerning one or more of the three issues on which Lipton was focused: (1) LMIC’s state of mind regarding its claims handling practices; (2) LMIC’s knowledge that multiple policy limits applied to the underlying claim; and (3) LMIC’s disregard of its own counsel’s advice regarding Lipton’s probable

95. See, e.g., McKeen v. USAA Cas. Ins. Co., Case No. 2:14-cv-396-DN-PMW, 2016 WL 4256948, at *4 & n.32 (D. Utah Aug. 11, 2016) (concluding that reserves were relevant in connection with the insured’s bad faith claim, apparently because they bore on the insurer’s state of mind); PCS Phosphate Co. v. Am. Home Assur. Co., No. 5:14-CV-99-D, 2015 WL 8490976, at *4 (E.D.N.C. Dec. 10, 2015) (“The timing and any changes in reserve amounts is relevant here because it is probative of whether American Home engaged in unreasonable delay in making a coverage determination.”); Keefer v. Erie Ins. Exch., Civ. No. 1:13-CV-1938, 2014 WL 901123, at *3 (M.D. Pa. Mar. 7, 2014) (“Since Plaintiff claims that Defendant acted in bad faith during its investigation of Plaintiff’s claim, a comparison between the reserve value of the claim and Defendant’s actions in processing Plaintiff’s claim could shed light on Defendant’s liability under the bad faith statute. The reserve amount is, therefore, relevant or could potentially lead to relevant information, and the court will order disclosure of such information.” (footnote omitted)); Nat’l Union Fire Ins. Co. v. Donaldson Co., No. 10–4948 (JRT/JJG), 2014 WL 2865900, at *4 (D. Minn. June 24, 2014) (“[T]he Magistrate Judge did not err in concluding that reserve information is relevant, particularly as evidence of Plaintiffs’ estimation of how it would apply coverage under the policies at any given point in time, which could bear on Donaldson’s claim for breach of the duty of good faith and fair dealing.” (footnote omitted)); First Tenn. Bank N.A. v. Republic Mortg. Ins. Co., 276 F.R.D. 215, 222 (W.D. Tenn. 2011) (concluding that reserves were discoverable because they were relevant to the plaintiff’s bad faith claims that the insurer “did not properly evaluate its risks and, following the economic downturn, operated in a manner that placed its interests above its insured”); Prof’l Sols. Ins. Co. v. Mohrlang, No. Civ. A07CV02481REBKLM, 2008 WL 4079290, at *4 (D. Colo. Aug. 28, 2008) (finding that reserve information was discoverable to show that the insurer recognized that were multiple claims against the insured and thus multiple liability limits were in play; the plaintiff argued that under the insurer’s claims guidelines, reserves would have to be posted for each claim, so that multiple reserves necessarily reflected the insurer’s acknowledgment of multiple claims); Miller v. Kenny, 325 P.3d 278, 298 (Wash. Ct. App. 2014) (explaining that reserves were relevant in a third-party bad faith case in which the insurer refused to settle within policy limits despite knowing “almost from day one that its insured was exposed to much greater liability”).

96. 56 Cal. Rptr. 2d 341 (Ct. App. 1996).

97. Id. at 346.
extra-contractual liability. On remand, Lipton would be entitled to reserve information unless the trial court could, “as a matter of law, conclude (as to each separate item of information) that it [was] not relevant to the subject matter or [was] not calculated to lead to the discovery of admissible evidence in Lipton’s bad faith action.”

Lipton has been criticized by knowledgeable observers as poorly reasoned, and the court indeed may have missed a couple of stitches. Specifically, in the run-up to its holding, the Lipton court noted that reserves are not the same as settlement authority, and that a reserve cannot be equated with an admission of liability or a claim’s value. Those rules are arguably inconsistent with the court’s later determination that Lipton might be entitled to discover LMIC’s reserves to show (a) LMIC’s state of mind regarding its claims handling practices; and (b) its disregard of its lawyer’s advice in evaluating Lipton’s possible extra-contractual liability. Furthermore, Lipton did not need reserve information to develop either aspect of his bad faith case.

The plaintiff in Grossi v. Travelers Personal Insurance Co., Brandon Grossi, was badly injured in a wreck in which he was a passenger in a Tarquinio Brothers Bakery truck. Tarquinio Brothers had $3 million in available insurance coverage. Grossi was also insured under his parents’ policy with Travelers, which provided $1 million in medical benefits and $300,000 in UIM coverage. Grossi made a UIM claim on which Travelers posted a $1000 initial reserve. The Travelers adjuster to whom Grossi’s UIM claim was assigned, Roxanne Youndt, valued the claim at $1.8 million after deducting Tarquinio Brothers’ $3 million in coverage based on information provided by Grossi’s lawyer; she did not attempt to independently evaluate or verify Grossi’s lost income. She then transferred Grossi’s UIM claim to Andrew Makar in Travelers’ major claims unit (MCU) without increasing the reserve from $1000. Makar never increased the reserve from $1000 even though Grossi’s lawyer provided an expert report valuing Grossi’s lost future income at over $4.25 million, and Travelers paid Grossi $25,000 to compensate him for lost income and further paid over $500,000 in medical expenses.

[98] Id. at 345 n.8 & 350.
[99] Id. at 350.
[100] Barker & Kent, supra note 83, § 16.03[12], at 16-50.
[101] Lipton, 56 Cal. Rptr. 2d at 349 (quoting a treatise).
[102] Id. (quoting In re Couch, 80 B.R. 512, 517 (S.D. Cal. 1987)).
[104] Id. at 1145.
[105] Id.
[106] Id.
[107] Id.
related to the accident. Makar allegedly dragged his feet in adjusting Grossi’s UIM claim and unreasonably refused to pay anything above the $3 million available from Tarquinio Brothers’ insurers, and Grossi eventually sued Travelers for bad faith. Grossi won a judgment of around $1.48 million in a bench trial, including some $1.25 million in punitive damages, and Travelers appealed.

In affirming the trial court judgment in all material respects, the Grossi court repeatedly and approvingly referred to the trial court’s heavy reliance on the minimal reserve amount as evidence of Travelers’ bad faith. For example, the Grossi court quoted the trial court as follows:

“One on January 23, 2007, Travelers had established a reserve of $1,000.00 on the underinsured claim (meaning a gross value of $1,000.00 due to the tortfeasor set off) which it maintained throughout the pendency of the claim. Travelers maintained this reserve despite the fact that liability was not an issue and there was no comparative negligence reduction; Travelers had paid over $500,000.00 in . . . reduced medical bills on the first party claim; [Grossi] had undergone seven surgeries and was permanently disabled, with Travelers making a . . . wage loss payment of the limits of $25,000.00. Travelers did not conduct an IME prior to establishing this reserve. Travelers failed to ever increase its reserve or settlement offer, in complete disregard of subsequent medical reports, vocational reports and other documentation (including an updated vocational report with future lost wages as high as $8,000,000.00); thus, throughout the pendency of the underinsured claim, Travelers’ evaluation of the total value of this claim (with the $3,000,000.00 tortfeasor credit) was $1,000.00.

There was no reasonable basis for the $1,000.00 reserve. The $1,000.00 reserve was not reasonable and was reckless in light of the following: 1) clear liability; 2) [Grossi] had undergone seven surgeries and was still treating three years after the accident, 3) the projections of lost earning potential and corroboration of the causal relationship and residual problems by [Grossi’s] treating physicians as well as the Travelers IME physician, Dr. Kann.”

In another place in the opinion the Grossi court quoted the trial court judgment concluding that Makar’s evaluation of Grossi’s claim in May 2007 “was not only contrary to the evaluation . . . performed by Roxanne

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108. Id. at 1145–46.
109. Grossi first won a $4 million arbitration award against Travelers. Travelers did not appeal the award and promptly paid Grossi the UIM policy limits of $300,000. Grossi, 79 A.3d at 1146.
110. Id. at 1146–47.
111. See, e.g., id. at 1149 (“Central to the trial court’s conclusion that Travelers acted in bad faith in its treatment of Grossi’s UIM claim was its finding that Travelers established and maintained only a $1,000 reserve throughout the life of the claim, without sufficient justification.”).
112. Id. (quoting the trial court judgment).
Youndt, but was an arbitrary figure, with absolutely no relationship to the information [he] had available to him at the time he performed his evaluation,” and that “‘Makar failed to articulate any reasonable, rational basis for the low reserve.’”113 In faulting Travelers for “blindly” rejecting Grossi’s lost income claim, the court agreed with the trial court that Makar’s decision to discount evidence supporting Grossi’s loss without explaining “‘any reasonable, rational basis for the low reserve’ was unreasonable.”114 The *Grossi* court further cited Travelers’ decision to set “an arbitrarily low reserve” as evidence of its flawed claim investigation and thus its bad faith,115 and concluded that the “minimal reserve” supported the trial court’s award of punitive damages.116

*Grossi* is a curious decision because the courts’ focus on Travelers’ reserve was unnecessary. There was ample evidence in the record to support the conclusion that Travelers acted in bad faith by under-valuing Grossi’s claim and by unfairly delaying payment if that was the way the courts wanted to go.

At the same time, there was evidence to support a conclusion that Travelers did not act in bad faith, and that the trial and appellate courts were confused or misled by irrelevant reserve information. First, Grossi settled his claim against Tarquinio Brothers for $950,000, which was less than one-third of Tarquinio Brothers’ liability coverage.117 That choice would seem to suggest that Makar’s belief that Grossi’s lost income claim was exaggerated was arguably reasonable. Second, Youndt pegged Grossi’s claim at $1.8 million without independently evaluating his lost income allegations merely “as a mechanism to transfer the claim” to the MCU for handling by a “more sophisticated” adjuster.118 In making the transfer, she noted that the MCU needed to investigate Grossi’s lost income claim.119 Even so, the *Grossi* court flogged Makar by comparing the $1000 reserve to Youndt’s initial, incomplete case valuation. Travelers had a good argument that the court was wrong to do so. Third, Makar either set or left the reserve at $1000 not because it reflected his valuation of Grossi’s claim—which he thought was legitimately disputable—but because state law required him to establish a reserve.120 Youndt presumably set the initial $1000 reserve for the same reason.

113. *Id.* at 1150 (quoting the trial court judgment).
114. *Id.* at 1152 (quoting the trial court judgment).
116. *Id.* at 1159.
117. *Id.* at 1169 (Bowes, J., dissenting).
118. *Id.* at 1168 (Bowes, J., dissenting).
119. *Id.* at 1170 (Bowes, J., dissenting).
120. *Id.* at 1169 (Bowes, J., dissenting).
To be sure, Makar should have substantially increased the reserve even though he thought that Grossi’s lost income claim was inflated. But his failure to do so was at worst evidence of negligence, which is not bad faith under Pennsylvania law. In the end, Grossi perhaps best serves as a cautionary signal to courts that if they permit the discovery of reserves, they must be prepared to carefully consider their admission into evidence at trial when the time comes because of the real risk that the information will confuse and mislead the fact finder, and unfairly prejudice the insurer.

D. First-Party versus Third-Party Cases

In deciding the relevancy and thus the discoverability of reserves, some courts distinguish first-party and third-party bad faith cases. As a California federal court explained in *American Protection Insurance Co. v. Helm Concentrates, Inc.*:

In considering whether an insurer acted in bad faith in denying its duty to defend under a “third party” liability policy the fact that it established a reserve, particularly for litigation costs, is probative on the issue of whether there is a “potential for liability.” Thus when an insurer, by its actions, acknowledges the potential for liability and fails to attempt to settle a claim against its insured and/or fails to defend, reserve information is relevant to the issue of good faith. On the other hand, in [bad faith litigation involving a] first party policy . . . the issues are whether the claimed loss is covered and whether the insurer acted in good faith in investigating the loss and in denying coverage . . . “potential liability” is not relevant because it does not trigger any duty under the first party policy. In other words, the policy either provides coverage for the loss or does not; the insurer’s good faith is determined by the manner and depth of its investigation and the determination of whether there was a good faith factual and/or legal question as to whether the loss was covered.

While the *American Protection* court considered reserves to be relevant in a third-party bad faith case but not a first-party bad faith case, in *Sunahara v. State Farm Mutual Automobile Insurance Co.* the Colorado Supreme Court speculated that reserve information might be relevant in

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124. Id. at 449–50.
125. 280 P.3d 649 (Colo. 2012).
first-party bad faith litigation. The Sunabara court ventured that in a first-party bad faith case, evidence of reserves “could shed light on whether the insurance company adjusted [the] claim in good faith, or promptly investigated, assessed, or settled [the] underlying claim.”

The first-party versus third-party distinction is not helpful when evaluating the relevance of reserves. Certainly, the American Protection court’s simple view of this distinction does not withstand scrutiny. In a third-party bad faith case, for example, an insurer’s recognition of “the potential for liability” does not mean that it was obligated to settle on behalf of the insured. Sometimes a vigorous defense is preferable to settlement. It is also wrong to broadly reject the relevance of reserves in a first-party bad faith case because “the issues are whether the claimed loss is covered and whether the insurer acted in good faith in investigating the loss and in denying coverage. . . . Potential liability . . . is marginally relevant at best.”

The issue in a first-part bad faith case is not always whether the insurer wrongfully denied coverage. Consider a case in which the insured alleges that the insurer low-balled her with respect to the payment of a covered first-party claim. Might not the insured want to argue that a higher reserve amount is relevant to whether the insurer adjusted her claim in good faith?

The essential question for relevance purposes is how the plaintiff proposes to use the reserve information if the court permits discovery. The answer to that question does not necessarily depend on whether first-party or third-party bad faith is alleged.

E. The Attorney-Client Privilege and Work Product Immunity in Connection with the Discovery of Reserve Information

Plaintiffs’ attempts at discovering reserves often draw objections and refusals to produce requested information or materials, or elicit instructions to insurance company witnesses not to answer related deposition questions, based on insurers’ attorney-client privilege, work product immunity, and other claims of privilege.

126. Id. at 657–58.
128. Id.
129. The attorney-client privilege applies to (1) communications (2) between privileged persons (3) in confidence (4) for the purpose of obtaining or providing legal assistance for the client. Restatement (Third) of the Law Governing Lawyers § 68 (Aml. Law Inst. 2000). “Privileged persons” include the client, the lawyer, agents of the client and the lawyer who facilitate communications between them, and agents of the lawyer who assist in the client’s representation. Id. § 70. Courts strictly construe the attorney-client privilege because it limits full disclosure of the truth. In re Pac. Pictures Corp., 679 F.3d 1121, 1126 (9th Cir. 2012); Ambac Assur. Corp. v. Countrywide Home Loans, Inc., 57 N.E.3d 30, 34 (N.Y. 2016). The party asserting the privilege bears the burden of establishing its application to particular communications. Ambac Assur. Corp., 57 N.E.3d at 34–35. This is a fact-specific inquiry.
nity, or both. This obviously is a sensitive area. It is also a complex one, recognizing that insurers establish reserves as part of their regular business practices, and (1) lawyers’ business advice to clients is not privileged; and (2) information must be generated or prepared “in anticipation of litigation” to qualify as work product. Documents prepared in the ordinary course of business, or that would have been prepared regardless of whether litigation was anticipated, are not entitled to work product immunity. Moreover, lawyers may provide clients with a mix of legal and business advice, and materials may be prepared for both a business purpose and in anticipation of litigation. These combinations force courts to determine whether the primary purpose of a communication was to provide legal advice or services, in which case it is privileged, or whether materials were prepared because of litigation or with litigation

130. Although courts and lawyers often refer to the “work product privilege,” the work product doctrine is actually a form of qualified immunity. Anderson v. Marsh, 312 F.R.D. 584, 592 (E.D. Cal. 2015); Wachovia Bank, N.A. v. Clean River Corp., 631 S.E.2d 879, 884 (N.C. Ct. App. 2006) (quoting Velez v. Dick Keffer Pontiac-GMC Truck, Inc., 551 S.E.2d 873, 876 (N.C. Ct. App. 2001)). The work product doctrine is codified in Federal Rule of Civil Procedure 26(b)(3) and state analogs. There are two types of work product: “fact” or “ordinary” work product, better described as “tangible” work product; and “opinion” or “core” work product, sometimes termed “intangible” work product. To qualify as tangible work product, the material to be protected must be a document or tangible thing prepared in anticipation of litigation by or for a party, or by or for the party’s representative. FED R. CIV. P. 26(b)(3). Opinion work product refers to a lawyer’s conclusions, legal theories, mental impressions, or opinions. Opinion work product may be contained within tangible work product. State ex rel. Erie Ins. Prop. & Cas. Co. v. Mazzone, 625 S.E.2d 355, 361 (W. Va. 2005) (Davis, J., concurring). A party may discover an adversary’s tangible work product if it demonstrates substantial need of the materials to prepare its case and it is unable without undue hardship to obtain the substantial equivalent of the materials by other means. Opinion work product, on the other hand, receives almost absolute protection against discovery. To discover an adversary’s opinion work product, a party must demonstrate something far greater than the substantial need and undue hardship necessary to obtain tangible work product. In fact, some states hold that opinion work product is absolutely immune from discovery. See, e.g., Henderson v. Newport Cty. Reg’l Young Men’s Christian Ass’n, 966 A.2d 1242, 1247 (R.I. 2009).


133. Solis v. Food Emp’rs Labor Relations Ass’n, 644 F.3d 221, 232 (4th Cir. 2011) (quoting Nat’l Union Fire Ins. Co. v. Murray Sheet Metal Co., 967 F.2d 980, 984 (4th Cir. 1992)); see, e.g., Mirachi v. Seneca Specialty Ins. Co., Civ. A. No. 10–3617, 2011 WL 2982401, at *1 (E.D. Pa. June 22, 2011 (rejecting the insurer’s work product claim in part because “aside from a blanket statement that the documents were prepared in anticipation of litigation, the documents themselves, with one exception, [gave] no indication that they were prepared outside of the ordinary course of business” (footnote omitted)).

as the primary motivating purpose, in which case they are work product. These are fact-intensive inquiries.

For the attorney-client privilege to apply to reserves, lawyers must have participated in the reserving process by offering legal advice to the insurance company employees responsible for setting the reserves. This will be difficult to establish with respect to aggregate reserves; indeed, their discovery is unlikely to reveal privileged communications. As the concurring Justice in State ex rel. Erie Insurance Property & Casualty Co. v. Mazzone reasoned, however, a court might apply the privilege to aggregate reserve information based on the “substantiality” of lawyers’ advice in regard to individual case reserves.

If individual reserve information, prepared by an attorney for his/her client with the expectation of confidentiality, is not a substantial component of the aggregate reserve information, then the attorney-client privilege should not attach to the aggregate reserve information. On the other hand, the attorney-client privilege should attach to aggregate reserve information, if individual reserve information prepared by an attorney is a substantial component of the aggregate reserve information.

Similarly, for aggregate reserve information to be protected by the work product doctrine, discovery of that information will generally have to reveal individual case reserve information that counts as work product. Absent disclosure of case reserve information, it is hard to see how the discovery of aggregate reserves will expose either tangible or opinion work product.

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136. See Simon v. G.D. Searle & Co., 816 F.2d 397, 402–03 (8th Cir. 1987) (“Assuming arguendo that the attorney-client privilege attaches to the individual case reserve figures . . . we do not believe the privilege in turn attaches to the risk management documents simply because they include aggregate reserve information based on the individual case reserve figures. . . . [W]e do not believe that the aggregate information discloses the privileged communications, which we are assuming the individual reserve figures represent, to a degree that makes the aggregate information privileged.” (footnotes omitted)); see, e.g., Burke v. Ability Ins. Co., 291 F.R.D. 343, 349–50 (D.S.D. 2013) (concluding “that evidence related to reserves in the aggregate is relevant, discoverable, and not protected by privilege because . . . they were prepared in the ordinary course of business”).
137. 625 S.E.2d 355 (W. Va. 2005).
138. Id. at 366 (Davis, J., concurring).
139. Id. (Davis, J., concurring).
140. See Rhone-Poulenc Rorer Inc. v. Home Indem. Co., 139 F.R.D. 609, 614 (E.D. Pa. 1991) (“Although these risk management documents . . . may not have . . . been prepared in anticipation of litigation, they may be protected from discovery to the extent that they disclose the individual case reserves calculated by [the] defendants’ attorneys. The individual case reserve figures reveal the mental impressions, thoughts, and conclusions of an attorney in evaluating a legal claim. By their very nature they are prepared in anticipation of litigation, and consequently, they are protected from discovery as opinion work-product.”).
As might be expected, the heaviest action circles the discovery of case reserves. Where case reserves have been established based at least in part on lawyers’ advice, their discovery may well reveal attorney-client privileged communications.141 If so, the court should not permit discovery.142 Case reserve information may also be privileged where an insurer shares it with a lawyer to facilitate the delivery of legal services.143

Even if the disclosure of case reserve information will not reveal attorney-client privileged communications, it often will reveal opinion work product. Courts afford opinion work product nearly absolute protection against discovery;144 in federal courts, a party must “make an ‘extraordinary showing of necessity’” to overcome opinion work product protection.145 Reserve information may also contain tangible work product, which, while not protected with the same rigor as opinion work product, is still shielded from discovery in all but the rarest of situations. On this second point, it is important to recall that work product immunity “is not confined solely to information and materials gathered or assembled by a lawyer, but also covers materials gathered by any consultant, surety, indemnitor, insurer, agent, or even the party itself.”146

Not surprisingly, courts regularly prohibit the discovery of case reserves based on work product immunity.147 Even if the amount of a case

147. See, e.g., Barge v. State Farm Mut. Auto. Ins. Co., Case No. C16-0249JLR, 2016 WL 6601643, at *6–7 (W.D. Wash. Nov. 8, 2016) (determining that reserve documents were prepared because of litigation and were entitled to work product protection); Decker v. Chubb Nat’l Ins. Co., Case No. 1:15-cv-88, 2015 WL 5954584, at *5–6 (S.D. Ohio Oct. 14, 2015) (involving a first-party bad faith claim arising out of the insurer’s denial of coverage for a fire loss); G & S Metal Consultants, Inc. v. Cont’l Cas. Co., No. 3:09-cv-493-JD-PRC, 2014 WL 5431223, at *6 N.D. Ind. Oct. 24, 2014) (“Thus, once litigation is anticipated, loss reserves are protected by the work product doctrine when there is evidence that the loss reserves were established or adjusted in consultation with counsel in anticipation of or during litigation.”); Progressive Cas. Ins. Co. v. FDIC, 298 F.R.D. 417, 426 (N.D. Iowa 2014) (concluding that Progressive, through the declaration of its counsel, met its burden of showing that part of its reserve information was prepared in anticipation of litigation and, thus, was protected from disclosure); Schreib v. Am. Family Mut. Ins. Co., 304 F.R.D. 282, 286 (W.D. Wash. 2014) (observing that “once litigation is anticipated, loss reserve documents by definition reflect the mental impressions, thoughts, and conclusions of attorneys.
reserve is not immune from discovery as work product, information regarding how the reserve was established or other communications concerning the reserve may be protected as work product. 148

F. Summary

Although it is often said that reserves generally are not discoverable, 149 or that the weight of authority holds that reserves are not discoverable, 150 this is a complex and confused area of the law. Depending on the facts, “[c]ogent arguments can be made either way for the discoverability of reserve information.” 151 Certainly, reserves do not constitute an admission of coverage, fault, or liability by an insurer, and they are not evidence of settlement authority. They generally do not reflect the true settlement, judgment, or verdict value of a case. 152 Reserve information may, however, be relevant for other purposes. Courts that would otherwise allow the discovery of reserves and related communications on relevance

148. See Starr Indem. & Liab. Ins. Co. v. Cont’l Cement Co., L.L.C., No. 4:11CV809 JAR, 2012 WL 6012904 at *4 (E.D. Mo. Dec. 3, 2012) (“[T]he actual amount of reserves set by Starr is not subject to the work product doctrine and is discoverable. . . . The Court, however, finds that [because] ‘the work-product doctrine covers information about the process of setting reserves—how and why they were set’—[Starr] is not required to answer questions that seek this type of information.’ . . . Therefore, Starr shall provide the reserves amount set but is not required to answer any questions or provide any documents regarding the process of setting reserves.” (citations omitted)).


150. Id. at 83.

151. Id. at 83.

152. See Silva v. Basin W., Inc., 47 P.3d 1184, 1189 (Colo. 2002) (stating that “a particular reserve amount does not necessarily reflect the insurer’s valuation of a particular claim,” and that “reserves should not be equated” with a “valuation by the insurer”); id. at 1190 (“Neither reserves nor settlement authority reflect an admission by the insurance company that a claim is worth a particular amount of money. Statutory requirements, limitations in the evaluation, and bargaining tactics limit the usefulness of reserves and settlement authority as valuations of a claim.”).
grounds must ensure that the requested discovery will not invade the insurer’s attorney-client privilege or work product immunity.

Insurers that object to the discovery of reserves based on relevance must be prepared to demonstrate why reserve information is irrelevant in the case at hand. If an insurer objects to discovery on attorney-client privilege or work product grounds, it must be able to show why communications or materials are in fact protected. More than one insurer has seen its reserve information exposed to discovery because it failed to demonstrate why the attorney-client privilege or work product doctrine applied—often for a reason as mundane as an inadequate privilege log.\textsuperscript{153}

Finally, even if a court finds that reserves are relevant and permits discovery, that ruling does not mean the information revealed will be admissible at trial.\textsuperscript{154} As noted earlier, relevance for discovery purposes is broader than evidentiary relevance at trial.\textsuperscript{155}

IV. DISCOVERY OF REINSURANCE INFORMATION

A. Background

Like reserves, plaintiffs routinely attempt to discover reinsurance information in bad faith litigation. In the case of reinsurance information, a plaintiff’s hope is that the insurer has shared information with the reinsurer that is relevant to the bad faith case and, indeed, may be evidence of the insurer’s bad faith.

To lay some foundation for the following discussion, reinsurance is essentially insurance for insurance companies.\textsuperscript{156} When obtaining reinsurance, an insurance company—the “cedent” or “ceding company”—pays a premium to a reinsurer in return for the reinsurer’s promise to indem-

\textsuperscript{153} See, e.g., Linville v. Nat’l Indem. Co., CV 14-0013 JAP/WPL, 14-0526 JAP/WPL, 2014 WL 12593993, at *4 (D.N.M. Sept. 30, 2014) (“National Indemnity did not even mention in the Privilege Log that it withheld documents that reflect reserves for Linville’s claim, which precluded Linville from assessing its work-product claim. The work-product doctrine may not be invoked when an insurer has failed to provide sufficient detail about the setting of the reserves to justify invocation of the doctrine.”).

\textsuperscript{154} See, e.g., Kropilak v. 21st Century Sec. Ins. Co., No. 8:12-CV-1816-T-17TGW, 2014 WL 3629618, at *1 (M.D. Fla. July 18, 2014) (finding “no relevant basis for which the reserves could serve at trial, and that any mention or evidence of reserves would confuse the issues and create a danger of unfair prejudice that would substantially outweigh any potential relevance”).


nify it for all or some portion of the insurer’s exposure on policies that it has issued to its insureds. Reinsurance agreements are strictly contracts of indemnity between a reinsurer and a cedent. Reinsurance does not alter the ceding insurer’s relationships with its insureds. Absent a rare “cut through” endorsement or clause, which entitles a policyholder to seek payment from the reinsurer if the ceding insurer becomes insolvent, the reinsurer generally is not directly liable to the ceding company’s insureds. In fact, the reinsurer usually has no relationship or communications with the cedent’s insureds. Policyholders typically do not know that reinsurance exists or that it applies to their claims.

Reinsurance takes two broad forms. “Facultative reinsurance” involves the reinsurer agreeing to indemnify the ceding insurer for all or part of the risk assumed under a single policy. “Treaty reinsurance” refers to a reinsurer’s agreement to assume the ceding insurer’s risk, typically on a quota share or excess of loss basis, for a stated period. Once the treaty terms have been negotiated, all policies falling within the treaty are covered until the treaty is terminated.

When a ceding insurer pays a claim or judgment and then seeks indemnification from its reinsurer, the reinsurer is generally precluded from questioning the cedent’s underlying decision by the “follow the fortunes” doctrine. Whether expressed or implied in a reinsurance agreement, the follow-the-fortunes doctrine obligates a reinsurer to indemnify its cedent for good faith payments made for claims reasonably encompassed by the underlying insurance policy, at least in the absence of fraud or bad faith. The doctrine prevents reinsurers from (1) wastefully re-litigating cedents’ coverage defenses; and (2) second guessing good faith settlements.

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161. Unigard, 4 F.3d at 1054.
163. JERRY & RICHMOND, supra note 2, at 996.
164. Id.
165. JOHN S. DIACONIS & DOUGLAS W. HAMMOND, REINSURANCE LAW § 3:2, at 3-2 to -4 (2005).
166. Id. § 3:2, at 3-2 to -3.
and obtaining de novo review of judgments establishing cedents’ liability to their insureds.167

B. Discovery of Reinsurance Agreements

Courts are split on the discovery of reinsurance agreements in bad faith cases, although the split is clearly not even. Some courts reason that reinsurance agreements should be discoverable only “when the reinsurance agreement is directly at issue and relevant to the litigation, and the insurer is the defendant in the case, not an outside party.”168 That situation will either never or almost never present itself.169 While the insurer certainly is a defendant in a bad faith case, any reinsurance agreement is neither directly at issue nor relevant to the litigation. A reinsurer’s potential obligation to indemnify a cedent for extra-contractual liability, if that obligation exists,170 does not put the reinsurance agreement directly at issue.

More federal courts hold that reinsurance agreements are discoverable in bad faith cases under Federal Rule of Civil Procedure 26(a)(1)(A)(iv), previously codified as Rule 26(a)(1)(D), which requires a party to voluntarily disclose “any insurance agreement under which an insurance business may be liable to satisfy all or part of a possible judgment in the action or to indemnify or reimburse for payments made to satisfy the judgment.”171 Rule 26(a)(1)(A)(iv) does not require a demonstration of rele-

167. Id. § 3:2, at 3-4 (quoting N. River Ins. Co. v. CIGNA Reinsurance Co., 52 F.3d 1194, 1199 (3d Cir. 1995)).
169. See, e.g., id. (“Here, the reinsurance agreements are . . . are requested for discovery as evidence to support plaintiff’s bad faith claim. Thus, this case does not fall within the exception for discoverability of reinsurance information.”).
170. See Keith A. Dotseth et al., The Reinsurance Contract, in 7 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 72.02[5][e], at 72-33 (Jeffrey E. Thomas & Susan Lyons eds., 2009 & Supp. 2016) (“Generally speaking, unless the reinsurance contract provides for [extra-contractual obligations] coverage, a reinsurer will not be obligated to reimburse a ceding company for such claims.” (footnote omitted)).
vance for disclosure.\textsuperscript{172} A reinsurance agreement’s ultimate lack of probative value does not foreclose disclosure or discovery under this rule.\textsuperscript{173}

It is not clear why an insurer should have to disclose a reinsurance agreement under Rule 26(a)(1)(A)(iv). Factors that weigh against the required disclosure of reinsurance agreements outnumber those that favor it.

First, the rule refers to “insurance agreement[s],” and while reinsurance may be described in shorthand as insurance for insurance companies, it is not like a liability insurance policy purchased by a corporation. An insurer does not purchase reinsurance to cover its potential bad faith exposure.\textsuperscript{174} Rather, an insurer purchases reinsurance for one or more of the following reasons: to expand its underwriting capacity; to stabilize its operating results; to protect against catastrophic losses attributable to disasters such as earthquakes and hurricanes; or to serve as a financing tool by reducing a potential drain its policyholder surplus.\textsuperscript{175}

Second, Rule 26 mandates the “[d]isclosure of insurance coverage [to] enable counsel for both sides to make the same realistic appraisal of the case, so that settlement and litigation strategy are based on knowledge and not speculation.”\textsuperscript{176} Rule 26 further mandates the disclosure of liability insurance policies “because insurance is an asset created specifically to satisfy the claim” and “because the insurance company ordinarily controls the litigation.”\textsuperscript{177} But reinsurance is not a source of potential recovery for a bad faith plaintiff like liability insurance is for a plaintiff in a third-party action. The ceding insurer is responsible for satisfying any bad faith judgment regardless of whether it has reinsurance, and perhaps unlike some defendants in civil litigation it has the resources to do so.\textsuperscript{178} A reinsurer does not control the defense of bad faith litigation against a ceding insurer. In short, the existence of reinsurance is not material to a plaintiff’s

\textsuperscript{172} Isilon Sys., Inc., 2012 WL 503852, at *3; Heights at Issaquah Ridge, 2007 WL 4410260, at *4.

\textsuperscript{173} See Great Lakes Dredge & Dock Co., 159 F.R.D. at 504 (“[R]einsurance in the face of denial of coverage might suggest bad faith. Great Lakes also believes bad faith would be demonstrated with the opposite outcome—lack of reinsurance. That hay could be made from either outcome is probably the best demonstration that the probative value of this information is little. . . . Nevertheless, reinsurance agreements are discoverable under Rule 26(a)(1)(D).”).

\textsuperscript{174} An insurance company that wants to cover its potential bad faith exposure does so by purchasing an errors and omissions policy. See, e.g., The Hartford, Insurance Company Errors and Omissions Policy, https://www.thehartford.com/sites/the_hartford/files/insurance-e-o-policy.pdf.

\textsuperscript{175} JERRY & RICHMOND, supra note 2, at 998–99.

\textsuperscript{176} FED. R. CIV. P. 26 advisory committee’s note to 1970 amendment.

\textsuperscript{177} Id.

litigation or settlement strategy in a bad faith case in the way liability insurance may be to a plaintiff in a third-party action against an insured. Thus, a bad faith plaintiff has no need to know of its existence.

Third, reinsurance is strictly a contract of indemnity between the cedent and the reinsurer. Rule 26(a) only mandates the disclosure of insurance agreements; it does not mandate the disclosure of other contracts or promises of indemnity, such as corporate agreements to indemnify employees, directors, or officers. By analogy, then, there is no basis to require the disclosure of reinsurance agreements.

Fourth, a reinsurance agreement has no probative value in a bad faith case. Neither the presence nor absence of reinsurance makes it more or less likely that the ceding insurer acted in bad faith in connection with the underlying case. Although Rule 26(a)(1)(A)(iv) does not condition disclosure on relevance or probative value at trial, it is pointless to mandate disclosure of a document which, barring unforeseeable circumstances, will have no effect on the course or outcome of the litigation.

C. Relevance of Reinsurance Communications and Other Information

Even if reinsurance agreements must be voluntarily disclosed or are otherwise relevant and therefore discoverable, that does not mean all communications between an insurer and reinsurer are discoverable. The Rule 26(a)(1)(A)(iv) disclosure requirement plainly does not extend that far. Any reinsurance information beyond the reinsurance agreement itself must be relevant to the plaintiff’s bad faith claim to be discoverable. That link is often missing, and courts regularly reject bad faith plaintiffs’ attempts to discover reinsurance communications or information beyond any applicable reinsurance agreement. As the First Horizon

181. Id.
185. See, e.g., Ill. Nat’l Ins. Co. v. Nordic Plc. Constr., Civ. No. 11-00515 SOM-KSC, 2013 WL 12133660, at *4 (D. Haw. Oct. 31, 2013) (“Reinsurance policies are discoverable pursuant to Rule 26(a)(1)(A)(iv), and no showing of relevance is required. . . . However other documents related to reinsurance are irrelevant and not discoverable.” (footnote and citations omitted)); Heights at Issaquah Ridge, 2007 WL 4410260, at *4 (“There is no connection between the claims asserted against defendant Steadfast, and Steadfast’s reinsurance of a block of its insurance policies, that would make that reinsurance relevant to the claims asserted here.”); Great Lakes Dredge & Dock Co., 159 F.R.D. at 504 (“The court concludes that the relevance of ‘all documents’ relating to reinsurance is too attenuated to be discover-
National Corp. v. Houston Casualty Co.\textsuperscript{186} court broadly declared, reinsurance-related communications are “not relevant to a claim of bad faith.”\textsuperscript{187} Relevance is especially lacking where treaty rather than facultative reinsurance is involved.\textsuperscript{188}

While reinsurance communications may be irrelevant and thus undiscoverable in many bad faith cases, courts have recognized their relevance for discovery purposes in others.\textsuperscript{189} National Union Fire Insurance Co. v. Donaldson Co.\textsuperscript{190} is illustrative. In that case, the insured, Donaldson, argued that National Union’s and American Home Assurance Co.’s communications with their reinsurers were relevant because they “would likely reveal what [the insurers] knew and when about their plans for applying coverage under the policies because they ‘would have had an obligation to disclose known facts’ to [their] reinsurers.”\textsuperscript{191} After observing that federal courts are split on the discoverability of reinsurance communications, the Donaldson court was persuaded that National Union’s and American Home’s communications with their reinsurers were “sufficiently relevant” to Donaldson’s bad faith claim to be discoverable.\textsuperscript{192}

D. Attorney-Client Privilege, Work Product Immunity, and Reinsurance-Related Communications

A finding of relevance does not end the discovery analysis, however, because even if an insurer’s reinsurance-related communications are relevant to a plaintiff’s bad faith claim, their discovery will be off-limits if they are protected by the attorney-client privilege or work product immunity. Unfortunately, this is a complex area of the law because of the nature of reinsurance, as well as the nature of communications between cedents and reinsurers.
By way of background, recall that the attorney-client privilege cloaks confidential communications between lawyers and clients. It is normally waived if an otherwise privileged communication is shared with a third-party who is not necessary to the client’s representation.193 There is an exception to this rule where the client and the third-party share a sufficient common interest, often described as the “common interest doctrine” or “common interest privilege.”194 In comparison, work product immunity is not lost by the disclosure of protected information to a third-party unless the third-party is an adversary or a conduit to an adversary.195 For information to receive work product protection, however, in federal court and in most states, it must have been prepared in anticipation of litigation.

Starting with work product, many disputes pivot on whether the materials a plaintiff seeks were prepared in anticipation of litigation. Ceding insurers must notify their reinsurers of claims for which they will seek indemnity and provide certain associated information. So, in many cases, a cedent’s reinsurance communications and materials will have been prepared in the ordinary course of business rather than in anticipation of litigation, and will not qualify as work product.196 But if the insurer can demonstrate that materials apparently created in the ordinary course of business would not have been prepared but for the existence or likelihood of litigation,197 or were prepared because of litigation,198 then the work product doctrine protects them from discovery. Furthermore, ceding insurers often prepare litigation-related materials for, or provide such materials to, reinsurers outside the bounds of regular claims reporting or routine business communications. Such materials enjoy work product immunity.199

194. The common interest doctrine is neither a new form of privilege nor an independent basis for asserting the attorney-client privilege. Rather, the doctrine provides an exception to the general rule that the attorney-client privilege does not attach when otherwise privileged communications are made in the presence of a third-party who is not necessary to the client’s representation, or is waived where otherwise privileged communications are shared with such a third-party. The common interest doctrine assumes a valid underlying privilege. Epstein, supra note 134, at 356.
In determining whether materials were prepared in the ordinary course of an insurer’s business or were prepared in anticipation of litigation, “[a]n insurer’s decision to decline coverage is usually the point at which the ordinary course of business ends and the anticipation of litigation begins.”

Materials prepared thereafter, and certainly those prepared in connection with subsequent litigation, are entitled to work product protection. The ordinary course of business should also be held to end when a liability insurer either offers its policy limits in settlement or rejects a policy limits settlement offer. In states in which the insured has the ability to reject a defense under a reservation of rights, the insurer’s ordinary course business should be held to end upon that action by the insured. Experience teaches that liability insurers can reasonably anticipate bad faith litigation any time they are unable to settle within policy limits or refuse to do so, or whenever they receive a demand to withdraw a defense under a reservation of rights. The fact that litigation does not always follow does not mean that it was not reasonably anticipated.

Assuming that materials or information qualify as work product, an insurer’s transmission or disclosure of them to a reinsurer does not expose them to discovery because the reinsurer, although a third-party, is neither an adversary nor a conduit to an adversary. In fact, an insurer’s decision to share work product with a reinsurer is consistent with maintaining confidentiality in light of the reinsurer’s shared interest in prevailing in the related litigation.

With respect to the attorney-client privilege, the issue in most cases is whether a ceding insurer that shares privileged communications with a reinsurer has waived the privilege through disclosure to a third-party, or whether the insurer and reinsurer share a common interest that will keep the privilege intact. There are decisions going both ways. In *ARTRA 524(g) Asbestos Trust v. Transport Insurance Co.*, the court held

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203. See Epstein, *supra* note 134, at 1167 (stating that “work-product protection applies if the material was prepared in anticipation of litigation, even if no litigation actually ensures”).

204. See, e.g., *Minn. Sch. Bds. Ass’n Ins. Tr.*, 183 F.R.D. at 631–32 (shielding as opinion work product defense counsel’s letters forwarded to the reinsurer).

205. *Id.*

that the common interest doctrine operated to protect privileged communications between Transport and its reinsurer because “the shared interests of the reinsurer and insurer are not so materially different from the shared interests of a direct insurer and its insured to conclude that the common interest [doctrine] does not apply.” Of course, the clear majority rule holds that an insured’s communications with its liability insurer are protected by the attorney-client privilege.

In contrast, the court in Fireman’s Fund Insurance Co. v. Great American Insurance Co. of N.Y. held that Max Specialty Insurance Co. (Max) and its facultative reinsurer, Arch Re, did not share a common legal interest. As a result, Max could not invoke the common interest doctrine to protect its communications with Arch Re as privileged. The court declined Max’s invitation to effectively accept a “categorical rule” that ceding insurers and their reinsurers share a joint legal interest because a reinsurer’s obligation to indemnify its cedent is tied to the ceding insurer’s obligation to indemnify its insured. In rejecting Max’s follow the fortunes argument, the Fireman’s Fund court reasoned that unlike the relationship between a liability insurer and its insured, where the insurer may have a duty to defend the insured, thereby requiring cooperation in litigation, the ceding insurer’s interests and those of the reinsurer may be aligned in some respects and incompatible in others. Thus, a court cannot assume a common interest based solely on the cedent-reinsurer relationship. Because Max asserted no other basis for recognizing a common interest, and further because Max could not show that it shared privileged material with Arch Re to formulate a common legal strategy or to obtain legal advice from Arch Re, its common interest argument fell flat.

In Progressive Casualty Insurance Co. v. FDIC, the court adopted a magistrate judge’s finding that Progressive did not share a common interest with its reinsurers merely because the reinsurers would have to indemnify Progressive if it was obligated to indemnify its insureds, and thus the privilege did not apply. The district court agreed with the magistrate judge that the follow the fortunes doctrine did not support Progressive’s

207. Id. at *14.
210. Id. at 140.
213. Id. at 141.
214. 49 F. Supp. 3d 545 (N.D. Iowa 2014).
215. Id. at 559.
common interest claim because its relationship with its reinsurers was commercial and financial.216 Progressive communicated with its reinsurers not to further a common legal interest, but to further its commercial interests.217 In addition, Progressive offered no evidence of a joint legal strategy or joint legal enterprise with its reinsurers, which also doomed its privilege argument.218 The latter point is important when considering the potential persuasive value of Progressive in other cases because the court’s narrow take on legal versus commercial interests is not unanimous. Some courts take a broader view of the common interest doctrine that “countenances sharing of legal advice even if the interest is primarily commercial or financial in nature.”219

The Fireman’s Fund court’s position that a ceding insurer and reinsurer cannot be assumed to share a common interest because unlike the liability insurer-insured relationship, where the insurer has a duty to defend and the insured owes a reciprocal duty to cooperate, a reinsurer has no duty to defend a cedent in litigation, requires analysis. In fact, notwithstanding some subsequent courts’ embrace of the decision, the Fireman’s Fund court’s view of common interest in this context is out of focus.

To start, not all liability insurers have a duty to defend their insureds. For example, an excess insurer typically has no duty to defend an insured; that is the primary insurer’s responsibility.220 A liability insurer that issues a defense-cost-indemnification policy may reimburse or advance the insured’s defense expenses, but it has no duty to defend the insured.221 But even lacking a duty to defend, a liability insurer generally must consent to any settlement that it will be required to fund in whole or part.222

Furthermore, a non-defending insurer typically has a contractual or legal right to associate in the insured’s defense.223 That right includes the entitlement to request from defense counsel and the insured information reasonably necessary to assess the insured’s potential liability and to determine whether the defense is being conducted appropriately.224 Because non-defending insurers may be liable for all or part of any judgment, they are entitled to have input into major defense-related decisions—even if

216. Id. at 558.
217. Id.
218. Id.
220. Jerry & Richmond, supra note 2, at 975–76.
223. Id. at 67.
those decisions will be made by the insured or another insurer.\textsuperscript{225} To offer such advice, and to make informed decisions regarding settlements that require their contribution, they need access to privileged information about the defense.\textsuperscript{226} Such sharing does not abrogate the attorney-client privilege between the insured and the defending insurer.\textsuperscript{227}

Similarly, reinsurers have no right to control cedents’ claims handling or their defense of their insureds in litigation.\textsuperscript{228} But reinsurers do have a right to associate in their cedents’ defense of insureds.\textsuperscript{229} “The ‘right to associate’ involves the right to consult with and advise the reinsured in its handling of a claim.”\textsuperscript{230} Indeed, the right to associate allows a reinsurer to be directly involved in the cedent’s litigation or claim management.\textsuperscript{231} Therefore, just as an insured should be permitted to share privileged information with a non-defending insurer without waiving the privilege, a ceding insurer should be permitted to do the same with its reinsurer.\textsuperscript{232}

\section*{V. DISCOVERY OF INSURANCE COMPANY EMPLOYEE PERSONNEL FILES}

In a continuing pattern in bad faith litigation, plaintiffs argue that they should be able to obtain the personnel files of the claims representatives who were responsible for the handling of the underlying claim or litigation. Plaintiffs generally assert three possible needs for the discovery of insurance company employees’ personnel files: (1) to prove a lack of employee credibility, qualifications, or training; (2) to determine whether any claims handlers were disciplined for misconduct in connection with the claim in question; or (3) to determine whether company policies, programs, or incentive plans encouraged employees to wrongfully deny, underpay, or delay the payment of first-party claims, improperly decline to defend third-party claims, or pathologically litigate third-party cases rather than reasonably settling them within policy limits.

\textsuperscript{225} Barker, \textit{supra} note 222, at 67.
\textsuperscript{226} Id.
\textsuperscript{228} Barker, \textit{supra} note 222, at 72.
\textsuperscript{229} Dotseth et al., \textit{supra} note 170, § 72.02[5][g], at 72-35.
\textsuperscript{231} Dotseth et al., \textit{supra} note 170, § 72.02[5][g], at 72-35.
\textsuperscript{232} Barker, \textit{supra} note 222, at 73.
\textsuperscript{233} See, e.g., White v. Cont’l Gen. Ins. Co., 831 F. Supp. 1545, 1556 (D. Wyo. 1993) (“In addition, the plaintiff uncovered evidence of what Continental refers to as its ‘bonus plan,’ Every Continental underwriter is required to amass 100 points per day in order to keep their job. 2.5 points are awarded if an underwriter either pays or denies a claim; however, 5 points are awarded if the underwriter can find a pre-existing condition that would enable Continental to deny coverage . . . . Based on this evidence . . . . there are genuine issues of material fact relating to the plaintiff’s bad faith claim.”).
Insurers, on the other hand, resist discovery of claims professionals’ personnel files based on relevance, the need to safeguard the sensitive information often contained in them, a desire to protect employees the against embarrassment or harassment, and the need to protect the employees’ privacy more generally. Employees’ privacy is a legitimate discovery concern, and courts are frequently sympathetic. As an Alabama federal court explained in Graham & Co., LLC v. Liberty Mutual Fire Insurance Co., public policy “strongly disfavors” the discovery of personnel files, and their discovery should be permitted only if (1) the material sought is clearly relevant; and (2) the need for discovery is compelling because the material is not otherwise readily obtainable.

Or, as the Tenth Circuit similarly observed in Regan-Touhy v. Walgreen Co., “personnel files often contain sensitive personal information . . . and it is not unreasonable to be cautious about ordering their entire contents disclosed willy-nilly.” In fact, trial courts should firmly require that material sought in discovery be relevant, and should restrict discovery when necessary to protect a party or person from annoyance, embarrassment, or oppression.

Courts must balance the relevance of the material sought, and thus plaintiffs’ need for discovery, with targeted employees’ rights to privacy and freedom from annoyance and harassment. Despite the heightened protection from discovery afforded personnel files, that balance generally tips in favor of discovery in bad faith cases, with some critical limitations.

234. See, e.g., Westport Ins. Corp. v. Hippo Fleming & Fertile Law Offices, 319 F.R.D. 214, 219 (W.D. Pa. 2017) (“The reasons supplied by Hippo for wanting the personnel files such as whether the claims employees had some incentive to deny its claim and the nature of the relationship between the company and its employees could likely be obtained through the depositions of those employees. . . . Hippo has not presented any other evidence to support their theory that the personnel files are likely to include information relevant to their claims. . . . Therefore . . . the heightened relevancy standard for personnel files is not met.” (citations omitted)); Am. Modern Select Ins. Co. v. Crain, Case No. 3: 14-cv-2952-TLW, 2015 WL 11027031, at *1 (D.S.C. July 24, 2015) (“In light of the confidential and proprietary nature of the materials contained within personnel files, there is a strong public policy against mandating their disclosure. . . . [P]roduction of an entire file should not be ordered when less intrusive means of discovery are available. . . . Plaintiff is directed to produce [the adjuster’s] background, job qualifications, and work experience. . . . [The insured] can seek additional information related to [the adjuster’s] employment history through a deposition. . . .” (citations omitted)).

236. Id. at *8 (quoting Coker v. Duke & Co., 177 F.R.D. 682, 685 (M.D. Ala. 1998)).
237. 526 F.3d 641 (10th Cir. 2008).
238. Id. at 648.
239. See id. at 648–49 (quoting Herbert v. Lando, 441 U.S. 153, 177 (1979)).
A Kentucky Supreme Court case, *Grange Mutual Insurance Co. v. Trude*, is representative. *Trude* arose out a car accident involving Dale Wilder and Sid Gabbard. Grange insured Gabbard. Wilder eventually became frustrated with the glacial pace of negotiations over his claim. He thus sued Gabbard and Grange, asserting a bad faith claim against the latter. The trial court bifurcated the claims. In discovery in the bad faith portion of the case, he sought the “personnel files and the records and policies concerning the compensation of various Grange employees,” including the adjusters who handled his claim and their supervisors. The trial court overruled Grange’s objections to these discovery requests and denied Grange’s request for a protective order. After unsuccessfully petitioning the Kentucky Court of Appeals for a writ of prohibition, Grange appealed to the Kentucky Supreme Court.

The *Trude* court agreed with Grange that many of the items likely to be found in the employees’ personnel files, such as original job applications, marital data, tax and dependent information, medical information, health insurance data, worker’s compensations claims, and retirement account information were irrelevant to Wilder’s bad faith claim and consequently were not discoverable. To the extent that Wilder’s discovery requests encompassed such materials or information, they were overly broad. But other information typically found in personnel files (e.g., materials related to job performance, bonuses, wage and salary data, disciplinary history) was relevant to Wilder’s claim and was therefore discoverable. “Job performance and disciplinary information could help show that the adjusters and their superiors had engaged in bad faith practices in adjusting Wilder’s initial claim or that they had engaged in bad faith practices at other times.” This information could also reveal Grange’s “knowledge or even approval of such practices.” Finally, as the court explained:

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240. *But see Graham & Co., LLC*, 2016 WL 1319697, at *8 (finding that the information sought in personnel files was not relevant and reasoning that the plaintiffs could “seek the information they want[ed] via other means allowed under the Federal Rules of Civil Procedure”).
241. 151 S.W.3d 803 (Ky. 2004).
242. *Id.* at 807.
243. *Id.* at 815 & n.38.
244. *Id.* at 807–08.
245. *Id.* at 815.
246. *Id.*
248. *Id.*
249. *Id.*
Wilder claim[ed] that the compensation of Grange’s employees could be keyed to obtaining low settlements, which in turn might encourage bad faith practices by adjusters and other employees. Wage, salary, and bonus data as to the employees described in the discovery requests shed light on this subject, as would the discovery requests as to how Grange’s overall compensation system works. Thus, insofar as the requested personnel records relate to compensation of the employees involved and the other records relate to how Grange’s overall compensation system works, they are discoverable.\(^{250}\)

After addressing other discovery issues that are not pertinent here, the Kentucky Supreme Court remanded the case to the court of appeals to enter a writ of prohibition that conformed to the opinion.\(^{251}\)

In short, courts generally permit discovery of some portions of the personnel files of the claims representatives who were significantly involved with the underlying claim or case if the plaintiff can articulate a sufficient connection between its bad faith theory and the information sought in the files. This is an achievable standard in most cases, although certainly not all.\(^{252}\) Assuming there is a connection, and thus information in the files is relevant for discovery purposes, courts typically allow the discovery of job applications, compensation information, information on incentive awards and programs, performance evaluations related to claims handling, information regarding defense and indemnity goals imposed on claims personnel, information concerning the employees’ qualifications, and materials

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\(^{250}\). Id.

\(^{251}\). Id. at 818–19.

\(^{252}\). See, e.g., Heaslip v. Gov’t Empls. Ins. Co., Case No. 8:16-cv-555-T-35TBM, 2016 WL 8928957, at *1 (M.D. Fla. Oct. 20, 2016) (“While . . . some . . . discovery into . . . personnel files may be relevant . . . in bad faith actions, Plaintiff . . . is seeking the entire personnel files for twelve employees without providing sound justification that such discovery is warranted or necessary. . . . Plaintiff fails to explain these individuals’ involvement in the claims handling. . . . It is entirely unclear . . . what role these individuals played in handling or adjusting the underlying claim, if they had any decision-making responsibility, or whether their training, experience, or performance evaluations have any arguable relevance to GEICO’s handling of the Heaslip claim.”); Gutierrez v. State Farm Lloyd’s, Civ. A. No. 7:14-CV-430, 2015 WL 13188353, at *7 (S.D. Tex. Jan. 22, 2015) (refusing to permit the plaintiff to embark on a fishing expedition to prove his groundless bad faith theories); Fullbright v. State Farm Mut. Auto. Ins. Co., No. Civ-09-297-D, 2010 WL 300436, at *4 (W.D. Okla. Jan. 20, 2010) (“Plaintiffs have not presented sufficient justification to support obtaining information from personnel files regarding merit pay or related salary information. Plaintiffs speculate that adjusters’ salaries are affected by the number of claims reduced or denied; however, that speculation is not sufficient to justify disclosure of personal and sensitive information contained in personnel files. The [p]laintiffs have also not provided justification for a review of disciplinary materials in an adjuster’s personnel file; absent such justification, the [c]ourt does not find such material reasonably calculated to lead to the discovery of admissible evidence.”); Sharp v. Travelers Pers. Sec. Ins. Co., No. 12 CV 6483, 2014 WL 8863084, at *13 (Pa. Ct. C.P., Lackawanna Cty. Mar. 7, 2014) (“Sharp has not . . . identified a ‘sufficient nexus’ between that purported bad faith claim and the personnel files. . . . Sharp may depose Travelers’ claims representatives to discover information regarding their training and performance evaluations, as well as [certain] company practices. . . .”).
reflecting professional discipline related to claims handling. Simultaneously, courts strive to safeguard employees’ privacy, and accordingly order that the insurer redact or otherwise withhold employees’ social security numbers; dates of birth; banking information, including account numbers; personal health or medical information; drug test results; family information, including child support matters; home addresses and telephone numbers; personal e-mail addresses and cellular telephone numbers; information relating to personal bankruptcies or wage garnishments; pension and retirement account information; tax forms and information; and any history of workers’ compensation or disability claims that did

not affect the employee’s ability to handle the case or claim in question. A court may further require that discoverable information in claims representatives’ personnel files be produced subject to a protective order, or otherwise be kept confidential.

A plaintiff should not be permitted to discover the personnel files of insurance company employees who had minimal or no involvement with the plaintiff’s claim. Nor should a plaintiff be allowed to discover the personnel files of supervisors to whom the responsible claims representatives reported unless the plaintiff can make a sufficient showing that the supervisors participated in the handling of the claim or case in which the bad faith allegedly occurred. Supervisory status alone does not justify discovery of an employee’s personnel file in most cases. At least some supervisors’ personnel files may be discoverable absent their direct participation in claim handling, however, where it is alleged that the insurer has institutional policies or programs, such as incentive compensation schemes, that encourage unreasonable claims practices by adjusters. Here the targeted employees tend to hold some form of vice president title or higher. Courts’ rationale in permitting discovery in these cases is that evidence of such policies or programs is more likely to be found in the personnel files of senior managers and claims executives than it is to reside in the personnel files of lower level claims staff and their immediate supervisors.


256. See, e.g., Markel Am. Ins. Co. v. Flugga, No. 5:11–CV–588–Oc–10PRL, 2012 WL 4356960, at *2 (M.D. Fla. Sept. 24, 2012) (stating that “the information provided to [the plaintiff] shall only be used in the instant litigation and for no other purpose . . . and shall not be shared with anyone who does not have a legitimate need to know the information on account of their involvement in this case”).


260. Id.
VI. DISCOVERY OF SIMILAR CLAIMS AND OTHER BAD FAITH CLAIMS, COMPLAINTS, OR CASES AGAINST OR INVOLVING THE INSURER

A. Background

Plaintiffs in bad faith cases frequently attempt to discover evidence of insurers’ adjustment of claims by other insureds “similar” to theirs in efforts to demonstrate that the insurer wrongfully denied, discounted, or otherwise mishandled their claims. An insured may also alleged that the insurer’s mistreatment of similarly situated insureds evidences a pattern or practice of bad faith. Repeated instances of claims-related misconduct may also support a plaintiff’s unfair trade practices allegations or punitive damage claim. For these same reasons, plaintiffs often seek discovery of other bad faith complaints or claims, and other bad faith cases against the insurer.

B. Plaintiffs’ Discovery of Other “Similar” Claims

The discovery of “similar” claims is disfavored in bad faith litigation. There are many problems with discovery requests seeking information on claims similar to a plaintiff’s claim, and good reasons to deny discovery based on relevance, over-breadth, undue burden, or proportionality. First, describing claims as “similar” is inherently vague and unmanageable. What makes claims similar? Is it the line of coverage, type of policy,

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262. See, e.g., Dobro v. Allstate Ins. Co., Case No.: 16cv1197-AJB (BLM), 2016 WL 4595149, at *7 (S.D. Cal. Sept. 2, 2016) (discussing burden and relevance); Gutierrez v. State Farm Lloyds, Civ. A. No. 7:14-CV-430, 2015 WL 13188353, at *5 (S.D. Tex. Jan. 22, 2015) (“The Court will not allow Plaintiffs to fish into unrelated third-party matters because that information cannot reasonably support whether Plaintiffs’ claims were undervalued. Even if Plaintiffs were able to establish an ostensible pattern or practice of undervaluation of claims in the Rio Grande Valley, it would not prove that this individual claim was undervalued.”); Dade Cty. Fed. Credit Union v. Cумис Ins. Soc’y, Inc., Case No. 10-23711-CIV-UNGARO/TORRES, 2011 WL 13100237, at *2 (S.D. Fla. Aug. 1, 2011) (“How [the] [d]efendant . . . investigated claims or determined coverage in other cases has little bearing on whether this claim is covered. . .”); AG Equip Co. v. AIG Life Ins. Co., No. 07-CV-556-CVE-PJC, 2008 WL 5205192, at *5 (N.D. Okla. Dec. 10, 2008) (focusing on relevance, over-breadth, and the additional discovery required to determine whether supposedly similar claims are actually similar); Cunningham v. Std. Fire Ins. Co., Civ. A. No. 07-cv-02538-REB-KLM, 2008 WL 2902621, at *9 (D. Colo. July 24, 2008) (concluding that the defendants’ conduct with regard to other claims was irrelevant and would not lead to the discovery of admissible evidence); J.C. Bern-Mas Inv., LLC v. Indian Harbor Ins. Co., Civ. A. No. 06-11135, 2008 WL 45407, at *2–5 (E.D. La. Jan. 2, 2008) (discussing relevance, over-breadth, undue burden, and privacy concerns); Retail Ventures, Inc. v. Nat’l Union Fire Ins. Co., Civ. A. No. 2:06-CV-443, 2007 WL 3376831, at *5 (S.D. Ohio Nov. 8, 2007) (agreeing with the insurer that the plaintiff’s discovery requests were unduly burdensome and overbroad, questioning the relevance of the information sought, and concluding that the requests were not likely to lead to the discovery of admissible evidence).
geography, time frame, amount in controversy, offending conduct by the insurer (e.g., claim denial, alleged delay in payment, alleged under-payment, or refusal to settle within policy limits), or accident or loss facts? Second every claim is, in fact, different, and an insurer’s conduct in relation to one claim proves nothing with respect to another claim.\textsuperscript{263} Furthermore, the discovery of supposedly similar claims invites multiple time-consuming mini-trials to determine why particular claims are dissimilar or why the insurer handled comparative claims differently, and thus why its conduct in the case at hand was either reasonable or unreasonable.\textsuperscript{264} Third, the task of researching similar claims can impose a huge burden on an insurer.\textsuperscript{265} Depending on how an insurer categorizes and organizes its files, a request for information on similar claims may require an insurer to search thousands of files and produce vast amounts of information.\textsuperscript{266} Modern electronic storage practices may lessen an insurer’s burden, but the burden remains substantial and in most instances undue.\textsuperscript{267} Moreover, given the limited relevance (if any) of information regarding similar claims, such discovery fails any thoughtful proportionality analysis.\textsuperscript{268} As a Delaware court reasoned

\begin{itemize}
  \item[263.] See William T. Barker, \textit{When Does Prior Work as the Insurer’s Claims Counsel Disqualify a Lawyer from Bringing a Bad Faith Suit or Testifying as an Expert?}, NEW APPLEMAN CURRENT CRITICAL ISSUES IN INS. LAW, Summer 2017, at 23, 37 (“Payment of some claims that properly could have been denied does not create any prescriptive obligations to pay other similar claims should they be presented. . . . The issue is whether the insurer was required to pay the claim before the court, not how similarly situated insureds have been treated.”).
  \item[265.] See, e.g., Clark Equip. Co. v. Liberty Mut. Ins. Co., No. C.A. 89C-OC-173, 1995 WL 867344, at *2 (Del. Super. Ct. Apr. 21, 1995) (“These affidavits [submitted by the insurers] are uncontested and describe the massive burden involving time, effort, and expense, as well as the disruption of business operations, that would be imposed upon defendants if discovery of other policyholder claims would be allowed.”).
  \item[266.] Jonathan L. Schwartz, \textit{It’s a Trap!—Successful Strategies for Avoiding Discovery Pitfalls in Coverage Cases}, DRI INS. COVERAGE AND PRAC. SYM. (DRI, Chicago, IL), Dec. 2012, at 274.
  \item[267.] See, e., First Horizon Nat’l Corp. v. Houston Cas. Co., No. 2:15-cv-2235-SHL-dkv, 2016 WL 5869580, at *7 (W.D. Tenn. Oct. 5, 2016) (notwithstanding the plaintiffs’ argument that the defendant’s handling of similar claims would not be unduly burdensome “because the claim files are available electronically and can be accessed with key word searches,” the defendants’ affidavits amply described “the massive burden involving time, effort, expense, and disruption of business operations that would be imposed upon [them] if discovery of other similar claims were allowed”).
  \item[268.] Additionally, this sort of discovery violates the privacy rights of the insureds whose claims the plaintiff seeks to discover. Nat’l Sec. Fire & Cas. Co. v. Dunn, 705 So. 2d 605, 608 (Fla. Dist. Ct. App. 1997); see, e.g., J.C. Bern Mas Inv., LLC, Civ. A. No. 06-11135, 2008 WL 45407, at *3 (E.D. La. Jan. 2, 2008). Those insureds may be able to consent to the discovery of their claim files, but the process of obtaining consent may be disproportionate to the needs the case, particularly in light of the limited relevance (if any) of the information to be discovered.
\end{itemize}
in sustaining an insurer’s objections to interrogatories seeking documents relating to its acceptance or denial of coverage for other environmental and delayed manifestation claims:

Aside from [the] burden [the discovery would impose on the insurers], the recent Delaware decisions offer several reasons for denying discovery. First, the existence of so many variables make the possibility of relevance too remote. Second, the manner in which the claims of other policyholders are handled would create extended mini-trials. Third, rational limits must be set on the extent of discovery in complex litigation of this nature, and other policyholder discovery would exceed those limits.269

In Tritschler v. Allstate Insurance Co.,270 the insured homeowner sued Allstate for bad faith for wrongfully refusing to pay a contractor’s overhead and profit directly to him in an actual cash value settlement when he, and not the unsatisfactory contractor that Allstate sent to repair his home as part of its “Quality Vendor Program,” had made the repairs.271 Allstate won summary judgment and Tritschler appealed.

One of the issues on appeal was the trial court’s refusal to allow Tritschler to conduct discovery in numerous areas on relevance and undue burden grounds, among them: (1) whether Allstate had “similar practices” in other states on overhead and profit, and use of a Quality Vendor Program; (2) whether Allstate’s homeowners policies in other states had similar actual cash value language; and (3) judicial and administrative rulings from other states on overhead and profit, election to repair, and use of a Quality Vendor Program.272 Tritschler argued that these issues were significant because he needed to explore Allstate’s knowledge that its practices were improper, and that the information from other states was relevant to show that Allstate knew that its practices were unreasonable.273 The Tritschler court rejected this argument, stating:

[T]he trial court could have found that the relevance of policies and insurance decisions from other jurisdictions was limited because insurance laws vary from state to state. Thus, the practices in other jurisdictions and any legal challenges to such practices do not, as a matter of law, bear on the propriety of those practices in Arizona. . . .

Furthermore, in order to comply with Tritschler’s request on this issue, Allstate would have to conduct a nationwide search of all pending and past litigation, published and unpublished court decisions, and regulatory determinations relating to the company’s calculation of overhead and profit. Such

271. Id. at 522–23.
272. Id. at 532.
273. Id.
action is unduly burdensome in light of the limited relevance of the information this discovery might ultimately reveal.\footnote{274}

The court therefore concluded that the trial court did not abuse its discretion in denying Tritschler’s “burdensome and overbroad motion to compel discovery” and granting Allstate’s motion for a protective order on these issues.\footnote{275}

It may be possible in some cases to narrow the request for other similar claims in ways to lessen the insurer’s burden or achieve some proportionality.\footnote{276} For example, it might be possible to confine “similar claims” to claims of the exact same type, such as denials of UIM claims or the denial of property damage claims under homeowners’ policies. It might then be possible to limit the universe of such claims to those in the same state as the plaintiff’s claim, and further limit discovery temporally, so that an insurer only had to produce responsive information for, say, a three-year period. But even then, the relevance of the information discovered, if any, is so minimal that there is little point in conducting the exercise. That was the conclusion the Texas Supreme Court reached in In re National Lloyds Insurance Co.\footnote{277}

In re National Lloyds arose out of September 2011 and June 2012 storms that damaged Mary Erving’s home in Cedar Hill, Texas. She filed claims with her homeowner’s insurer, National Lloyds, which sent adjusters to inspect Erving’s home in response to each claim. National Lloyds thereafter paid the claims.

Thinking that National Lloyds had underpaid her claims, Erving sued the company for breach of contract, bad faith, fraud, conspiracy to defraud, and violations of the Texas Deceptive Trade Practices Act and Insurance Code.\footnote{278} In discovery, she requested all claim files from the past year for properties in Dallas and Tarrant Counties involving the two adjusting firms that handled her claims, Team One Adjusting and Ideal Adjusting.\footnote{279}

\footnote{274. Id. at 532–33.}
\footnote{275. Id. at 533.}
\footnote{277. 449 S.W.3d 486 (Tex. 2014).}
\footnote{278. Id. at 487–88.}
\footnote{279. Id. at 488.
National Lloyds objected to the discovery on the grounds that it was overbroad, unduly burdensome, and sought information that was neither relevant nor calculated to lead to the discovery of admissible evidence. Erving moved to compel discovery. The trial court ordered National Lloyds to produce the files for claims handled by Team One and Ideal Adjusting, but limited the order (1) to claims related to properties in Cedar Hill and (2) to the storms that damaged Erving’s home. National Lloyds then petitioned the Texas Supreme Court for a writ of mandamus.

The Texas Supreme Court observed that Erving essentially wanted to compare National Lloyds’ evaluation of the damage to her home with the company’s evaluation of the damage to other homes to show that her claims were undervalued. But the court did not see how National Lloyds’ “overpayment, underpayment, or proper payment” of other policyholders’ claims was “probative of its conduct with respect to Erving’s undervaluation claims at issue in this case.” This was especially so given the many variables associated with a particular claim, such as when it was filed, the condition of the property at the time, and the type and extent of damage caused by the covered event. Poring over claim files in the hope of locating similarly situated policyholders whose claims were estimated differently from Erving’s claims would at best be an unwarranted fishing expedition.

Erving contended that the trial court did not abuse its discretion in ordering the challenged discovery because its discovery order was narrowly tailored. Specifically, Erving argued that the trial court’s discovery order was reasonably limited in time and geographic scope to the two storms and Cedar Hill properties. But while reasonable temporal and geographic limits on discovery are required, those limits do not alone render the desired information discoverable. Because the information Erving sought was not reasonably calculated to lead to the discovery of admissible evidence, the trial court’s order compelling discovery was necessarily overbroad.

In conclusion, the In re National Lloyds court conditionally granted the insurer mandamus relief and directed the trial court to vacate its discovery order.

280. Id.
281. Id.
282. Id. at 489.
283. In re National Lloyds, 449 S.W.3d at 489.
284. Id.
285. Id. (quoting Texaco, Inc. v. Sanderson, 898 S.W.2d 813, 815 (Tex. 1995)).
286. Id.
287. Id.
288. Id. at 489–90.
289. In re National Lloyds, 449 S.W.3d at 490.
290. Id.
C. Discovery of Other Bad Faith Claims or Complaints of Bad Faith Against Insurers

Plaintiffs’ efforts to discover other bad faith claims against insurers or complaints of bad faith against insurers made with state insurance regulators suffer from many infirmities like those that betray the discovery of other similar claims: (1) the issue in a typical bad faith case is the insurer’s conduct in that case, not other cases, and evidence of other bad faith claims or complaints is therefore irrelevant;\(^\text{291}\) (2) every bad faith claim is fact-specific and involves unique circumstances, so evidence of other claims or complaints is of extraordinarily limited relevance, if any;\(^\text{292}\) (3) different states have different standards for imposing bad faith liability, so offending conduct in one state may not be actionable in another, again diminishing any possible relevance; (4) if other bad faith claims or complaints are unfounded, they cannot possibly be relevant to the current case; and (5) discovery into other bad faith claims or complaints is in most cases overbroad,\(^\text{293}\) imposes an undue burden on the insurer,\(^\text{294}\) and is disproportionate to the needs of the case. If offered at trial, evidence of other bad faith claims or complaints threatens the possibility of distracting and time-consuming mini-trials.\(^\text{295}\)

Nevertheless, some courts do find that other bad faith claims or complaints are relevant and therefore discoverable.\(^\text{296}\) To avoid overly broad discovery and reduce the risk that the insurer will bear an undue burden in responding to the plaintiff’s requests, these courts typically narrow the scope of discovery by imposing time limits, geographic constraints, or other limitations on the information to be produced.\(^\text{297}\)


\(^{295}\) Royal Bahamian Ass’n v. QBE Ins. Corp., 745 F. Supp. 2d 1380, 1385 (S.D. Fla. 2010).


\(^{297}\) See, e.g., Am. Auto. Ins. Co., 2017 WL 80248, at *6 (“To minimize the burden to [Fireman’s Fund], production shall be limited to paid claims/settlements and lawsuits in Hawaii for a 10-year period (2005–2015) involving CGL policies that included the same provisions/exclusions that formed the basis of the denial of coverage [in this case]. The production
Even courts that might generally prohibit the discovery of other bad faith claims or complaints on relevance grounds may conclude that this information is discoverable in narrow circumstances. First, such evidence may be relevant where the plaintiff alleges a violation of a state unfair trade practices act or similar statute that requires her to prove that the insurer engaged in the challenged conduct with such frequency as to constitute or indicate a general business practice. Indeed, the plaintiff may well need this discovery to make a prima facie case against the insurer. Second, a plaintiff’s need to prove its entitlement to punitive damages may justify such discovery. This is certainly true where proof of a general unlawful business practice is required to recover punitive damages. Third, discovery of other bad faith claims or complaints against an insurer may be supportable in institutional bad faith cases. The plaintiff’s theory in an institutional bad faith case is that the insurer’s claims policies or procedures, claims protocols and associated software, or performance and compensation criteria for claims representatives are collectively or individually intended to unfairly shrink indemnity payments to claimants or deprive insureds of policy benefits. Courts that allow the discovery of other bad faith claims or complaints on relevance grounds still must recognize insurers’ over-breadth, undue burden, and proportionality objections and reasonably limit discovery as appropriate based on the facts of the case.


300. See Fla. Stat. § 624.155(5) (2016) (“No punitive damages shall be awarded under this section unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and these acts are: (a) Willful, wanton, and malicious; (b) In reckless disregard for the rights of any insured; or (c) In reckless disregard for the rights of a beneficiary under a life insurance contract.” (emphasis added)).


D. Discovery of Other Bad Faith Litigation Involving an Insurer

Finally, there is the discovery of other bad faith litigation involving an insurer to consider. Everything that can be said about the discovery of other bad faith claims or complaints against insurers applies to the discovery of other bad faith litigation. The issues are very similar. Courts regularly refuse to permit discovery of other bad faith cases involving insurers based on a lack of relevance.\textsuperscript{303} Beyond relevance concerns, a court may refuse to allow such discovery because it is overly broad, disproportionate to the needs of the case, or imposes an undue burden on the insurance company.\textsuperscript{304}

Some courts permit the discovery of other bad faith cases, reasoning that such information is relevant to the plaintiff’s bad faith claim in the case at hand.\textsuperscript{305} In many cases, courts hold that the insurer need only furnish the plaintiff with a list of the other bad faith cases against it, typically including the case name and number, and venue.\textsuperscript{306} They may further


\textsuperscript{304}. See, e.g., McCrink, 2004 WL 2743420, at *6.


pare down these lists by limiting the time or jurisdictions from which the lists must be drawn, or by restricting the types of cases or policies on which the list will be based.\(^{307}\) In this way they limit the burden that this discovery might otherwise impose on the insurer—and certainly reduce the burden in comparison to that potentially imposed by the discovery of other bad faith complaints or claims. Other courts, rather than going the case list route, simply limit the scope of the discovery by time, geography, type of case or policy, or some combination of factors.\(^{308}\) A reasonably limited list of cases is preferable from an insurer’s perspective because it goes farthest in minimizing its administrative burden. This approach is also fair to plaintiffs, who can retrieve case materials from identified courts if they decide that this is, in fact, a fertile area of discovery. If an insured is unable to obtain critical documents from court files, it can always ask the court to revisit its prior ruling and order the insurer to produce those documents if they are in its possession or control.\(^{309}\)

VII. CONCLUSION

Litigation is fueled by discovery. Many lawyers believe that cases are won or lost in discovery. This is as true in insurance bad faith litigation as elsewhere. It is not surprising, then, that bad faith litigation is often characterized by discovery disputes. A handful of discovery issues surface time and again. This Article has attempted to analyze those issues and outline general rules for understanding or resolving them. Unfortunately, slight


307. See, e.g., Robertson, 2017 WL 1398342, at *3 (ordering the insurer to supply the plaintiff “with a list of all bad faith lawsuits filed against it during the last ten (10) years, which involve an allegation that [it] wrongfully denied a claim for life insurance benefits on the ground of material misrepresentation by the applicant”); Graham & Co., LLC, 2016 WL 1319697, at *5 (limiting the cases to be identified to other first-party bad faith cases in Alabama within the last four years); Grove, 2014 WL 11636148, at *2 (ordering State Farm “to produce a list including the name, case number, and county of filing of all lawsuits filed against [it] in Oklahoma in the last five years which assert claims based on the denial of homeowner[s] insurance coverage due to the ‘earth movement’ exception as it relates to plumbing, or which assert claims based on the denial of homeowner insurance coverage claims due to ‘wear, tear, scratching, deteriorating, inherent vice, latent defect or mechanical breakdown’ exclusion as it relates to plumbing); Giunto, 2013 12131306, at *7 (imposing a five year time limitation and further stating that the insurer was only required to “list lawsuits in which it was found to be liable or it stipulated to liability for bad faith; a plaintiff’s unfounded allegations are not enough to make the information relevant”).


309. Obviously, the insurer should have the opportunity to oppose the plaintiff’s motion or other request seeking this information.
factual differences between cases, trial courts’ broad discretion in managing discovery, and a lack of controlling authority in many jurisdictions create a great deal of uncertainty for bad faith litigants at odds over discovery. Because the case law is uneven and trial courts’ approaches to discovery issues often are not confidently predictable, both plaintiffs and insurers have an incentive to try to negotiate reasonable resolutions of discovery disagreements. If they cannot do so or choose not to do so for strategic reasons, they must be prepared to carefully and thoroughly advocate their positions in the trial court, because if they lose there the abuse of discretion standard of review they will confront on appeal is daunting.
AN ANALYTIC “GAP”:
THE PERILS OF RELENTLESS ENFORCEMENT OF PAYMENT-BY-UNDERLYING-INSURER-ONLY LANGUAGE IN EXCESS INSURANCE POLICIES

Jeffrey W. Stempel

ABSTRACT

Excess liability insurance, as the phrase implies, sits atop primary insurance or a lower layer of excess insurance and is required to cover only claims that are above the policy’s “underlying limit” and reach the “attachment point” of the excess policy in question. Historically, the law was largely indifferent to whether the underlying limit was exhausted by full payment from the underlying insurer or by other means such as payment by the policyholder due to an underlying insurer’s insolvency or because the policyholder and underlying insurer had compromised a coverage dispute for less than 100 percent coverage by the underlying insurer, with the policyholder “filling the gap” of the remaining underlying limit in order to reach the attachment point of an excess policy.

This was the legacy of the 1928 Zeig v. Massachusetts Bonding Co. case, a short but influential Augustus Hand decision. Over time, excess insurers...
began adding language to their policies that stated the entire underlying limit should be paid solely by an underlying insurer in order to trigger coverage. Courts have generally enforced such language and the American Law Institute’s draft Restatement of the Law of Liability Insurance has endorsed this approach.

But both the ALI and courts enforcing anti-Zeig “payment-only-by-underlying-insurer” clauses have failed to fully appreciate the pernicious impact of literal application of these provisions, which are often in the nature of boilerplate language that is not specifically negotiated or appreciated by policyholders. Routine application of anti-Zeig clauses runs counter to traditional contract concepts as well as to the overall socioeconomic objectives of insurance and sound risk management.

Several alternative approaches would better serve the risk management objectives of excess liability insurance. One modest alternative would be to enforce payment-only-by-underlying-insurer clauses only if they are the product of specific negotiation and understanding of the parties. Another would be to treat these clauses like anti-assignment clauses, which are not enforced when a policyholder assigns insurance rights after a loss because the rationale for the clause has evaporated since the assignment involves no increase of risk to the insurer. In similar fashion, an excess insurer appears in many cases to have no valid interest in the source of satisfaction of an underlying limit. A third and preferred approach—one fairest to excess insurers fearing that attachment will be achieved through suspect settlements designed to access towers of excess insurance without sufficient vetting of claims—would be to treat payment-only-by-underlying-insurer clauses in a manner akin to notice provisions, where late notice by the policyholder bars coverage only if the insurer can demonstrate substantial prejudice.

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I. INTRODUCTION

A. The Nature of Excess Insurance

Excess liability insurance plays an important role in risk management. Businesses and governments often purchase liability insurance in “towers” of coverage composed of various “layers” of coverage.\(^1\) After typically

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\(^1\) Liability insurance is often purchased in towers (e.g., $1 million primary, $5 million first level excess, $10 million second level excess, $20 million third level excess) both because an individual insurer might balk at taking on so much risk from a single policyholder (at least in a single primary policy) and because purchasing liability insurance in layers reduces premium costs. Although businesses are sued with some frequency, large losses are comparatively rare. See Gabarick v. Laurin Maritime (Am.), Inc., 649 F.3d 417, 422 (5th Cir. 2011) (applying Louisiana law) (“Because coverage is only triggered after the primary insurance limit has been exhausted, excess insurance is generally available at a lesser cost than the primary policy since the risk of loss is less than for the primary insurer.”) (internal quotation marks omitted). But when the high-level excess policy is reached, the excess insurer could owe a very large amount (e.g., $20 million in this example) even though it did not charge a particularly high premium for the policy. See generally Emmett J. Vaughn, Fundamentals of Risk and Insurance 631–33 (8th ed. 1999); George Rejda, Principles of Risk Management and Insurance 321–22 (9th ed. 2004) (same); James S. Trieschmann, Robert E. Hoyt & David W. Sommer, Risk Management and Insurance 213–14 (12th ed. 2005) (same). But because of the economics of insurance in which premiums are collected and invested long before losses are paid, insurers can profit in spite of paying large losses. See Jeffrey W. Stempel & Erik S. Knutsen, Stempel & Knutsen on Insurance Coverage § 1.03[A] (4th ed. 2016); Kenneth S. Abraham, Insurance Law & Regulation 108–13 (4th ed. 2005); Jeffrey W. Stempel, Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute, 12 Conn. Ins. L.J. 349, 353 (2006); Letter from Warren Buffet to Shareholders (2000), at 8-1, http://www.berkshirehathaway.com/letters/2000.html (describing great benefits of earning investment income on the “float,” which he describes as “money we hold but do not own” and praising the company’s 1966 acquisition of National Indemnity Company and National Fire & Marine Insurance Co. as a significant engine of Berkshire’s growth, estimating that the acquisition has resulted in more than $100 billion in income).
agreeing to assume some of the risk itself through a retention or deductible, the policyholder typically purchases a primary policy, followed by a first-layer excess policy, second-layer excess policy, and so on.\(^2\) The goal is to assemble a tower of liability protection at an affordable price.

Primary insurance is considerably more expensive per $1,000 than is excess insurance not only because of the greater risk of claims but also both because the primary insurer typically has a duty to defend suits, with defense costs ordinarily not eroding the policy limits,\(^3\) and because comparatively few claims involve amounts larger than the limits of the primary policy. Excess insurance, even in large amounts, is comparatively

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2. This article will primarily discuss excess liability insurance rather than excess property insurance. Excess liability insurance in the United States is most commonly sold to businesses as “general” liability insurance, director’s and officer’s liability insurance, or commercial automobile liability insurance. Personal lines excess coverage also exists but largely in the form of personal umbrella policies so as to provide additional liability protection to individuals.

3. The typical primary general liability policy requires the insurer to defend potentially covered claims against the policyholder (and other persons qualifying as “insureds” under the policy) based on the allegations of the complaint with defense expenses incurred by the insurer not eroding the limits of the policy. See Randy J. Maniloff & Jeffrey W. StempeL, General Liability Insurance Coverage: Key Issues in Every State, at ch. 5 (3d ed. 2015) (also noting differences among jurisdictions regarding use of extrinsic evidence in addition to examination of the face of the complaint and insurance policy); Jeffrey W. Stempel, Peter Nash Swisher & Erik S. Knutsen, Principles of Insurance Law 595–604 (4th ed. 2012). After a business policyholder is sued, the policyholder refers or “tenders” the lawsuit to the primary insurer and asks the primary insurer to provide a defense. The primary liability insurer has a “duty to defend” a potentially covered lawsuit against the policyholder. If a single contention of the plaintiff is potentially covered, the insurer must defend the entire lawsuit. Insurers may defend pursuant to a “reservation of rights” to contest ultimate coverage, which means that the insurer will defend the claim until issues of coverage are resolved by the court (or by a compromise settlement on coverage between the insurer and the policyholder). See Stempel & Knutsen, supra note 1, § 9.03[C]. See also Restatement of the Law of Liability Insurance §§ 13–27 (Proposed Final Draft) (Am. Law Inst. Mar. 28, 2017) (restating norms regarding duty to defend in general, including reservation of rights and providing commentary and case law discussion).

The standard general liability policy gives the insurer the right and duty to defend claims. As is oft-stated in the case law, the duty to defend is “broader” than the duty to pay claims: the duty to pay is based on the actual determination of coverage under the facts of the case as adjudicated, while the duty to defend is based on the “potential” for coverage based upon the allegations of the plaintiff’s complaint (the so-called four corners, or, in some jurisdictions, eight corners, test based upon comparison of the face of complaint and the face of the policy). See Maniloff & Stempel, supra, at ch. 5.

In addition to having a “duty to defend,” the primary insurer in the United States usually also has a “duty to settle,” or what might better be described as a duty to make reasonable settlement decisions. See Restatement of the Law of Liability Insurance § 24(1) (“When an insurer has the authority to settle a legal action brought against the insured or the authority to settle the action rests with the insured but the insurer’s prior consent is required for any settlement to be payable by the insurer, and there is a potential for a judgment in excess of the applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.”); Stempel & Knutsen, supra note 1, § 9.05[B]; Stempel, Swisher & Knutsen, supra, at 628, 633; Kent Syverud, The Duty to Settle, 76 Va. L. Rev. 1113 (1990).
less expensive because any defense costs paid by the excess insurer reduce the limits of coverage rather than being “outside limits” as is typically the case for primary insurers\(^4\) and because the excess insurer need not provide coverage until underlying limits of insurance have been “exhausted”\(^5\) and the “attachment point”\(^6\) of the excess policy has been reached.

For example, a small business policyholder may have a $10,000 retention, followed by a $1 million primary commercial general liability (CGL) policy, followed by a $5 million first-layer excess policy and a $10 million second-layer excess policy. A larger business may have as much as a $1 million retention, a $5 million primary policy, a $10 million first-layer excess policy, a $15 million second-layer excess policy, a $25 million third-layer excess policy, a $50 million fourth-layer excess policy, and a $100 million fifth-layer excess policy.

The excess policy typically “follows form” to the underlying primary insurance and provides the same coverage so that the full tower of liability insurance is seamless.\(^7\) Whatever is covered in the primary policy should be covered by the first-layer excess policy, and so on. These arrangements typically work without undue controversy. But, as discussed below, where one of the lower-layer insurers is insolvent or contests coverage, this creates problems.

In the case of insolvency, the policyholder will generally be responsible for the amount of coverage that would have been provided by the insolvent insurer and must pay this amount itself. But because these payments are not made by an underlying insurer, an excess insurer may argue that its attachment point has never been reached. In a case of disputed coverage, the policyholder and the underlying insurer may compromise the matter, with the underlying insurer paying less than full policy limits and the policyholder making up the difference. As discussed below, where an excess policy contains a payment-only-by-underlying-insurer clause, this

\(^4\) As noted above (note 1), a primary insurer’s expenditures defending the policyholder normally do not erode policy limits. See DPC Indus., Inc. v. Am. Specialty Lines Ins., 615 F.3d 609, 615 n.3 (5th Cir. 2010) (observing that most policies provide for defense in addition to indemnity limits); Restatement of the Law of Liability Insurance § 14(3) (“Unless otherwise stated in the policy, the costs of the defense of the action are borne by the insurer in addition to the policy limits”); Allan D. Windt, Insurance Claims and Disputes § 4.12 (5th ed. 2012) (“sums paid by the insurer pursuant to its duty to defend are owed in addition to the full policy limit”).

\(^5\) “Exhaustion” is a term of art in insurance that refers to the limits of a policy no longer being available through payment of claims.

\(^6\) The “attachment point” refers to the dollar amount at which the excess insurance is triggered and required to respond to a claim.

\(^7\) Following form means that the scope of coverage provided by the excess policy is congruent with that provided by the underlying policy. See Stempel & Knutsen, supra note 1, § 16.01.
also poses the risk that the excess insurer sitting above this settling insurer will contend that its attachment point has not been properly reached.

This article examines whether an excess insurer must respond whenever its “underlying limit” has been paid—by any source—or whether the excess insurer can insist on enforcing policy language that states that the underlying limit can be satisfied only by payments from the underlying insurer—with no “filling of the gap” by the policyholder.

B. The Dilemma Posed by Payment-Only-by-Underlying-Insurer Clauses: Policy Text vs. Purpose, Function, and Social Utility (and at Least One Party’s Intent)

How should insurance law treat situations of insolvency or settlement in which the underlying limit is not satisfied completely by underlying insurer payments? On the one hand, if the excess insurance policy has language requiring that payment of the underlying limit come only from the underlying insurer, the excess carrier has a pretty good argument that this is what the “contract” requires. But on the other hand, strict enforcement of such policy provisions discourages settlements and can work real unfairness to a policyholder that has paid frequently substantial premiums and now finds itself unable to access even a cent of the purchased excess coverage due to settlement. In cases of underlying insurer insolvency, where the policyholder cannot be blamed for taking the risk of settlement in the face of a payment-only-by-underlying-insurer clause (which the policyholder, its broker, and counsel may have simply missed), the forfeiture of excess insurance coverage seems a particularly severe penalty.

Courts are divided on this issue. Although there is not a large body of case law, more recent decisions have been receptive to enforcing language in the policy requiring that the underlying limit may be satisfied only through payment by the underlying insurance company. The American Law Institute (ALI), in the current draft of its Restatement of the Law of Liability Insurance, takes the position that such language in excess li-

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8. Or the policyholder and counsel may simply have miscalculated judicial treatment of the “payment by insurer only” clause, reasoning in a jurisdiction without clear precedent that the clause would not be strictly enforced.

9. See Restatement of the Law of Liability Insurance § 40, which was substantially approved by the Institute on May 16, 2016, at its Annual Meeting. Additional sections of the Restatement and the Restatement as a whole are expected to be submitted to the Institute for final approval at the 2018 Annual Meeting. The ALI project began in 2010 as the Principles of the Law of Liability Insurance and was converted to a Restatement during the fall of 2014. The difference between publishing a Restatement and publishing Principles is not particularly pronounced. The primary distinction is that Restatements are focused primarily on stating what the law is, albeit with recognition of minority and majority rules and commentary; a Principles project is viewed as less bound by the strict letter of the law and less constrained in advocating resolutions that are not particular established by case law. See Am. Law Inst., Capturing the Voice of the Am. Law Institute: A Handbook for Ali Reporters
ability policies should be enforced. At the same time, there is, as one might expect, considerable sentiment, particularly among policyholder counsel (but also brokers and academics) for resisting literal enforcement of a requirement that only underlying insurer payments can satisfy the underlying limit.

The concern of opponents of the ALI position is that language in an insurance policy may be boilerplate language in a form that is not closely read or understood by policyholders and should not be strictly enforced. It may not reflect the intent of the parties (certainly not that of many policyholders, particularly those ill-served by their brokers) and certainly undermines the basic purpose of excess insurance (to provide needed additional coverage when policyholder liability reaches a certain amount). It also creates a variety of pernicious socioeconomic effects: undermining risk distribution; threatening business solvency; undercompensating victims; increasing disputing costs; creating undue forfeiture of contract benefits and windfalls for excess insurers based on events that do not really harm the excess insurer.

II. THE CONFLICT OVER WHEN AN UNDERLYING LIMIT HAS BEEN EXHAUSTED AND THE ATTACHMENT POINT OF EXCESS INSURANCE HAS BEEN REACHED

Under ordinary circumstances, the policyholder, the primary insurer, the excess insurers, and their attorneys all work together to defend a claim (through trial and appeal if it is viewed as a weak claim) or, more commonly, to settle the claim within the limits of the policies spanned by the claim. Disputes can arise, however, when these parties have different interests and there are concerns on the part of an excess insurer about whether its attachment point has been reached only after sufficient resistance to the claim by the policyholder and underlying insurers.11

See generally Douglas Richmond, The Rights and Responsibilities of Excess Insurers, 78 DEN. U. L. REV. 29 (2000); Michael M. Marick, Excess Insurance: An Overview of General Principles and Current Issues, 24 TORT & INS. L.J. 715 (1989); see also Syverud, supra note 3, at 1202, n.248 (discussing issues surrounding excess insurers’ potential settlement obligations, particularly in cases where the primary insurer fails to defend or settle).
Excess insurance is designed to begin providing coverage when the “underlying limit” of primary insurance has been exhausted. Usually this takes place in straightforward fashion because the primary insurer has paid or is required to pay its entire policy limit as part of a settlement or judgment against the policyholder. But, as discussed below, there are circumstances where the primary insurer may not pay full policy limits but the underlying limit has been satisfied, usually through payment by the policyholder in order to reach the attachment point of the next layer of excess insurance. In these cases, excess insurers may argue that their attachment points can be reached only if it is an underlying insurer that has paid the money to reach the attachment point.

As a result, the issue of when an excess insurance policy’s “attachment point” has been reached becomes crucial. Until the attachment point has been reached, the excess insurer is not required to provide coverage. But once the “underlying limit” of coverage has been satisfied and the attachment point has been reached, excess policies are responsible, often for millions of dollars of coverage.

The issue may present itself when underlying insurance is unavailable because of insolvency or when an underlying insurer and the policyholder are in a coverage dispute and resolve that dispute by having the underlying insurer pay something less than full policy limits—with the policyholder paying an additional amount necessary to reach the policy limit—and then seeking further coverage from the excess insurer that sits “atop” the lower insurer in a “tower” of insurance coverage. When an underlying insurer is insolvent or pays less than its full share because of a coverage dispute with the policyholder, forcing the policyholder to “fill the gap” between the amount received by the underlying insurer and the attachment point of the excess policy, a conflict arises. Contrary to the excess insurer, the policyholder takes the position that the excess insurance attachment point has been reached and that it is irrelevant where the money comes from in order to reach the attachment point.


Excess insurers contend that a clear term of its policy (e.g., “the underlying limit must be paid by an underlying insurer”\(^{12}\)) should be enforced and that enforcement is necessary to prevent policyholders from paying

\(^{12}\) Or, to quote real-world examples from prominent cases:

Coverage hereunder shall attach only after all such “Underlying Insurance” has been reduced or exhausted by payments for losses . . . [and in] the event of the depletion of the limit(s) of liability of the “Underlying Insurance solely as a result of actual payment of loss thereunder by the applicable insurers, this Policy shall continue to apply to loss as excess over the amount of insurance remaining.
a relatively small amount of money (some portion of the primary policy limits or all of the primary policy limits) in order to reach a much larger amount of money that is the excess insurance policy limit. 13

Excess insurers argue that requiring payment to come from an underlying insurer provides the excess insurer with the protection of having the lawsuit fought hard by a primary insurer. Excess insurers contend that it is otherwise too easy for a plaintiff and a policyholder and a primary insurer with relatively low limits to reach a deal that serves their purposes at the expense of the excess insurer (and other excess insurers higher up in the tower of coverage). 14

As discussed below, 15 these arguments are not persuasive in situations where the policyholder has, in fact, incurred liability and expended funds to fill any gap between primary insurer payment and the excess insurer’s attachment point—at least so long as a coverage compromise with an underlying insurer is not fraudulent, collusive, or substantively unreasonable. Where policyholders pay “real money” or its equivalent to replace (in cases of insolvency) or “top off” underlying insurer payment or gaps in coverage due to insolvency or compromise of a coverage dispute, the prospect of collusion aimed at shifting liability to the insured is suffi-


Underwriters shall be liable only after the insurers under each of the Underlying policies have paid or have been held liable to pay the full amount of the Underlying Limit of Liability.


[Attachment requires that] (a) all Underlying Insurance carriers have paid in cash the full amount of their respective liabilities, (b) the full amount of the Underlying Insurance policies have been collected by the plaintiffs, the Insureds or the Insureds’ counsel, and (c) all Underlying Insurance has been exhausted.

See Citigroup Inc. v. Fed. Ins. Co., 649 F.3d 367, 372 (5th Cir. 2011) (applying Texas law) (holding that this policy “leaves no ambiguity about how the underlying policy is exhausted. The policy clearly explains that exhaustion occurs through payment, in cash, and of the full amount of the underlying insurer’s limit of liability.”).


15. See infra text accompanying notes 54–96 (addressing problems created by literal enforcement of payment-by-underlying-insurer-only clauses).
ciently low that excess insurers should not be able to escape coverage responsibility based solely on the source of the underlying payments.

But where the attachment point of an excess policy is allegedly reached only by exhaustion of an underlying policy by a below-limits settlement alone without any payment by the policyholder, excess insurers have grounds for questioning whether an attachment point has been met through legitimate means. This article does not endorse the view that, for example, settling a coverage dispute with a $1 million primary insurer for $500,000 requires that the $5 million first-layer excess insurer must begin providing coverage at the $500,000 mark rather than the $1 million attachment point set forth in the excess policy. Consequently, excess insurer arguments aimed at avoiding what might be termed “de facto drop-down due to settlement,” which have considerable force, do not


17. “Drop-down” liability of an excess insurer takes place when the excess carrier is required to attach at a point lower than that stated in its policy due to the insolvency of an underlying insurer. See Stempp & Knutsen, supra note 1, § 16.03[B]. It is largely a historical relic. Earlier versions of excess policies sometimes contained exhaustion and attachment language that triggered the excess insurance once the amount of “recoverable” or “collectible” underlying insurance had been met. Because insolvent underlying insurance is not recoverable, this was sometimes held to make the excess insurance attachment point correspondingly lower, in effect forcing the excess insurer to drop down. See, e.g., Reserve Ins. Co. v. Pisciotta, 640 P.2d 764 (Cal. 1982) (finding amount-recoverable language to require excess insurer to drop down to insolvent primary insurer’s level); MacNeal, Inc. v. Interstate Fire & Cas. Co., 477 N.E.2d 1322 (Ill. Ct. App. 1985) (finding amount-recoverable attachment language sufficiently ambiguous to be resolved in favor of policyholder). In the absence of such language, which insurers have long avoided in order to minimize drop-down liability, courts have rather consistently refused to require an excess insurer to attach at a level below that stated in the policy. See, e.g., Zurich Ins. Co. v. Heil Co., 815 F.2d 1122 (7th Cir. 1987) (applying Illinois law).

This article does not endorse drop-down liability for excess insurers but merely argues that an excess insurer should attach whenever its underlying limit has been satisfied by payment regardless of the identity of the payer. Although this payment should ordinarily be in cash or its equivalent, payment by other means (e.g., dismissing a counterclaim of demonstrable value) may at times suffice. An exploration of the types of noncash payments sufficient to satisfy underlying limits and reach excess insurance attachment points is beyond the scope of this article.

Also beyond the scope of this article are settlements between a policyholder/defendant and a plaintiff in which the plaintiff receives an assignment of defendant rights to a liability policy that includes confessions of judgment and stipulations regarding liability and damages pursuant to particular state tort law provisions. See, e.g., Schnitz v. Great Am. Assurance Co., 337 S.W.3d 700, 703 (Mo. 2011) (discussing “section 547.065 agreement” established pursuant to Missouri law).
undermine the thesis of this article—that excess insurance should attach after the underlying limit has been met through any combination of real value paid by underlying insurers and policyholders. 18

B. Policyholder Arguments That Source of Payment Should Not Ordinarily Matter (and Their Limits)

Excess insurer arguments for enforcement of payment-only-by-underlying-insurer clauses are not baseless but neither are they very persuasive. For one, if the excess insurer’s fear is that it will be victimized by a conspiracy among plaintiff, policyholder, and primary insurer, that same risk exists almost as much if a primary insurer with relatively low limits pays its full limits of coverage. For example, a primary insurer with limits of $50,000 or $100,000 that is forced to defend (with defense costs outside limits) a serious claim or group of claims hardly needs the policyholder to tell it that exhausting the policy quickly will transfer coverage responsibilities to the excess insurer and free the primary carrier from the burdens of protracted defense. 19

In addition, if the excess insurer feels it has been victimized by a “sweetheart deal” that was not truly at “arm’s length” but was done by parties trying to accommodate one another in order to take advantage of the excess insurer, the excess insurer has the right to challenge the settlement on the grounds that it was fraudulent, the product of collusion, a sham settlement, or unreasonable in amount or terms. 20 In other words, the excess insurer concerned about being “set up” by the policyholder and underlying insurer(s) can litigate that issue on its merits and avoid or re-

18. See, e.g., O’Connor, Caveat Settlor, supra note 16; O’Connor, Rights of Excess Insurers, supra note 16. One insurer counsel (the author was then with Steptoe & Johnson, a firm well known for representing insurers in coverage matters) once appeared to agree with the thesis of this article. See Rights of Excess Insurers at 34 (“most courts correctly have held that a policyholder must fill any gap in coverage caused by its below-limits settlements, thereby precluding a policyholder and its lower-level insurers from adversely affecting a non-settling excess insurer’s coverage obligations through their own settlement”) (footnote omitted). Subsequently, he more clearly embraced the insurer position that “payment-required-by-underlying-insurer-only” clauses should be strictly enforced in favor of excess insurers. See Caveat Settlor.

19. Substantive law limits the primary insurer’s ability to do this without penalty, in that a primary insurer’s unreasonable exhaustion of policy limits through unduly fast and generous settlement in order to prematurely terminate defense obligations constitutes bad faith that provides the policyholder with a claim for relief, characterized as tort in most states, that could subject the primary insurer to extra-contractual damages, including punitive damages. See generally MANILOFF & STEMPLE, supra note 3, at ch. 21 (discussing standards for determining bad faith and consequences); STEMPLE & KNUTSEN, supra note 1, at ch. 10 (discussing bad faith concept and liability).

20. See Miller v. Shugart, 316 N.W.2d 729 (Minn. 1982) (insurer may challenge settlement to which it did not agree and avoid coverage if settlement substantively unreasonable or result of fraud or collusion); United Servs. Auto. Ass’n v. Morris, 741 P.2d 246 (Ariz. 1987) (same); STEMPLE & KNUTSEN, supra note 1, § 10.
duce coverage if it prevails on the merits. If, for example, discovery reveals an unreasonable settlement or that the policyholder’s filling of a gap was paid in name only without actual cash or its equivalent, the excess insurer can defeat coverage on the merits irrespective of the presence or absence of a payment-only-by-underlying-insurer clause.

In contrast to putting the excess insurer to its proof regarding its fears of insufficiently vigorous defense below, robotic enforcement of underlying-insurer-must-pay clauses creates a total forfeiture of coverage likely to be well out of proportion to any injury inflicted on the excess carrier. Allowing the excess insurer to escape all coverage responsibility merely because the policyholder compromised a coverage dispute (and certainly because of the mere happenstance of insolvency of an underlying carrier) effectively provides excess insurers with a “super-exclusion” that, even if supported by reasonably clear policy text, becomes an unfair windfall that visits a disproportionate forfeiture upon the policyholder while simultaneously discouraging settlement and increasing judicial workload.

Furthermore, when making a settlement that was not approved by the insurer, the policyholder is generally required to bear the burden of persuasion regarding the reasonableness of the settlement terms21 while the insurer logically bears the burden of persuasion to show fraud or collusion regarding the settlement. The excess insurer may challenge the reasonableness of a settlement or its procedure even if it loses the attachment point or failure-to-satisfy-underlying-limit defense.22 As a matter of national judicial policy, settlement is generally encouraged.23 But if payment-only-by-underlying-insurer clauses are enforced literally, a policyholder cannot settle a coverage dispute with an underlying insurer without losing all of its remaining excess coverage. As a practical matter, this means that settlement will be much more difficult and can be achieved only if all insurers in a tower (or at least up to the limit of the liability exposure presented by the case) agree to the settlement.

21. See Restatement of the Law of Liability Insurance § 25(3)(c) & (d) (Proposed Final Draft) (Am. Law Inst. Mar. 28, 2017). See, e.g., Truck Ins. Exch. v. VanPortHomes, Inc., 58 P.2d 276 (Wash. 2002) (policyholder must show reasonableness of settlement or consent judgment; once this is shown, burden shifts to insurer “to show the settlement was the product of fraud or collusion”).

22. See Sbogart, 316 N.W.2d 729 (insurer may challenge settlement to which it did not agree and avoid coverage if settlement substantively unreasonable or result of fraud or collusion); Morris, 741 P.2d 246 (same); Stemper & Knutson, supra note 1, §§ 9.03–9.05.

23. See generally Crosby v. Jones, 705 So. 2d 1356, 1358 (Fla. 1998) (settlement of claims encouraged as a matter of public policy); see also Marc Galanter & Mia Cahill, Symposium on Civil Justice Reform: “Most Cases Settle”: Judicial Promotion and Regulation of Settlements, 46 Stan. L. Rev. 1339, 1364 (1994) (more than 95 percent of cases settle before trial). But see Owen Fiss, Comment, Against Settlement, 93 Yale L.J. 1073 (1984) (arguing that a minimum number of cases must be adjudicated or development of law atrophies and rights are not sufficiently vindicated in public forum).
This in turn gives an individual excess insurer too much leverage in settlement discussions. With settlement undermined in this way, an additional practical impact is reduced settlement, which in turn requires additional and more extensive litigation. This in turn raises disputing costs imposed on the parties, the judicial system, and society at large. Policyholders have raised this point with limited success. More successful have been arguments based on the lack of clarity of excess insurer exhaustion clauses. Even when they appear to have payment-only-by-underlying-insurer clauses, these provisions have sometimes been found insufficiently clear to permit the excess insurer to avoid attachment.

Although contending that an insurance policy is ambiguous is a time-honored first line of argument for policyholder counsel, it has increasingly become a losing argument if the excess insurer’s payment-only-by-underlying-insurer language is sufficiently clear. Insurers, being perhaps the paradigmatic “repeat players” in litigation, will inevitably generate sufficiently clear clauses. Standard-issue neoclassical contract theory focusing heavily on policy text thus favors excess insurers in the long run—with pernicious results. Adoption of the ALI Restatement that such clauses should be literally enforced will likely further shift the tide in favor of insurers.

III. THE HISTORY OF THE ISSUE

For decades, it was apparently accepted that a policyholder with less than 100 percent of its underlying policy available (because of insolvency or a compromise with the underlying insurer regarding coverage) could use its own funds to “fill the gap” between what had been paid by the underlying

24. In the interests of clarity and keeping this article to something resembling a reasonable length, I have provided fairly simply hypotheticals in which each excess layer of coverage is provided by a single excess insurer. In practice, excess layers are often composed of a combination of insurers, each signing on to a percentage of the risk. It is not particularly unusual to have as many as a dozen insurers (including Lloyd’s or London Market entities) comprising an excess layer. To the extent each of these is considered an “underlying insurer,” there exists the potential for an insurer with only 5 percent of the risk in a given layer to effectively impede resolution of a $200 million matter.


26. See Marc Galanter, Why the “Haves” Come Out Ahead: Speculations on the Limits of Legal Change, 9 L. & Soc’y Rev. 95 (1974) (classic article positing the now widely accepted view that institutional “repeat player” litigants, such as governments, businesses, and insurers, have a substantial advantage over episodic “one shot” litigants, such as individual plaintiffs in pursuing legal relief). The institutional player can more readily spread disputing costs and capture the benefits of past experience, even negative past experience; for example, an insurer that loses a coverage dispute can revise policy language to minimize the risk of similar losses in the future). Plaintiffs and policyholders may be able to obtain some of the advantages of repeat players if they retain experienced counsel—but there is, of course, no guarantee that individuals and small businesses will select such counsel.
insurer and the full underlying limit, thereby “triggering” the attachment of the excess insurance. Over time, excess insurers increasingly inserted language into their policies stating that the underlying limit must be paid by an underlying insurer, implying that payment of the underlying limit by other sources is not sufficient. During the past two decades, courts became increasingly receptive to enforcing such language.

A. The Traditional Zeig Approach

For most of the twentieth century, the leading case on this issue was Zeig v. Massachusetts Bonding and Insurance Co.,27 which essentially holds that an excess insurer’s attachment point is reached when the underlying limit is satisfied, regardless of whether that payment is made by an underlying insurer or the policyholder or a combination of the two. Zeig also took the position that satisfaction of the underlying limit could be through compromise or forgiveness of a claim as well as an actual cash payment so long as the policyholder could demonstrate that the amount of a loss or claim met or exceeded the excess insurer’s attachment point.28

Ironically, Zeig involved a first-party property insurance claim. But its analysis is readily applicable to third-party liability insurance matters. In Zeig, the policyholder (Manhattan dressmaker Louis Zeig) had purchased $15,000 of property insurance as well as the Massachusetts Bonding excess policy at issue. The insured property was burglarized, resulting in claimed losses of more than $15,000. The primary insurer disputed the amount of covered loss and settled with Zeig for $6,000. He then sought excess insurance coverage for the amount of loss exceeding $15,000, arguing that the $15,000 underlying limit had been satisfied due to the combination of the $6,000 paid by the primary insurer and that as policyholder he was entitled to additional coverage because the actual amount of the burglary loss exceeded $15,000.29

27. 23 F.2d 665 (2d Cir. 1928) (applying New York law).
28. This aspect of Zeig is sometimes over-read by both its supporters and its critics. Supporters may note that, pursuant to Zeig, settlement that releases the underlying insurer from liability exhausts the underlying limit even if the policyholder does not make additional payments. This reading is a bit misleading in that it implies that the settling policyholder can then receive excess insurance benefits without more. However, Zeig makes it quite clear that there is more to be done by the policyholder. Even if the policyholder does not make a cash outlay, it must nonetheless demonstrate loss or liability in an amount equal to the underlying limit, regardless of the amount paid by underlying insurers. The attached excess insurer retains the right to contest coverage based on other defenses, such as exclusions, breach of conditions, fraud, collusion, or an unreasonably generous settlement with the claimant. Conversely, excess insurers sometimes over-read Zeig as requiring cash outlays by the policyholder equal to the difference in amount between the underlying insurer’s settlement payments and the excess insurer’s attachment points. Zeig, however, appears to permit the policyholder to access excess insurance by demonstrating the amount of the claim without regard to out-of-pocket payments.
29. See Zeig, 23 F.2d at 666.
The excess insurer argued that unless the underlying primary insurer had itself paid the full $15,000 primary policy limits, there could be no triggering of excess coverage. The trial judge agreed with the excess insurer, essentially concluding that policyholder Zeig had forfeited his right to obtain excess insurance by settling with his primary insurer for less than 100 cents on the dollar. The Second Circuit reversed, ruling that the policyholder should be entitled to “prove the amount of his loss, and, if that loss was greater than the amount of the expressed limits of the primary insurance, he was entitled to recover the excess to the extent of the policy in suit.”

The court reasoned that the defendant excess insurer had no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in excess of the limits of those policies. To require an absolute collection of the primary insurance to its full limit would in many, if not most, cases involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable. A result harmful to the insured, and of no rational advantage to the insurer ought only to be reached when the terms of the contract demand it.

We can see no reason for a construction so burdensome to the insured.

The excess policy language at issue in Zeig stated that the excess policy “shall apply and cover only after all other [underlying] insurance . . . shall have been exhausted in the payment of claims to the full amount of the expressed limits of such other insurance.”

Despite siding with the policyholder regarding the issue of the source of funds satisfying the underlying limit, the Second Circuit in Zeig also stated that “[i]t is doubtless true that the parties could impose such a condition precedent to liability upon the policy, if they chose to do so.” But reading the exhaustion clause in the actual case makes it hard to imagine how excess carriers could have been any clearer.

30. See id.
31. See id.
32. See id.
33. See id. The Zeig court then discussed the particular language of the excess insurance policy at issue, noting that the policy provides only that [the underlying limit] be “exhausted in the payment of claims to the full amount of the expressed limits.” The claims are paid to the full amount of the policies, if they are settled and discharged, and the primary insurance is thereby exhausted. There is no need of interpreting the word “payment” as only relating to payment in cash. . . . Only such portion of the loss as exceeded, not the cash settlement, but the limits of these policies, is covered by the excess policy.

Id.
Nevertheless, excess insurers and the ALI in the current Restatement
draft have characterized Zeig as merely stating a “default” rule that can
be changed if the language of an excess policy states that the underlying
limit must be satisfied by payments from an underlying insurer. Although
the Zeig court arguably did not have to decide the issue, the clause in
question appears to have been rather clear and was nonetheless found in-
sufficient by the Second Circuit. In any event, Zeig’s statement regarding
power to alter the default rule is arguably mere dicta. Further, its assump-
tion appears to be that the default rule could be altered only if “the par-
ties” actually agreed to such a term—rather than having such a term
merely inserted into an essentially standardized policy form by the excess
insurer. Moreover, a fair reading of the exhaustion clause in Zeig is that
the excess insurer anticipated that the underlying limits would indeed be
“paid by the underlying insurer” but the policyholder nonetheless
was not forced to forfeit coverage due to compromise with the underlying
insurer. Further, it also should be noted that the Zeig court not only stated
that its default rule could be altered by the parties but also that any such
terms regarding the source of satisfaction of the underlying limit should
“demand” enforcement.35

Regarding the importance of settlement in liability and insurance cov-
erage litigation, the Zeig court observed that

claims are paid to the full amount of the policies, if they are settled and dis-
charged, and the primary insurance is thereby exhausted. There is no need of
interpreting the word “payment” as only relating to payment in cash. It often
is used as meaning the satisfaction of a claim by compromise or in other
ways. To render the policy in suit applicable, claims had to be and were sat-
isfied and paid to the full limit of the primary policies. Only such portion of
the loss as exceeded, not the cash settlement, but the limits of those policies,
is covered by the excess policy.36

34. Id. (excess policy provided that it would be “exhausted in the payment of claims to the
full amount of the expressed limits”). Although this phraseology was not sufficiently clear to
save the excess insurer from attachment in the face of a claim large enough to consume the
underlying limit, an excess carrier using this policy language would appear to have expected
that the limit would be paid by an underlying insurer rather than the policyholder or another
entity.

35. See id. (“A result harmful to the insured [which would lose all excess coverage because
of settling at less than 100 cents on the dollar with the primary insurer], and of no rational
advantage to the insurer [which is asked to pay only when its attachment point has been
reached by the size of the loss] ought only be reached when the terms of the contract demand
it.”) (emphasis added). Of course, in the ninety years since Zeig, excess insurers have articu-
lated a rational reason for preferring that underlying insurance be exhausted only through
payments by the underlying insurer, arguing that this provides greater assurance that the
claim was thoroughly vetted and defended. But this argument is not powerful enough to jus-
tify a complete forfeiture of excess insurance coverage in cases of insolvency or compromise
of a coverage dispute.

36. See id.
B. Application of Zeig Fades as Insurers Successfully Add Anti-Zeig Language to Policies

As noted above, for most of the twentieth century, Zeig was cited as providing “the rule” regarding satisfaction of the underlying limit and attachment of the excess policy. Many early twenty-first-century cases continued this pattern. Eventually, however, insurers realized that Zeig could

37. See, e.g., Koppers Co., Inc. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3d Cir. 1996) (applying Pennsylvania law) (approving Zeig and noting that “settlement with the primary insurer functionally ‘exhausts’ primary coverage and therefore triggers the excess policy—by settling the policyholder loses any right to coverage of the difference between the settlement amount and the primary policy’s limits”); Sherwin-Williams Co. v. Ins. Co. of Pa., 106 F.3d 258 (6th Cir. 1997) (applying Ohio law) (noting Zeig approach with apparent approval); Christiana Gen. Ins. Corp. v. Great Am. Ins. Co., 979 F.2d 268 (2d Cir. 1992) (applying New York law) (summarizing Zeig as stating that “excess carrier must pay claims to extent its layer is pierced even though underlying carrier settled with insured for less than the full amount of underlying carrier’s liability”); Archer Daniels Midland v. Aon Risk Servs., Inc., 1999 U.S. Dist. LEXIS 23527 (D. Minn. Feb. 25, 1999) (applying Minnesota and Illinois law); Gould, Inc. v. Arkwright Mut. Ins. Co., 1995 U.S. Dist. LEXIS 22609, at *7–8 (M.D. Pa. Nov. 8, 1995) (describing Zeig as “seminal case on exhaustion of underlying insurance” and applying Zeig to permit policyholder to contribute payment to reach underlying limit and attachment point of excess insurance policy); Stargatt v. Fid. & Cas. Co., 67 F.R.D. 689 (1975) (predicting Delaware law) (applying Zeig and construing Lloyd’s excess policy to be reached so long as the underlying limit was exhausted by settlement or paid to resolve claims even if payment was not by underlying insurer); Benroth v. Cont’l Cas. Co., 132 F. Supp. 270 (W.D. La. 1953) (finding attachment point of excess policy reached by liability against policyholder equal to or exceeding underlying limit without regard to source of payment or actual payment of underlying limit); see also JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 24.02[2][b] (2012) (“As a general rule, payment of the underlying limits from any source counts toward exhaustion.”); Mills Ltd. P’ship v. Liberty Mut. Ins. Co., 2010 Del. Super. LEXIS 563 (Nov. 5, 2010) (policyholder “correctly contends that ‘the majority of courts, including courts applying Delaware law, hold that settlement with an underlying carrier functionally exhausts that carrier’s coverage’” (following Zeig despite excess policy term stating that the policy “only provides coverage when” the underlying limit is “exhausted by reason of the insurers of the Underlying Policies paying or being held liable to pay in legal currency the full amount of the Underlying Limits of Liability as loss”; policyholder had settled with underlying insurers for roughly 80 cents on the dollar).

be interpreted as providing only a presumptive or “default” rule on the question of satisfaction of the underlying limit and that an excess insurance policy could perhaps be drafted to avoid the Zeig rule. Excess insurers began to insert such anti-Zeig clauses into their policies and began to have success enforcing such provisions. This development was praised by insurer counsel as a victory for enforcement of contract language. Predictably, policyholder counsel disliked this development.

C. The Issue Comes to the Surface as the American Law Institute

Restatement of the Law of Liability Insurance Accepts Zeig as a Default Rule but over Some Objection Endorses Cases Favoring Enforcement of Anti-Zeig Clauses

In its Tentative Draft No. 1 of the Restatement of the Law of Liability Insurance, the American Law Institute (ALI) essentially embraced case law supporting application of anti-Zeig language in excess insurance policies. Although endorsing Zeig as a default rule, the ALI took the position

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39. See Zeig, 23 F. 2d at 666 (applying general federal common law) (case decided prior to 

Erie v. Tompkins (“A result harmful to the insured, and of no rational advantage to the insur er, ought only to be reached when the terms of the contract demand it.”)). Excess insurers were not generally required pursuant to Zeig to “drop down” and provide coverage in the event of the insolvency of an underlying insurer absent specific policy language. See, e.g., Zurich Ins. Co. v. Heil Co., 815 F.2d 1122, 1124 (7th Cir. 1987); New Process Baking Co. v. Fed. Ins. Co., 923 F.2d 62, 63 (7th Cir. 1991). However, if the underlying insurer’s limits were paid by the policyholder and relevant excess insurance did not contain a “payment by insurer only” clause, Zeig was generally interpreted to permit policyholders to fill the gap created when an insurer became insolvent.

40. See, e.g., Martin Res. Mgmt. Corp. v. Axis Ins. Co., 2015 U.S. App. LEXIS 18279 (5th Cir. Oct. 21, 2015) (applying Texas law) (discussed further at text accompanying notes 71–85, infra); Citigroup Inc. v. Fed. Ins. Co., 649 F.3d 367, 372 (5th Cir. 2011) (applying Texas law) (policyholder’s settlement with underlying insurer for less than full limit of policy precludes attachment of excess insurance where excess policy required that underlying insurers “have paid in cash the full amount of their respective liabilities”); Comerica Inc. v. Zurich Am. Ins. Co., 498 F. Supp. 2d 1019, 1032 (E.D. Mich. 2007) (applying Michigan law); Qualcomm, Inc. v. Certain Underwriters at Lloyd’s, London, 73 Cal. Rptr. 3d 770 (Ct. App. 2008). But see Title Fremont Reorganizing Corp. v. Fed. Ins. Co., 2010 U.S. Dist. LEXIS 14675 (N.D. Cal. 2010) (holding that where excess policy speaks of underlying limit becoming “payable” rather than paid, Qualcomm does not control and case is subject to Zeig approach); see also Ali v. Fed. Ins. Co., 719 F.3d 83, 91 (2d Cir. 2013) (applying New York law) (where excess policy provides for attachment “only after all” underlying insurance “has been exhausted by payment of claim(s)” or exhaustion “solely as a result of payment of losses thereunder,” actual payment is required; excess policies are not triggered unless there has been “actual payment of losses” rather than “the mere accrual of losses in the form of liability”); actual payment required but not necessarily by underlying insurers); Fed. Ins. Co. v. Srivastava, 2 F.3d 98 (5th Cir. 1993) (applying Texas law) (enforcing excess policy term requiring actual payment to satisfy underlying limit, but that did not specify identity of payer where policyholder settled below policy limits and apparently did not fill the gap between settlement amount and excess insurance attachment point).
that the Zeig approach does not apply if “otherwise stated in the policy.” 41

Although embracing Zeig as a default approach, the Reporters and Council 42 accepted the excess insurer argument that an excess insurer could avoidZeig and insist that underlying limits and their attachment points be satisfied only if an underlying insurer was the entity paying the underlying limit. Draft § 40 thus approved of the results in Comerica and Qualcomm, two prominent cases enforcing payment-only-by-underlying-insurer clauses and setting forth in some detail the case for their application. 43

In response, some members of the Institute proposed that the section be amended so that the first paragraph would read: “When an insured is covered by an insurance policy that provides coverage that is excess to an underlying insurance policy, the following rules apply, unless otherwise stated in the excess insurance policy, unless a term in the excess policy that was specifically negotiated by the parties has a plain meaning to

41. Restatement of the Law of Liability Insurance § 40 states:

§ 40. Excess Insurance: Exhaustion and Drop Down

When an insured is covered by an insurance policy that provides coverage that is excess to an underlying insurance policy, the following rules apply, unless otherwise stated in the policy.

(1) The excess insurer is not obligated to provide benefits under its policy until the underlying policy is exhausted.

(2) The underlying policy is exhausted when an amount equal to the limit of that policy has been paid to claimants for a covered loss, or for other covered benefits subject to that limit, by or on behalf of the underlying insurer or the insured.

(3) If the underlying insurer is unable to perform, whether because of insolvency or otherwise, the excess insurer is not obligated to provide coverage in the place of the underlying insurer.


42. The ALI has a membership of roughly 3,000 voting members who give final approval to Restatements by vote at its Annual Meeting held in May of each year. But primary administration of the Institute is by its Council (a group of between forty-two and sixty-five and the director, executive director, and staff), which oversees projects such as the Restatements. Restatements are launched when approved by the Council, which in turn selects Reporters who do the primary research, analysis, and drafting of the Restatements. Drafts are reviewed by a selected group of Advisers as well as by any Member who volunteers to serve on the Members Consultative Group for that particular Restatement. Nonmembers following developments may, of course, also comment. The process of producing a Restatement generally requires a minimum of four years, but often takes longer.

43. See Comerica Inc., 498 F. Supp. 2d 1019; Qualcomm, Inc., 73 Cal. Rptr. 3d 770. Comerica and Qualcomm embraced enforcement of anti-Zeig clauses based on the view that specific excess policy language reflects a valid insurer concern that without payment by the underlying insurer, the excess insurer is exposed to unnecessary risk that claims will not be adequately vetted and negotiated and that policy language should be allowed to displace the default rule of indifference of the identity or even the payment of the underlying liability.
the contrary. Proponents of the Amendment argued that the Zeig default rule should not be too easily displaced by mere form or boilerplate language often buried in policy forms without the knowledge of the purchasing policyholder and that there is seldom any specific or express discussion about the issue of policyholder payments to fill the gap between underlying insurer payments and the attachment point of an excess policy. Proponents of the amendment noted that most “disputes settle and most settlements are compromises.”

The proponents further argued that to permit an insurer to further bury an unexpected forfeiture of coverage in the boilerplate of excess policy forms would be inconsistent with the overall principles and approach of the Restatement and that the “unless otherwise stated in the policy” language in the draft would permit the excess insurer to evade coverage based solely on its ability to insert an unreasonably favorable anti-Zeig clause into its policy and escape all coverage responsibility. Amendment proponents set out a further brief on the issue, contending that it was unfair to permit the excess insurer to avoid coverage based on an anti-Zeig clause unless it was specifically negotiated and agreed to by the policyholder and the excess insurer—and unless the excess insurer could prove it would be unfairly prejudiced if the insurer-must-be-the-one-to-pay language was not enforced as written.

44. See Proposed Amendment to the excess attachment section of the Restatement (on file with author and available to ALI Members at ali.org) (boldface removed) (presented at 2016 ALI Annual Meeting).
45. Id.
46. See id. The amendment proponents contended that the Section’s approval of blanket enforcement of anti-Zeig language was problematic in that

- It violates the principle of avoiding disproportionate forfeiture, as embodied both in this draft Restatement (see, e.g., § 30 cmt. e; § 37 cmt. b) and in the Restatement (Second) of Contracts (see, e.g., § 229);
- It potentially provides unfair windfalls to excess insurers by allowing them to avoid the substance of their contractual obligations;
- It constitutes a trap for unwary policyholders that may overlook boilerplate excess policy provisions (which may not be clear until adjudicated), stating that only payments by an underlying insurer (as contrasted to payments by the policyholder alone or in combination with an underlying insurer) can be used to reach the attachment point of the excess insurance;
- It impedes settlement of the underlying claims otherwise covered by the excess liability insurance as well as settlement of insurance disputes;
- It will likely burden courts with increased litigation; and
- It fails to vindicate the risk management function of excess insurance.

47. See id.
48. See id.
The Proposed Amendment was presented to the 2016 ALI Annual Meeting during its May 16 session and was defeated in a show of hands vote that was sufficiently clear that the exact votes on each side were not tallied, the margin perhaps as great as a three-to-one. When the Restatement becomes finally approved (most likely at the ALI’s May 2018 annual meeting), this will clearly be a benefit to excess insurers, who, as a matter of course, insert into their policies language requiring that the underlying limit can be satisfied only by payments made by an underlying insurer.

IV. THE ERROR OF RELENTLESS LITERAL APPLICATION OF ANTI-ZEIG POLICY LANGUAGE

A. Illustrating the Difference Between the Zeig Approach and the Qualcomm/ALI Approach

In the wake of the ALI’s current version of the Liability Insurance Restatement, what might be termed the Qualcomm/Comerica approach (after the two leading cases supporting excess insurers on this issue50) has been ascen-

49. As the chief proponent of the defeated amendment, I was on the floor at the time of the vote. Although this is what political commentators might call a landslide, a few factors may have made the vote more lopsided than the actual sentiment of the legal profession. The motion was the last one discussed during the time allotted for presentation of the draft Restatement. It was heard, debated, and voted upon at roughly 5:15 p.m. By that time of day, many members had left and many of those in attendance were lawyers affiliated with the insurance industry who were undoubtedly continuing to attend the session because of their particular interest in the issue (as might have been the case with some policyholder lawyers as well, of course).

A more important factor is that the ALI membership has a strong tradition of generally backing any draft that has reached the floor because it represents the thoughtful work of the Reporters, aided by Advisers and a Members Consultative Group, which has then been approved by the Council. The Council might be described as an elite executive committee that has a reputation for giving close scrutiny to all ALI projects. Consequently, the general membership is reluctant to support an amendment at this stage of the proceedings. During the May 16 session, twelve other amendments were proposed and defeated. Consequently, the clear rejection of the proposed change may not reflect overall legal opinion so strongly as to doom policyholders in future litigation.

50. See Comerica Inc. v. Zurich Am. Ins. Co., 498 F. Supp. 2d 1019 (E.D. Mich. 2007); Qualcomm, Inc. v. Certain Underwriters at Lloyd’s London, 73 Cal. Rptr. 3d 770 (Ct. App. 2008). Although Comerica is a federal case, I regard Qualcomm as the lead anti-Zeig case. In addition to containing a more extensive discussion of the issue, Qualcomm has stronger precedential effect. Pursuant to California custom and practice, the decision of a single Court of Appeal panel on an issue is binding on trial courts throughout the state and generally considered binding upon subsequent appellate panels throughout the state and within the same district unless it is displaced by a subsequent California Supreme Court decision, is viewed as inconsistent with Supreme Court precedent, or is in conflict with another appellate decision. See Auto Equity Sales v. Superior Court, 57 Cal. 2d 450, 455; 369 P.2d 937, 939–40 (1962) (most frequently cited case in state regarding stare decisis (“Decisions of every division of the District Courts of Appeal are binding upon all the justice and municipal courts and upon all the superior courts of this state. . . .”); Cal. Rule of Court 8.115 and Commentary; Apple Valley Unified School Dist. v. Vavrinek, Trine, Day & Co., LLP, 98 Cal. App. 4th 938, 947 (2002); Opsal v. United Servs. Auto. Ass’n, 2 Cal. App. 4th 1197, 1203–04
dent during the past twenty years. Although cases continue to support Zeig, this has largely been a default rule (similar to the ALI approach) in cases where courts have found the excess insurer’s exhaustion language to be insufficiently clear to overcome the Zeig presumption.51 Where policy language is unclear, of course, it is construed against the drafter (almost always the insurer) absent persuasive extrinsic evidence to the contrary.52 Perhaps reflecting some uneasiness about allowing excess insurers to contract around the Zeig approach, some of these courts have arguably strained to find the attempted payment-must-be-by-underlying-insurer language sufficiently ambiguous to invoke the Zeig approach.53

For variety of reasons, some echoing the arguments of the proponents of the unsuccessful ALI amendment, a strictly formal and textual approach to the issue of exhaustion and attachment is unwise. A few simple illustrations reflect the perniciousness of judicial slavishness to even a clearly worded anti-Zeig clause.

(1991). But see Marriage of Shaban, 88 Cal. App. 4th 398, 409 (2001) (custom of horizontal stare decisis is not rigidly applicable to panels of the same court and later panels are not strictly prohibited from disagreeing with a prior panel’s decision); Sears v. Morrison, 90 Cal. Rptr. 2d 528, 534 (Ct. App. 1999) (where there is conflict between appellate court decisions, the “trial court may choose the decision it finds most persuasive”). Much to my surprise, there has not been much resistance to Qualcomm by other appellate panels. Based on the expressed views of insurance coverage counsel in the state, Qualcomm and its strict enforcement of anti-Zeig language appears to be treated throughout the state as binding law (“from Mexico to the Oregon border,” as one policyholder lawyer described it). In addition to having such intrastate deference, Qualcomm has been more extensively cited by courts and secondary sources (141 times) than Comerica (85 times) as of December 20, 2016.

51. See, e.g., Lexington Ins. Co. v. Tokyo Marine & Nichido Fire Ins. Co., Ltd., 2012 U.S. Dist. LEXIS 59635, at *9 (S.D.N.Y. 2012) (“In the absence of unambiguous language requiring exhaustion via full payment of the underlying policy, no such exhaustion is required” and applying Zeig where policy appeared not to have any anti-Zeig language); Title Fremont Reorganizing Corp. v. Fed. Ins. Co., 2010 U.S. Dist. LEXIS 14675 (C.D. Cal. Feb. 1, 2010) (finding it insufficient to overcome Zeig where policy language provided for attachment “if such loss is properly payable [under the primary policy], or would be, except for exhaustion of the Underlying insurance . . .”); In re Nw. Airlines Corp., 393 B.R. 337 (Bankr. S.D.N.Y 2008) (finding that requirement of “payment” of underlying limits could mean either payment in cash or “satisfied” and resolving issue against insurer after consideration of extrinsic evidence). But see Ali v. Fed. Ins. Co., 719 F.3d 83, 88 (2d Cir. 2013) (applying New York law) (giving effect to anti-Zeig clause that stated that excess policy “shall attach only after all such Underlying Insurance has been exhausted . . . solely as a result of payment of losses thereunder”).

52. See STEMPPEL & KNUTSEN, supra note 1, § 4.08; STEMPPEL, SWISHER & KNUTSEN, supra note 3, §§ 2.01–2.11.

1. Illustration No. 1: The Insolvent Underlying Insurer

Consider a claim by the estate of a decedent who died from carbon monoxide (CO) poisoning due to a defective furnace installation. The decedent was a thirty-eight-year-old partner in a profitable investment banking firm. Investigation quickly confirms that the furnace was negligently installed. The furnace installer, a small local business, has $1 million of primary general liability insurance for each occurrence as well as an excess policy paying $5 million on top of the primary policy limits.

The policyholder defendant tenders the claim to the primary insurer and notifies the excess insurer. But the primary insurer is insolvent and the excess insurer refuses to assume the duty to defend, noting that its policy covers defense expenditures as part of the policyholder’s “ultimate net loss” but does not require a defense. Although the policy provides that the excess insurer may become involved in defending the claim (something that would ordinarily be prudent for the excess insurer if the primary insurer were not defending), the excess insurer declines—for problematic reasons that will become clear in a moment.

Left without an insurer-provided defense, the furnace maker retains counsel at its own expense, incurring $150,000 in defense costs in the matter. Plaintiff’s counsel builds a strong case during discovery. Without participation by a liability insurer, the furnace maker lacks sufficient funds to settle the case in view of the likely range of damages awards. Trial ensues, resulting in a verdict of $10 million. Faced with this $10 million (plus prejudgment interest) judgment, the only option for the furnace maker is a Chapter 7 bankruptcy unless the excess insurer concedes coverage and attempts to persuade the plaintiff to accept 50 cents on the dollar in settlement. If the excess insurer continues to deny coverage or fails in seeking settlement, the policyholder/defendant/furnace maker must attempt to settle through an assignment of its rights under the excess policy (the primary policy being essentially worthless) to the plaintiff, perhaps with a covenant not to execute and perhaps with some cash payment from the policyholder.

If no such arrangement can be made, the plaintiff can attempt to collect either from the debtor’s estate or directly from the solvent excess insurer. Although there are occasional exceptions, most courts treat a liability insurance policy as outside the bankrupt debtor’s estate on the ground that a tortfeasor/debtor’s victim is an intended beneficiary of the liability policy.

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54. Subject to the possibility that the policyholder might obtain some coverage payment through the relevant state’s insurance guarantee fund. See Mark S. Dorfman & David A. Cather, Introduction to Risk Management & Insurance 153–54 (10th ed. 2013); Vaughn & Vaughn, supra note 1, at 101. However, guarantee funds often have limits below the policy limits of the insurance being guaranteed or these funds may apply only to consumer policies rather than commercial policies.
and that the benefit of the policy should not be diluted by being included in the debtor’s estate where it will be subject to the claims of other creditors. If one substitutes a larger commercial entity for the small business furnace maker, the policyholder/defendant may be able to come up with the $1 million that otherwise would have been provided by the insolvent primary insurer.

Under any of these variants, there is no possibility that the first million of payments to the decedent’s estate will come from a liability insurer. If the Zeig approach is applied to this situation, the result is not optimal compensation (the plaintiff’s judgment, presumably based on a fair trial and a reasonable jury verdict, is only partially paid). But taking Zeig’s sensible approach at least makes the outcome sufferable in terms of compensation, risk management, and socioeconomic policy.

The plaintiff will not obtain the full $10 million judgment, at least in the case of the relatively poor small business that lacks the resources to pay $5 million more of its own funds (the $1 million gap because of the insolvent primary insurer and the amount of the judgment exceeding its $6 million of liability insurance—as well as interest on the award). The defendant may be driven to bankruptcy. But if the plaintiff or policyholder can demonstrate that the plaintiff suffered covered injury in an amount exceeding the tower of liability insurance, the excess insurer (and any higher-level excess insurers had there been a higher tower) will at least provide the compensation that the small business tortfeasor was unable to provide.

Recall that Zeig provides that the tortfeasor/policyholder/defendant need not have actually filled a gap in coverage with its own money as long as it can demonstrate that the amount of liability reaches an excess insurer’s attachment point. In the instant illustration, this is easily done because there is a valid judgment well in excess of the excess insurer’s attachment point.

But if the excess policy contains an anti-Zeig clause, with the court in turn subjecting this illustration to the Qualcomm/ALI approach, the result is disappointing and arguably absurd. Even though it is clear that the policyholder has a legitimate liability (it has been adjudicated by a presumably competent court) well in excess of the excess insurer’s attachment point and policy limits, the excess insurer pays nothing toward the judgment. In this example, the excess insurer not only avoided payment on the

56. I am taking the (I hope not controversial) position that injured victims (or their estates and survivors) should be fully compensated for their injuries. Insurance serves a vital, arguably essential function in achieving this goal in that most tortfeasors would, without insurance, lack the resources to fully compensate victims. See Kenneth S. Abraham, The Liability Century: Insurance and Tort Law from the Progressive Era to 9/11, at 39–40 (2008); see generally Jeffrey W. Stempel, The Insurance Policy as Social Instrument, 51 Wm. & Mary L. Rev. 1489 (2010).
judgment but—by gambling that it could get away with denying coverage altogether (rather than stepping in to protect the policyholder when the primary insurer was not available to defend)—also avoided paying for any defense expenditures, even though defense expenditures are part of the ultimate net loss that was to be covered by the policy.

Talk about a windfall! The excess insurer that collected premiums, perhaps for years or even decades (small businesses, like individuals, are less likely to shop for lower premiums and change insurers frequently), is under the Qualcomm approach permitted to retain those premium dollars and accumulated investment income even though the policyholder clearly has been subjected to a covered liability of a magnitude far greater than the policy’s attachment point. The result is at least troubling and perhaps better described as ridiculous or absurd.

And it is certainly a large—indeed, a complete—forfeiture of the contract rights of the policyholder. Taking a hyper-formalist view, one can say, of course, that the excess policy’s anti-Zeig clause has been breached or the condition it establishes is unmet. But even if this type of formalistic analysis, which was purportedly rejected more than thirty years ago in the Restatement of Contracts, is correct, the Qualcomm consequences of this

57. Insurers realize that many customers tend to renew existing coverage without much thought or recoil in the face of modest but steady price increases and now have the technology to predict which policyholders are most subject to such “price optimization” during the renewal process. Some insurance departments prohibit the practice, but it nonetheless presents insurers an opportunity to increase profits through charging different customers different premiums for policies presenting similar risks. On price optimization, see generally Andrea Wells, The Price of Price Optimization, Ins. J. (Nov. 17, 2015), www.insurancejournal.com/news/national/2015/11/17/389153.htm.

58. The Restatement (Second) of Contracts is largely viewed as functionalist or instrumental and not strictly formalist in that the Restatement, although generally favoring application of plain meaning of text, does not relentlessly apply text in derogation of the overall purpose of a contract and party intent and departs from earlier contract formalism in a number of ways. For example, the Contracts Restatement (1) permits the establishment of contract by detrimental reliance and promissory estoppel (§ 90); (2) modifies traditional common law rules on the contract-forming effect of part performance (§ 45); (3) moves away from the prior distinctions between conditions precedent and subsequent and unilateral and bilateral contracts; (4) expressly approves of judicial disregard of contract text on grounds of unconscionability (§ 208) and public policy (§ 178); (5) establishes a preference for construction of contracts that favors the public (§ 207); and (6) imposes an obligation of good faith and fair dealing on contracting parties (§ 205). See RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 40 (Proposed Final Draft) (AM. LAW INST. Mar. 28, 2017), discussing examples of judicial refusal to give literal enforcement to text. This functionalist approach is also reflected in the ALI’s expressed conception of the nature and role of Restatements. See ALI COUNCIL, REVISED STYLE MANUAL (Jan. 2015), available at all.org:

A Restatement thus assumes the perspective of a common-law court, attentive to and respectful of precedent, but not bound by precedent that is inappropriate or inconsistent with the law as a whole. . . . A significant contribution of the Restatements has also been anticipation of the direction in which the law is tending and expression of that development in a manner consistent with previously established principles.
“breach” or “failure of condition” are far too devastating to impose on the policyholder—particularly when the lack of full payment by the underlying insurer was not the result of any conduct by the policyholder.

Even if a Qualcomm treatment of this matter is consistent with the text of the excess insurance policy, it is rather clearly inconsistent with the intent, purpose, and function of the policy and the deal made by the policyholder and the excess insurer—which was to provide additional liability insurance when the primary insurance ran out or was exceeded. As discussed at greater length below, it is erroneous and dangerous for courts to focus on language alone, even quite clear language, as providing a definitive and conclusive assessment of the meaning of the contract.

Here, the excess policy was designed, of course, to provide additional liability insurance for big claims. The insurer added an anti-Zeig clause to provide some greater assurance that its attachment point would not be reached too easily in cases where the underlying insurer did not provide the defense, attempted settlement, and grudging payment thought to better protect the excess insurer. Although this may be a perfectly legitimate goal for excess insurers, making any noncompliance with the textual provision grounds for complete abrogation of contract duties is simply too great a penalty—particularly in cases such as Illustration No. 1 where the bona fides of the claim are clear.

Further, although the anti-Zeig clause may reflect a legitimate excess insurer concern, in many cases, it will not have been one specifically negotiated or even discussed by policyholder and insurer. The policyholder will often have been unaware of the provision both at the time the excess insurance is purchased and at the time of loss. Written insurance policies are usually not provided to policyholders until weeks or months after the policy is purchased.59 Under these circumstances, it is not surprising that

The Restatement process contains four principal elements. The first is to ascertain the nature of the majority rule. If most courts faced with an issue have resolved it in a particular way, that is obviously important to the inquiry. The second step is to ascertain trends in the law. If 30 jurisdictions have gone one way, but the 20 jurisdictions to look at the issue most recently went the other way, or refined their prior adherence to the majority rule, that is obviously important as well. Perhaps the majority rule is now widely regarded as outmoded or undesirable. If Restatements were not to pay attention to trends, the ALI would be a roadblock to change, rather than a “law reform” organization. A third step is to determine what specific rule fits best with the broader body of law and therefore leads to more coherence in the law. And the fourth step is to ascertain the relative desirability of competing rules. Here social-science evidence and empirical analysis can be helpful.

59. Support for the text proposition that policies often are not issued in writing until considerably after sale: see Jeffrey W. Stempel, The Insurance Aftermath of September 11: Myriad Claims, Multiple Lines, Arguments over Occurrence Counting, War Risk Exclusions, the Future of Terrorism Coverage, and New Issues of Government Role, 37 TORT & INS. L.J. 817 (2002) (noting that even though a package of property and liability insurance policies covering the World
policyholders (and their agents) often do not read the policies closely when they arrive in the mail months later. In this environment, excess insurers can include text in an excess policy that not only was not within the contemplation of the policyholder but may even be contrary to the understanding of the policyholder. The Qualcomm approach of giving great credence to such clauses regardless of contracting context thus can elevate the form of policy text above both the substance of contracting intent or the purpose of the instrument.

In addition, the Qualcomm approach to this insolvency illustration imposes substantial costs on society. As a result of the excess insurer’s clever decision to add anti-Zeig language to the policy, the victim of a tortfeasor of modest means is grossly undercompensated for serious injury and even death. Because the victim in this illustration is a presumably fairly wealthy investment banker (who did not have dependents and probably had substantial assets as well as first-party life insurance), the illustration is not particularly heart-rending. But substitute a thirty-eight-year-old plumber, electrician, carpenter, manager, teacher, police officer, fire fighter, or social worker with a spouse and three young children. The value of the life negligently snuffed out then will not reach investment banker heights (at least as measured by the judicial system) but certainly exceeds the attachment point of the excess policy and probably the policy limits as well. And in this case, the spouse (even if a decent wage-earner) and children clearly have lost much economically—losses that will not be recouped from a small business tortfeasor without liability insurance.

In turn, some of the economic costs will be absorbed by social service agencies—making taxpayers provide the compensation that should have come from the excess insurer. Taxpayers and society also will absorb less readily quantified costs if the spouse and children are forced to forgo educational opportunities, lose a home, become crime victims (or criminals), and other detriments that are all more likely if the family cannot maintain the middle-class life it had prior to the CO poisoning of the relatively young income-earning spouse.

In this illustration, which presents essentially no danger that the excess insurer will be forced to attach prematurely in response to a weak or underdefended claim, the Qualcomm methodology of slavish and literal adherence to policy text produces an embarrassingly awful result, one I find absurd, or at least ridiculous and embarrassing in a legal system purportedly based on rational analysis and results. Courts applying what might be termed the “absurd result” canon of contract and statutory con-
struction are often unclear about their definitional standard.60 Decisions have a certain “I know it when I see it” quality.61 But condemnation of Qualcomm treatment of Illustration No. 1 is more than consistent with many judicial decisions defining or finding an absurd result.62

Under other circumstances, excess insurer concerns about the actual payment of underlying limits and the identity of the payer may be more compelling than in Illustration No. 1. Consider the following illustration.

2. Illustration No. 2: Settling a General Liability Claim with an Underlying Insurer

Assume the same tragic CO poisoning of the thirty-eight-year-old single investment banker with the same $6 million tower of liability insurance protection purchased by the small business policyholder. The estate sues the furnace maker for the defective installation or repair of the furnace that poisoned him. The primary insurer defends but asserts a reservation of rights based on the standard form pollution exclusion in the policy.63 The claim is in a jurisdiction that has not yet decided the coverage

60. Although the text of an insurance policy or contract is generally considered the most effective reflection of the parties’ agreement and mutual promises, courts will not give literal enforcement to text where this would produce an “absurd result.” See Olguin v. Allstate Ins. Co., 237 N.W.2d 694 (Wis. 1976); MacKinnon v. Truck Ins. Exch., 73 P.3d 1205 (Cal. 2003); W. Cas. & Sur. Co v. Budrus, 332 N.W.2d 837, 861 (Wis. Ct. App. 1983). Insurers might respond that a clause like that in Qualcomm (excerpted in note 12, supra) that allows attachment after an underlying insurer has been adjudicated liable could avoid the absurdity. But this view requires that a policyholder or its assignee incur what appears to be needless effort, expense, and delay in pursuing a judgment against an insolvent insurer as a prerequisite to recovery of excess insurance previously purchased. And many anti-Zeig clauses require actual payment by the underlying insurer rather than simply determination of payment responsibility.

61. “I know it when I see it” has become something of a gestalt expression for situations in which a court or other observer has a strong characterization of a matter that is not readily described in incremental or definitional terms. It is most associated with Justice Potter Stewart’s comment regarding his ability to recognize pornography without the need for a precise definition. See Jacobellis v. Ohio, 378 U.S. 174, 197 (1964). What is remembered less often is his additional conclusion that the material under review “is not it.” See id. at 198.

62. See, e.g., Bethke v. Auto-Owners Ins. Co., 825 N.W.2d 482, 493 (Wis. 2013) (rejecting insurer’s argument that because rental car company was self-insured, rental car could not be “underinsured” and that UIM coverage was not triggered; “interpreting [the term ‘underinsured motor vehicle’] to exclude self-insured rental vehicles from coverage leads to an absurd result here,” prompting rejection of the argument); Murphy v. Travelers Ins. Co., 2 N.W.2d 576, 581 (Nev. 1942) (“when the strict enforcement of a provision of an insurance policy will result in unreasonable and unjust forfeitures, or an absurd result, the courts will refuse to enforce the strict meaning of the language of the policy”); Rathbun v. Globe Indem. Co., 184 N.W.2d 903, 905 (Neb. 1921) (“construction of the policy should not end in an unreasonable or absurd result and cannot defeat the manifest intention of the parties and the very object and purpose they had in entering into the contract at all”).

63. A typical pollution exclusion contained in a general liability policy states that any claim “arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape” of a pollutant falls outside coverage, with “pollutant” defined as “any solid, liquid, gaseous or thermal irritant or contaminant, including smoke vapor,
issue, one on which the courts have differed. The excess policy follows form to the primary policy.

The situation presents a significant coverage issue, one on which either insurer or policyholder may prevail. Because the issue is unresolved in the jurisdiction, the primary insurer (correctly) realizes there is a potential for coverage and defends the claim pursuant to a reservation of rights. Because the claim presents obvious exposure to a damage award of more

soot, fumes, acids, alkalis, chemicals, and waste,” with waste including “materials to be recycled, reconditioned, or reclaimed.” See, e.g., Insurance Services Office, Commercial General Liability Policy CG 00 01 12 07 (2007), reprinted in Stempel, Swisher & Knutsen, supra note 3, app. E.

Because of the lengthy and broad definition of “pollutants” and the sweeping language of the exclusion, insurers have often successfully argued that the exclusion applies to bar coverage even for liability claims against a policyholder that are ordinarily not regarded as pollution claims. See Manilloff & Stempel, supra note 3, at ch. 15 (state-by-state survey reflects split of authority but that insurers have often successfully obtained literal application of exclusion). See, e.g., Hirschhorn v. Auto-Owners Ins. Co., 809 N.W.2d 529 (Wis. 2012) (bat guano in vacation home); Maxine Furs, Inc., v. Auto-Owners Ins. Co., 426 F. App’x 687 (11th Cir. 2011) (Indian curry aroma that spoiled furs fell into pollution exclusion); Reed v. Auto-Owners Ins. Co., 667 S.E.2d 90, 92 (Ga. 2008) (applying exclusion to carbon monoxide leak claim similar to that of Illustration Nos. 1 & 2); Quadrant Corp. v. Am. States Ins. Co., 110 P.3d 733 (Wash. 2005) (illness to apartment tenant from fumes from deck sealant due to deck construction); see generally Jeffrey W. Stempel, Reason and Pollution: Correctly Construing the “Absolute” Exclusion in Context and in Accord with Its Purpose and Party Expectations, 34 Tort & Ins. L.J. 1 (1998) (criticizing literal application of text of pollution exclusion to bar coverage in such cases, noting that drafting history of the exclusion indicates insurance industry concern over traditional pollution claims such as groundwater contamination or fouling of air over dispersed area).

64. See Manilloff & Stempel, supra note 3, at ch. 15 (state-by-state survey shows roughly equal division of states giving literal application to broad CGL policy pollution exclusion text so as to bar coverage for claims such as carbon monoxide poisoning that involve isolated exposure of victim to harmful materials because of negligence of policyholder). Roughly twenty states do not have definitive authority from the state’s highest court concerning the pollution exclusion. See id. (nine states have state intermediate court precedent but not high court precedent; eight states have federal court authority thus making an Erie prediction but no state high court authority; three states have essentially no on-point authority at any level). See also id. at ch. 17 (discussing state division over application of qualified pollution exclusion, which has similarly broad language but restores coverage if the release or discharge of pollutants is “sudden and accidental”).

65. Because the duty to defend is based on the facts as alleged by the claimant and is subject to the potential-for-coverage standard, it is only logical that until the jurisdiction has controlling precedent on the application of the pollution exclusion that forecloses coverage for CO poisoning, there exists a potential for coverage. If the primary insurer refused to defend under these circumstances, it would be in breach of the duty to defend, a breach that in many (but not the majority of) jurisdictions prohibits the primary insurer from contesting coverage. See Jeffrey W. Stempel, Enhancing the Socially Instrumental Role of Insurance: The Emerging Opportunity Presented by Treatment of the Duty to Defend, 5 U.C.-Irvine L. Rev. 587 (2015).

Until coverage has been clearly foreclosed by unquestionably applicable precedent, the potential for coverage exists and the primary insurer is obligated to defend until it can obtain a ruling in the case at hand. Any different approach violates the potential for coverage standard and has the practical effect of unreasonably negating the duty in any circumstances where the law is unclear.
than $1 million, the policyholder and the primary insurer notify the excess insurer.

Despite its reservation of rights, the primary insurer (correctly) realizes that the claim presents a great potential for a verdict and judgment in excess of the $1 million policy limits. Recognizing its duty to make reasonable settlement decisions, realizing that continued defense will be costly, and concerned that failure to at least attempt settlement will expose it to bad faith liability, the primary insurer offers its policy limits in settlement. The claimant rejects a $1 million settlement offer by the primary insurer. The excess insurer declines to contribute to the settlement offer or otherwise participate in settlement negotiations with the claimant.

Trial ensues and a verdict of $10 million is rendered. The primary insurer and the policyholder resolve their coverage dispute (about whether CO poisoning deaths of this type are a loss stemming from “pollution” rather than poisoning caused by a defective repair or product) on a 70/30 basis, with the primary insurer agreeing to provide $700,000 of liability coverage and the policyholder contributing $300,000 from its own funds. The policyholder now seeks payment from the excess insurer.

Under these circumstances, it hardly seems that the excess insurer is harmed by the active defense efforts below and the coverage compromise between the policyholder and the primary insurer. Although the pollution exclusion issue is not free from doubt, policyholders have frequently prevailed in situations like confined CO poisoning that are relatively remote from the environmental contamination that spawned the absolute pollution exclusion. The 70-30 split coverage compromise is not unreasonable. Had the primary insurer litigated the issue to conclusion, it might well have paid $1 million in coverage as well as missing the other benefits of settlement. The settlement certainly appears reasonable and not the product of any unfair collaboration between primary insurer and policyholder.

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66. Settlement on these terms is fairly realistic. Although states with significant pollution exclusion precedent divide roughly in half concerning approaches to the exclusion (textual literalism that tends to favor insurers vs. a functional, purposive approach to contract that tends to favor policyholders), the scorecard for CO poisoning cases is somewhat more favorable to policyholders. See Maniloff & Stempel, supra note 3, at ch. 15 (of states with cases involving CO poisoning such as that set forth in the Illustration, ten states find CO poisoning outside pollution exclusion while three states find CO poisoning within pollution exclusion).


68. Presumably, the settlement extinguished any continued defense obligation of the primary insurer as well as relieving the primary carrier from paying pre- or post-judgment interest or possibly even the policyholder’s counsel fees incurred in litigating the coverage issue.
Perhaps more important, it does not preclude the excess insurer from litigating or compromising the pollution exclusion coverage issue. If the excess insurer successfully rolls the dice, it may escape coverage liability on the merits (e.g., a judicial determination that CO poisoning qualifies as excluded pollution liability). But if the court finds to the contrary, the excess insurer must do what it contracted to do—pay defense costs and judgment/settlement liability for this claim that pretty clearly is one worth more than the primary policy’s limits of $1 million.

But pursuant to the Qualcomm/ALI position, an excess insurer with an anti-Zeig clause never faces the merits of the pollution exclusion or other substantive coverage issues. The excess insurer simply skates away from its promised excess coverage because the policyholder compromised a coverage dispute with the primary insurer. This approach results in a massive forfeiture of purchased coverage, reduced compensation to the victim(s), and undermining of socioeconomic policy that should give pause to legal policymakers.

3. Illustration No. 3: Settling a D&O Claim—The *Martin Resource*

Case as a Troubling Example of the Qualcomm/ALI Approach

A similarly troubling illustration drawn from actual litigation is *Martin Resource Management Corp. v. Axis Insurance Co.*,

Policyholder Martin Resource purchased $10 million of directors & officers insurance from Zurich, $10 million of first-layer excess insurance from AXIS, and $10 million of second-layer excess insurance from Arch. Plaintiffs filed a stock-dilution claim against Martin, which sought coverage from its insurers, who disputed coverage, requiring Martin to defend the claim while simultaneously suing its insurers to obtain coverage.

Zurich and Martin compromised their coverage dispute, with Zurich paying $6 million (60 percent, which suggests something more than a nuisance or customer accommodation settlement) and Martin paying at least an additional $4 million (at least as I read the court’s description that does

69. 803 F.3d 766 (5th Cir. 2015) (applying Texas law).
70. Some of this may be a result of the manner in which the case was litigated, in which the policyholder’s primary argument appears to be that the payment-only-by-insurer language was sufficiently ambiguous to provide the policyholder with the benefit of contra proferentum or use of the Zeig default rule. See id. at 773, n.8 (policyholder did “not contend that an excess-insurance contract that unambiguously precludes exhaustion by below-limits settlements violates Texas’s public policy”).
71. The court’s opinion does not state the amount of defense costs expended by Martin Resources.
not give exact figures). Martin then sought coverage from its excess insurers, arguing that their attachment points had been met by this $10 million in payments (which suggests that Martin paid more than $14 million defending the stock dilution claim, an amount that when combined with Zurich’s $6 million payment would be sufficient to reach Arch’s attachment point of $20 million).

Arch, the second-layer excess insurer with a $20 million attachment point, settled with Martin. But AXIS, despite having a lower $10 million attachment point, successfully avoided paying even a dollar in coverage because its policy contained language stating

> The Insurance afforded under this Policy shall apply only after all applicable Underlying Insurance has been exhausted by actual payment under such Underlying Insurance, and shall only pay excess of any retention or deductible amounts provided in the Primary [Zurich] Policy and other exhausted Underlying Insurance.72

The Martin Resource court found this language clear and unambiguous and enforced it literally even though policyholder Martin was not asking excess insurer AXIS to provide coverage until after $10 million had been paid in apparently vigorous defense of the litigation. The court’s rationale, which can be defended on neoclassical contract textual grounds, is nonetheless troubling in its almost religious attitude toward insurance policy text, which may be boilerplate contained in a document that arrived weeks or months after the risk was placed and may not have been read or appreciated by even a relatively experienced policyholder or broker.73

Throughout the opinion, the Fifth Circuit, perhaps constrained by Texas law, takes the view that satisfaction of the underlying limit by a “gap” payment from the policyholder is “not a reasonable interpretation of the contract” because policy text requires that the underlying limit be paid by the underlying insurer(s) with no gap payments.74

But as discussed below, the Fifth Circuit/Texas approach errs in steadfastly equating every term or word on the face of the policy with “the contract.” The contract is better viewed as the overall agreement and not sim-

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72. Martin Res., 803 F.3d at 769.

73. It has become fashionable to say that it is broker malpractice to fail to notice “only insurer payment counts” clauses and to discuss them with the policyholder before agreeing or refusing to agree. Absent special circumstances (e.g., insurers may have hidden the clause or been deceptive about inserting it into a policy; other contextual factors that may excuse the broker), I generally agree but see a policyholder suit against the broker (and its errors & omissions policy) as an inadequate solution for failing to require an excess insurer to provide promised coverage as long as the excess insurer is not actually harmed by the identity of the entity that pays an underlying limit.

74. See Martin Res., 803 F.3d at 770. The Martin Resource court read Texas law as mandating that the anti-Zeig language of the AXIS policy be strictly enforced. Whether this is a correct or required reading of Texas law is beyond the scope of this article.
ply the text of the policy that represents a memorialization of the insuring agreement.\textsuperscript{75} To be sure, the particulars of this overall agreement are generally summarized in the policy text. Not every aspect of the contract can be discussed or negotiated. But neither can the text fully address all aspects of the contract, such as industry custom and practice and effectuation of the purpose of the contract. Literal enforcement of policy text might even run counter to those values and undermine the basic purpose of the contract—and the basic agreement and understanding of the parties.

The court then goes into a textual assessment of other policy language that supports its view that “all” means “all” and should be given its literal meaning without regard to whether satisfaction of the underlying limit through payment by Zurich and Martin Resource ($6 million + $4 million (or more) equals $10 million), which is the amount of the underlying limit.

This portion of the opinion reads at times like a classic English opinion, slicing and dicing words on a page without much, if any, reflection concerning the underlying business arrangement memorialized by the words on the page.\textsuperscript{76} The court never once addresses the issue of whether an excess policy fails of its essential purpose if 100 percent of promised coverage is lost because the policyholder settled a coverage dispute with the underlying insurer.

With the wisdom of hindsight, the policyholder’s conduct may have been unwise or even foolish. But is it sufficiently blameworthy to give the excess insurer the windfall of avoiding coverage even though the claim at issue reached its attachment point? Giving payment-only-by-underlying-insurer language such sweepingly literal effect converts the term into a super-exclusion even though the excess insurer is not being asked to do anything inconsistent with the insuring agreement of the policy (in a case that seems to have been vigorously defended).\textsuperscript{77}

\textsuperscript{75} See text accompanying notes 131–40.

\textsuperscript{76} See Martin Res., 803 F.3d at 770:

With regard to the amount that must be paid, it is unreasonable to construe the AXIS policy to allow exhaustion by a below-limit settlement. The AXIS policy requires “actual payment” of “all applicable Underlying Insurance.” The AXIS policy defines “Underlying Insurance” as the policies stated in the endorsement section [which] only contains the Zurich policy. . . . The word “all” makes clear that, under the AXIS policy, a settlement does not exhaust the Zurich policy when it is for less than the limit of liability.

\textsuperscript{77} To be fair to the Martin Resource court, it was apparently constrained by Texas contract law, although it seemed to accept these constraints without regret. See id. at 768. Federal courts are, of course, bound by \textit{Erie} to follow state contract precedent, even if they dislike it. See, e.g., Trident Ctr. v. Conn. Gen. Life Ins. Co., 847 F.2d 564 (9th Cir. 1988) (grudgingly applying California law).
Unfortunately, this approach to contract construction places too much emphasis on text—which is but a memorialization of the agreement and objective of the contract—and too little on the purpose and function of an insurance policy. Even for business insurance involving brokers and counsel, it is far from clear that every word of a policy represents “written expression of the parties’ intent.” It is not infrequent for one or more of the parties to have no familiarity with some terms of the policy, let alone any understanding or concept of all policy terms.

A more common phrasing of contract law than quoted in Martin Resource is that courts should give effect to the intent of the parties, which is usually best indicated by the text of the contract documents. To be sure, unambiguous policy language is normally given its clear facial meaning. Even in jurisdictions like California that are less formalist than Texas, language must be reasonably susceptible to the meaning proffered by the party seeking to present intrinsic evidence of meaning. Despite this deference for text, however, courts frequently refuse to give literal effect to text that thwarts contract and public policy objectives and is inconsistent with party intent and the purpose of the instrument.

The Martin Resource decision—however troubling in its tunnel vision—is not necessarily incorrect as a matter of neoclassical formalist contract law. What is disturbing is that the decision fails to even consider the operation of liability insurance and its socioeconomic role in risk management. And, of course, the court does not address questions of disproportionate forfeiture, undue windfalls to a contract party, public policy, or—perhaps most important—areas where insurance doctrine has declined to give literal interpretation to even the most unambiguous of policy terms because to do so runs counter to other important facets of insurance law.

Also disturbing is the court’s conclusion that “the AXIS policy unambiguously precludes exhaustion by below-limit settlement.” The AXIS language, however clear, says something less than that. More important, the Fifth Circuit’s sweeping pronouncement reflects an unwise judicial view that literal enforcement of problematic policy provisions matters more than a construction of the policy that serves larger law and policy goals of efficient dispute resolution and risk management as well as substantive fairness and avoidance of undue forfeiture. In effect, policyhold-
ers are punished for settling with an underlying insurer rather than litigating to the last post-trial motion or appeal. This creates very negative incentives for the justice system.

But whatever its faults, the Martin Resource decision is consistent with the trend of the times in giving literal enforcement to anti-Zeig clauses, although there are occasionally cases to the contrary.82 Final publication of the ALI Restatement is likely to make the situation worse. Prudent brokers and policyholder counsel therefore must be vigilant regarding such clauses. And to be fair to excess insurers, less severe versions of such clauses are often made available to policyholders.83

B. The Pernicious Impact of Automatic Enforcement of Anti-Zeig Clauses

These Illustrations reflect considerable problems with the sweeping literal enforcement of anti-Zeig provisions in excess policies. Under the default rule of Zeig, the excess insurer’s underlying limit would be considered satisfied and its attachment point reached because $1 million has been paid by a combination of the primary insurer and the insured or will certainly be paid once the plaintiff executes on the judgment.

And under this regime, although the excess insurance would attach, the excess insurer in the first two Illustrations would still be able to assert its pollution exclusion defense to coverage and any other potentially applicable coverage defenses, including any contention that the settlement was unreasonable or collusive.

Proponents of the Qualcomm approach seem to forget this fact in arguing that it is unfair to deny the excess insurer its anti-Zeig defense. But strict enforcement of an anti-Zeig clause works a greater unfairness in that it prevents the excess insurer’s obligation from ever being triggered,

82. See, e.g., Maximus, Inc. v. Twin City Fire Ins. Co., 856 F. Supp. 2d 797, 801–02 (E.D. Va. 2012). But Maximus did so on the ground that the policy text was sufficiently ambiguous to find for the policyholder rather than directly on disproportionate forfeiture or similar policy-oriented grounds. The Martin Resource court is highly critical of Maximus and may be correct as a matter of linguistics—but that hardly makes Martin Resource prudently decided.

83. For example, one insurer’s provision regarding underlying insurance provides that the underlying limit is satisfied

[i]n the event and only in the event of the reduction or exhaustion of the Underlying Limit by reason of the insurers of the Underlying Policies and/or the Company and/or the Insured Persons paying in legal currency Loss covered under the respective Underlying Policy as provided [in the policy].

This requirement of payment in legal currency is designed to prevent the attachment of the excess policy based on mere assignment or forgiveness of claims or other concessions that might be deemed to have value. An excess insurer reasonably wants to attach only after actual monetary payment, which ensures that the underlying limit really has been exhausted through the adversarial dispute resolution process rather than through an “on paper” arrangement between a policyholder and an underlying insurer (perhaps one with far lower limits than the excess policy at issue) that may give rise to what might be termed a soft form of collusion that is implicitly unfair to the excess insurer but hard to prove.
even though it is clear that the amount of the policyholder’s liability exceeds the attachment point. While refusal to enforce the condition does deprive the excess insurer of a powerful defense, the defense is so powerful in some situations that it results in a complete forfeiture to the policyholder without any proof that the excess insurer was actually harmed by the lack of the underlying insurer’s full payment.

By contrast, under my proposed treatment of anti-Zeig clauses, an excess insurer that can actually demonstrate that it was damaged by the settlement or the payment of part of the underlying limit by the policyholder can indeed avoid coverage on grounds of fraud, collusion, or a meritless complaint and also retain its right to litigate core coverage issues such as the applicability of a pollution exclusion or other limitation on coverage. But it may not escape all liability simply because of the happenstance of the source of satisfaction of an underlying limit.

Applying a Zeig approach even in the face of clear underlying-insurer-must-pay language is very similar to the longstanding judicial treatment of anti-assignment clauses, cooperation clauses, consent-to-settle clauses, and prompt notice clauses.84

The Illustrations are relatively simple and straightforward, but they serve to illuminate the problems created by the *Qualcomm* approach through demonstrating how literal application of an anti-Zeig clause can easily bring pernicious and even absurd results. Excess insurers undoubtedly would argue that most real-world cases are not so stark and that requiring underlying insurer payment as a condition precedent to coverage is not unfair in more complex situations involving multiple parties, consecutive policy periods, settlements on the merits rather than full adjudication, settlements that involve exchanges other than or in addition to cash, and the like.85 Perhaps.

My response is simply that excess insurers wishing to avoid coverage because of the particular deficiencies of a settlement, however simple or complex the context, should be required to defeat coverage on the merits. If the settlement is a “sweetheart deal” between plaintiff, policyholder, or underlying insurers, the excess insurer should have to prove it. Fraud, collusion, *ex gratia* payments, or unreasonable settlement terms or amounts

84. See text accompanying notes 101–75, infra.

85. See, e.g., O’Connor, *Caveat Settlor*, supra note 16; O’Connor, *Rights of Excess Insurers*, supra note 16; Carrie Cope, Qualcomm, Inc. v. Certain Underwriters at Lloyd’s London: No Drop Down Required, Insured’s Expectation of Coverage Defeated by Clear Policy Language to the Contrary, LEINEXIS EMERGING ISSUES ANALYSIS (Apr. 2008) (appearing to take favorable view of Qualcomm); see also McCarter & English, *Addressing the Complications Arising from Coverage Settlements Involving Multiple Insureds and Insurers, and Non-Covered Parties*, LEINEXIS EMERGING ISSUES ANALYSIS (May 2012) (describing cases using both Zeig approach and Qualcomm approach involving multiple parties, claims, policies, and policy periods as well as non-cash settlements).
remain valid defenses for an excess insurer even if it cannot use anti-Zeig language as a get-out-of-jail-free card. If the consideration given for a settlement is “funny money” (e.g., dismissal of claims without value, credits for worthless or undesired purchases), this too provides a valid objection to coverage.

If excess insurers are genuinely concerned that without full payment by underlying insurers satisfaction of underlying limits is suspect, they should simply have to prove their suspicions rather than being able to completely avoid otherwise valid coverage obligations merely because underlying limits were satisfied by a different payer or in another manner sufficient to demonstrate that the claim in question reached the attachment point.

1. Allowing an Excess Insurer to Avoid Coverage for Judgments or Settlements Based on the Source of Payment of the Underlying Limit Runs Counter to the Principle of Avoiding Disproportionate Forfeiture and Creates Unfair Windfalls for Excess Insurers

The ALI Restatement’s embrace of Qualcomm is particularly surprising in that the Restatement presumably would follow the important axiom that liability insurance issues should be decided in a manner that avoids disproportionate forfeiture.86 This is a sound approach enshrined in the maxim that the “law abhors a forfeiture.”87 Under circumstances such as those described in the above Illustrations, the loss of insurance policy/contract benefits to the policyholder (or its assignee) is clearly disproportionate to any “breach” of a condition or term in the policy. Unless the excess insurer can actually demonstrate harm that it would not have faced had there been payment of the underlying limit solely by an underlying insurer(s), enforcement of the condition/term merely enriches the excess insurer (by $5 million under these Illustrations) on the basis of what might be termed a mere technicality (the identity of a payer or the absence of an underlying insurer due to insolvency).

The flip side of undue forfeiture visited upon the policyholder (which paid premiums for the excess insurance) is an unreasonable windfall to the excess insurer. In underwriting the excess policy, the excess insurer un-

86. In discussion with the Advisors, the Reporters and Professor Abraham expressed support for a presumption against disproportionate forfeiture in crafting the Restatement. Particularly noted was an article by Professor Robert Works that made this observation primarily in the context of claims-made insurance. See Robert Works, Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case, 5 CONN. INS. L.J. 506 (1998). Even if this were not the conscious intent of the Institute, it is a mainstream legal principle of considerable value.

doubtedly made actuarial estimates of the likelihood that it would be faced with claims piercing into its layer of coverage. Under the CO poisoning hypotheticals of the Illustrations, this is exactly what happened. Although an event the excess insurer would prefer to have avoided, it was part of the risk-shifting and risk-distribution arrangement made by insurers selling liability coverage. But due to the mere happenstance of either underlying insurer insolvency (Illustration No. 1) or a compromised coverage dispute (Illustration Nos. 2 & 3), the excess insurer not only avoids a claim arguably within coverage (depending on resolution of the pollution exclusion dispute) but avoids coverage completely, without even being troubled to litigate its coverage position or prove any harm from the settlement.

By any reasonable understanding, this is a big windfall<sup>88</sup> for the excess insurer. By permitting an excess insurer to deny the attachment of its coverage based on the happenstance of who pays the underlying limit, Qualcomm creates myriad opportunities for policyholders to suffer disproportionate forfeiture. As illustrated above, following a Qualcomm approach can cause the policyholder to lose millions of dollars of purchased excess insurance (tens of millions in the case of large commercial towers of coverage), merely because it compromised a coverage dispute with a single underlying insurer for anything less than 100 cents on the dollar. Under the Zeig approach, excess insurers are adequately protected from paying claims at an amount lower than their attachment point as long as the underlying limits are paid. They need no further protection.

If an excess insurer was prepared to pay amounts in excess of the attachment point when it took the policyholder’s premium, it should not be completely relieved of that obligation at the point of claim simply because some of the underlying amount spent to reach the attachment point came from a policyholder rather than an underlying insurer—which can happen equally through settlement by the parties or insolvency of an underlying insurer.

2. Anti-Zeig Language as a Trap for the Unwary

Cases like Qualcomm based their decisions on a view that text takes primacy—even in derogation of the dominant purpose and function of the liability insurance contract. These cases also tend to reflect an attitude that commercial policyholders should be sufficiently sophisticated “big boys” to read both the printed forms and the negotiated endorsements of their excess policies care-

<sup>88</sup> Dictionaries commonly define a windfall as “an unexpected, unearned, or sudden gain or advantage.” See MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 1434 (11th ed. 2003). Legal dictionaries and precedent have defined a windfall as “An unanticipated benefit . . . in the form of a profit not caused by the recipient.” See Windfall, BLACK’S LAW DICTIONARY 1738 (9th ed. 2009).
fully, understand the full implications of any “unless otherwise stated” language, and either bargain to eliminate it or make other arrangements with competing insurers. This “caveat policyholder” viewpoint is misplaced for several reasons.

a. The Realities of Insurance Policy Placement—Expecting the policyholder to have encyclopedic knowledge of every term in a policy is unrealistic in light of the manner in which insurance is sold. Sophisticated customers aided by sufficiently expert brokers and attorneys may be able to examine policies prior to purchasing and may even specifically negotiate the text of the policy. But this is not the norm. Typically, insurance is sold with basic agreement as to a few key terms such as price, retention, policy period, and premium. But seldom is specific language discussed or the full policy provided to the insurance applicant for inspection and analysis.

Courts applying the implicit “caveat policyholder” approach appear not to appreciate that in the real world, insurance placement proceeds at a brisk pace that may leave comparatively little opportunity for close reading of policy language before premiums are paid and coverages are bound. For example, the policy—with the actual printed form language contradicting the default Zeig approach—may not be delivered to the policyholder for months after the insurance is purchased. When it does, any substantive review is likely to be confined to the endorsements that the risk manager specifically negotiated and agreed upon, not the printed form that is commonly assumed to express only the basic form-following function of the excess coverage.

This is particularly true for individual and small business policyholders. Their first look at the full text of the policy may not come for weeks or months. And individuals and small businesses will normally lack the assistance of brokers and counsel in plying the insurance marketplace and reviewing purchase options.

The Qualcomm approach (and current § 40 of the ALI Restatement) makes no distinction between consumer insureds and commercial insureds. The deference to anti-Zeig clauses applies to individuals (e.g., a middle-class wage earner with a personal umbrella policy) and small businesses (the hypothetical furnace repair company in Illustration Nos. 1 & 2 above) as well as to Fortune 500 corporations. Many of the policyholders adversely affected will have no information about anti-Zeig clauses in general or any anti-Zeig clauses in the policies sent to them long after their purchases. When they learn—in the context of a coverage denial—it will be too late.

89. See Stempel, Insurance Aftermath of September 11, supra note 59 (policy text regarding World Trade Center not available at time of September 11 attacks even though policy period began in July).
Even sizeable corporations and governments make mistakes and may miss problematic language in an excess policy. Like consumers, they often do not receive the final written policy until long after purchase. A common practice is the issuance of a “certificate of insurance” to a commercial purchaser at the time of sale. This certificate records only the bare details of the contract. Worse yet, to the extent the certificate tends to establish coverage, courts refuse to follow the certificate language once the full policy has been issued.

Although contract traditionalists might have little sympathy for policyholders and note that there is a “duty to read” the policy (when it eventually arrives), this critique is unrealistic. A policyholder that purchased insurance weeks ago reasonably presumes that the language of the policy memorializing the purchase will be in accord with the insurance product purchased—in this case, excess insurance. Further, insurers have fiduciary-like duties toward their policyholders and presumably can be trusted not to issue a policy with language that undermines any basic purpose of the insurance product. In this environment, one is unlikely to see an ever-vigilant policyholder eagerly ripping open the envelope containing a newly issued policy and pouring over every word in search of landmines that may have been authored by the insurer.

Expecting super-vigilant-cum-paranoid policyholder behavior is also impractical and economically wasteful. Policyholder employees are pre-


91. Some jurisdictions provide that when the policyholder has had the opportunity to review the policy, then the policyholder is presumed to know, assent to, and understand the terms. See Busker on the Roof P'Ship v. Warrington, 283 A.D.2d 376, 377 (N.Y. App. Div. 2001); Am. Bankers Ins. Co. v. Tellis, 192 So. 3d 386, 390–91 (Ala. 2015). However, other jurisdictions do not impose this duty on policyholders unless it would be “unreasonable” for them not to read it. See Huu Nam Tran v. Metro. Life Ins. Co., 408 F.3d 130, 137 (3d Cir. 2005) (applying Pennsylvania law).

92. See, e.g., Bd. of Regents v. Royal Ins. Co., 517 N.W.2d 888 (Minn. 1994); Atwater Creamery Co. v. W. Nat'l Mut. Ins. Co., 366 N.W.2d 371 (Minn. 1985) (adopting reasonable expectations principle that permits policyholder's objectively reasonable expectations of coverage to control despite adverse policy text if text is hidden or unfairly surprising but not if coverage-defeating text is located in portion of the policy (e.g., an exclusion) where it should have been noticed by policyholder).

Even this limited concept of the reasonable expectations approach, where policyholder expectations can be defeated by policy text that may well have never been read by the policyholder, would appear to limit enforcement of anti-Zeig clauses. This is so because although they defeat coverage, they are not denominated as exclusions and are not stated as part of the attachment point or underlying limit set forth in the policy’s declarations page.

93. See generally Stempel & Knutsen, supra note 1, at ch. 9 (insurer has duties to policyholder that are fiduciary in nature and in some cases (e.g., when insurer is defending a liability claim) fully fiduciary).
sumably focused on the work of the policyholder, which presumably is what a system premised on markets, entrepreneurism, and economic growth would want. To the extent that a policyholder that thought it had made a prudent risk management purchase (a tower of excess or umbrella insurance) is diverted from its core commercial activity (e.g., designing, making, building, selling) of more productive work by a need to flyspeck policies for anti-Zeig clauses or other unexpected limitations of coverage, inefficiency results.

In the typical insurance placement environment, a policyholder and its broker can simply fail to appreciate the risk of anti-Zeig clauses, hence the common lack of discussion of such clauses and the common failure of policyholders to search the eventually resulting excess policy for anti-Zeig language. Even commercial policyholders can fail to catch anti-Zeig language that may have been included in the policy issued without any discussion or perhaps even contrary to the understanding of the parties. Brokers and risk managers may have thought that the Zeig rule governed (as it did in California before Qualcomm) only to be surprised by a case, like Qualcomm, rejecting that longstanding approach. It is unwise and unfair to visit upon policyholders the drastic sanction of losing all excess coverage based on error by a broker or other policyholder representative (risk managers, consultants, or lawyers also may have overlooked the issue or failed to catch a documentation error) unless an insurer is actually harmed by the Zeig approach to attachment.

In addition, anti-Zeig language may not be particularly clear, which further increases the risk that policyholders may overlook it or read it in a way

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94. If this were the case, the erroneously inserted language should be subject to challenge even in the absence of fraud. But many courts refuse to consider extrinsic evidence of policy meaning of the text if the policy is clear on its face. This type of mistake should preclude judicial enforcement of the incorrectly inserted term. Other courts may (erroneously) invoke the parol evidence rule. Even if a document recites that it is fully integrated (which insurance policies seldom do), the correct approach to the parol evidence rule is to at least permit evidence on the issue of whether a writing is in fact accurate. See David Epstein, Bruce Markell & Laurence Ponoroff, Making and Doing Deals: Contracts in Context 488–522 (4th ed. 2014) (noting that this is the majority approach to the doctrine and implicitly criticizing excerpted case to the contrary); Farnsworth, supra note 78, § 7.3.

95. One obvious excess insurer response to this factor is to argue that failure to catch the problem of the lurking underlying-insurer-must-pay clause is to recognize it as professional negligence by the broker or other policyholder representative, in turn triggering the malpractice liability policies of the representative. Although the analysis may be correct (counsel for large commercial policyholders appear to regard such oversights as falling below the brokers’ standard of care), efforts to make the policyholder whole in this manner entail substantial collateral litigation, expense, and uncertainty, imposing unnecessary transaction costs on the judiciary, third parties, and society—all in the service of allowing an excess insurer to avoid all coverage responsibility regardless of the merits of the coverage claim. In addition, in cases involving individuals and small businesses, the relevant brokers or other intermediaries may lack sufficient errors and omissions coverage to rectify the loss suffered by the policyholder (or assignee claimant) if the underlying-insurer-must-pay clause is enforced.
that differs from the construction ultimately adopted by a court adjudicating a coverage dispute that ensues years later. Although this concern can perhaps be cured by courts consistently requiring crystal-clear clarity in such clauses, that solution is probably unrealistic in light of the dispersion of insurance law authority (due to the state-law-centered nature of insurance)\(^{96}\) and judicial variation in analysis and jurisdictional authority.

**b. Mainstream Contract Law Doctrine Counsels Against Overliteral Application of Anti-Zeig Language**—The actual operation of insurance policy placement, which frequently involves little specific focus on the text of the policy (particularly for individual and small business purchasers), also makes a case for taking a jaundiced eye toward anti-Zeig clauses on traditional contract law grounds.

Standard Anglo-American contract law tends to provide little escape from a contract provision that one party comes to regret.\(^{97}\) A policyholder faced with an insolvent insurer or a recalcitrant underlying insurer unwilling to concede coverage but willing to settle undoubtedly regrets having an anti-Zeig clause in the policy. But importantly, the policyholder probably did not specifically discuss or negotiate the clause and may not have been aware of it at all. As discussed further below, one response to the problem is to realize that although policy text is one important indicium of the meaning of the policy, the intent of the parties, and the purpose of the contract, policy text is not necessarily definitive evidence of any of these things. The policy text is not even, strictly speaking, the contract.\(^{98}\)

**i. Mistake, Unconscionability, or Contracts Restatement § 211 as Grounds for Avoidance of Anti-Zeig Language**—Even in this “a deal’s a deal” atmosphere,\(^{99}\) standard contract law permits relief not only

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96. At a minimum, the McCarran-Ferguson Act, 15 U.S.C. § 1101, largely makes substantive insurance law and regulation a matter of state law. See Stempel, Swisher & Knutsen, supra note 3, at 213–22. There is also the potential application of federal common law for excess policies implicated in claims pursuant to the Employee Retirement and Income Security Act (ERISA). See Stempel & Knutsen, supra note 1, § 3.04. And because diversity jurisdiction often exists for insurer-policyholder disputes, many decisions are rendered in federal trial and appellate courts, which do not provide binding authority. Meanwhile, decisions in state trial courts are not binding on other trial courts and in many states differing appellate court rulings may not be binding throughout the state. Above all, judges reading the very same language often come to considerably different conclusions as to the meaning of the text in question. See Stempel, Swisher & Knutsen, supra note 3, at ch. 11 (juxtaposing liability insurance cases from differing courts where the courts divide as to the meaning of the very same language in standardized insurance policies).


98. See text accompanying notes 131–40, infra.

99. But, at the risk of being unduly repetitive, this article takes the position that anti-Zeig clauses should not be considered part of the excess insurance arrangement unless specifically negotiated or actually understood to be part of the contract by the policyholder.
for a mutual mistake of both parties\footnote{A mistake is “a belief that is not in accord with the facts.” See \textit{Restatement (Second) of Contracts} § 151 (Am. Law Inst. 1981). Where both parties when making a contract are mistaken “as to a basic assumption on which the contract was made” and this mistake “has a material effect on the agreed exchange,” the contract is “voidable by the adversely affected party unless he bears the risk of the mistake under the rule stated in [Restatement] § 154. See \textit{Restatement (Second) of Contracts} § 152(1). Courts may ameliorate the impact of mistake through reformation, through restitution, or by provision of other relief from the strict enforcement of the contract. See \textit{Restatement (Second) of Contracts} § 152(2).} but under certain circumstance it also relieves a party of its unilateral mistake, a principle adopted by the Restatement of Contracts.\footnote{See \textit{Restatement (Second) of Contracts} §§ 153 and 154.}

An unconscionable provision is one that is either sufficiently the product of bargaining misconduct or unreasonably favorable to a contracting party.\footnote{Unconscionability, although not specifically defined in the UCC or the Restatement, is generally “recognized to include an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party.” \textit{Williams v. Walker-Thomas Furniture Co.}, 350 F.2d 445, 449 (D.C. Cir. 1965) (cited as a commonly accepted definition in \textit{Farnsworth}, supra note 78, § 4.28 at 301). \textit{Accord Perillo}, supra note 78, § 9.40 (noting lack of universal agreement on precise definition and reviewing various formulations of unconscionability concept). More recently, courts have tended to adopt a sliding-scale approach in which a provision that is too one-sided will not be enforced even if the aggrieved party had some degree of choice. \textit{See, e.g.}, \textit{Gonski v. 2d Jud. Dist. Ct.}, 245 P.3d 1164 (Nev. 2010); \textit{8 Richard A. Lord, Williston on Contracts} § 18:10 (4th ed. 2010); \textit{Armendariz v. Found. Health Psychcare Servs., Inc.}, 6 P.3d 669 (Cal. 2000).} Although

\begin{itemize}
\item[(a)] the effect of the mistake is such that enforcement of the contract would be unconscionable or
\item[(b)] the other party had reason to know of the mistake of his fault caused the mistake.
\end{itemize}

\section*{§ 154 When a Party Bears the Risk of a Mistake}

A party “bears the risk of a mistake” when
\begin{itemize}
\item[(a)] the risk is allocated to him by agreement of the parties, or
\item[(b)] he is aware, at the time the contract is made, that he has only limited knowledge with respect to the facts to which the mistake relates but treats his limited knowledge as sufficient, or
\item[(c)] the risk is allocated to him by the court on the ground that it is reasonable in the circumstances to do so.
\end{itemize}

\textit{102. Unconscionability, although not specifically defined in the UCC or the Restatement, is generally “recognized to include an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party.”\cite{Williams v. Walker-Thomas Furniture Co.} 350 F.2d 445, 449 (D.C. Cir. 1965) (cited as a commonly accepted definition in \textit{Farnsworth}, supra note 78, § 4.28 at 301). \textit{Accord Perillo}, supra note 78, § 9.40 (noting lack of universal agreement on precise definition and reviewing various formulations of unconscionability concept). More recently, courts have tended to adopt a sliding-scale approach in which a provision that is too one-sided will not be enforced even if the aggrieved party had some degree of choice. \textit{See, e.g.}, \textit{Gonski v. 2d Jud. Dist. Ct.}, 245 P.3d 1164 (Nev. 2010); \textit{8 Richard A. Lord, Williston on Contracts} § 18:10 (4th ed. 2010); \textit{Armendariz v. Found. Health Psychcare Servs., Inc.}, 6 P.3d 669 (Cal. 2000).}
many courts require both “procedural” and “substantive” unconscionability to trigger this power of review, better-reasoned decisions use a “sliding scale” approach in which a sufficient amount of either contracting defect or substantive unfairness may prevent application of the one-sided term.\textsuperscript{104}

The Restatement of Contracts further provides:

Where a writing that evidences or embodies an agreement in whole or part fails to express the agreement because of a mistake of both parties as to the contents or effect of the writing, the court may at the request of a party reform the writing to express the agreement, except to the extent that rights of third parties as good faith purchasers for value will be unfairly affected.\textsuperscript{105}

Thus, despite the general reverence for the language of a contract document, there is mainstream authority supporting modification or even complete nonenforcement of sufficiently unfair terms, terms obtained unfairly, or terms found in a contract document about which one of the contracting parties was mistaken. “An increasing number of cases have permitted avoidance where only one party was mistaken,” and avoidance “is generally allowed if two conditions concur: (1) enforcement of the contract against the mistaken party would be oppressive, or, at least, result in an unconscionably unequal exchange of values, and (2) avoidance would impose no substantial hardship on the other than loss of bargain.”\textsuperscript{106}

In the absence of actual injury to excess insurers due to the absence of payment by an underlying insurer, anti-\textsuperscript{Zeig} clauses placed in excess policies as a matter of course would appear to satisfy this requirement—and perhaps would be unenforceable in many circumstances (such as the three Illustrations previously set forth) on unconscionability grounds even in the absence of mistake.\textsuperscript{107}

Where the contract memorialization is routine or standardized, courts have particular license to ensure that the specific language of boilerplate provisions does not impose unanticipated unfairness at odds with the understanding of the adversely affected party and does not gut the purpose of the contract. Where one party to a contract “has reason to believe that the party manifesting such assent would not do so if he knew that the writing contained a particular term, the term is not part of the agreement.”\textsuperscript{108}

Taken together, these accepted principles reflected in the Contracts Restatement make a strong case for disregarding anti-\textsuperscript{Zeig} clauses and other lopsided terms that would cause complete forfeiture of contract

\textsuperscript{104}. See, e.g., \textit{Gonski}, 245 P.3d 1164.
\textsuperscript{105}. \textit{RESTATEMENT (SECOND) OF CONTRACTS} § 155.
\textsuperscript{106}. See \textit{Perillo}, supra note 78, § 9.27 at 321 (footnotes omitted).
\textsuperscript{107}. \textit{RESTATEMENT (SECOND) OF CONTRACTS} § 208. By its terms, § 208 and the cases upon which it builds did not require mistake to support judicial action against unconscionable provisions. See, e.g., \textit{Gonski}, 245 P.3d 1164; \textit{Walker-Thomas Furniture Co.}, 350 F.2d 445.
\textsuperscript{108}. \textit{RESTATEMENT (SECOND) OF CONTRACTS} § 211.
benefits—unless the excess insurer relying on the clause can demonstrate injury from any failure to satisfy the conditions of the clause. And to the extent that a policyholder’s failure to anticipate, detect, or appreciate an anti-Zeig clause can be characterized as a mistake, this may provide an additional traditional ground for refraining from literal application of anti-Zeig provisions.

In light of the realities of insurance policy placement and documentation, one can reasonably posit that policyholders reasonably expect not to have coverage defeated by anti-Zeig clauses of which they were unaware at the time of contracting. Absent evidence of actual discussion of such clauses, it is more than reasonable to assume that a policyholder was not aware of the clause.

The reasonable expectations concept well-developed in insurance law posits that policyholders should be accorded coverage consistent with their objectively reasonable expectations (e.g., expecting excess insurance to attach at its attachment point regardless of the source of underlying payment) and that they not be bound by coverage-defeating language that is hidden, unclear, or unfairly surprising. Cases applying the reasonable expectations approach have found this standard met when language tending to operate as an exclusion or defeat coverage is found in a “Definitions” or “Conditions” section of a policy rather than in the “Exclusions” portion of the policy. As reflected in the three Illustrations set forth above, anti-Zeig language in an attachment section of a policy effectively becomes an exclusion as well as being a provision consumer policyholders and many business policyholders would not expect.

One can argue, of course, that the policyholder who failed to read an excess policy closely (when it finally arrives) is, in the language of Contracts Restatement § 154, “aware, at the time the contract is made, that he has only limited knowledge with respect to the facts [contract language] to which the mistake relates but treats his limited knowledge as sufficient [by purchasing the policy without reading].” One can argue that the risk of mistake lies with the policyholder who contracted for the excess policy without first gaining sufficient information about possible anti-Zeig language in the policy. As provided in Restatement § 154(b), a policyholder adversely impacted by anti-Zeig language it did not antic-
ipate could be said to have acted with limited knowledge but riskily treated its limited knowledge as sufficient. But this view seems inapt in the fluid setting of excess insurance sales.

If excess insurance policies—even long and complex forms—were laid on a table before the policyholder prior to the sale of the policy, this position would have something to recommend it. But in light of the actual operation of insurance policy sales and placement, with memorialization coming so far after the sale and with little or no discussion of the bulk of policy terms, this position is harsh. A policyholder should be considered sufficiently mistaken to permit relief from anti-Zeig clauses only if this aspect of the policy (exhaustion of underlying limit and attachment), including any purported necessity for payment only by underlying insurers, was adequately disclosed or discussed.

When there was no policy available at the time of contracting, the case for treating policy text as either “the” contract or the best evidence of party intent or contract purpose becomes very weak. Consumers and small businesses may not even have enough market power to obtain a copy of the policy prior to purchase.

Although traditional contract doctrine imposes a “duty to read” on contracting parties, this seems unrealistic in the real world of risk management. Is the policyholder who detects an anti-Zeig clause after poring over the policy that arrives weeks after sale really supposed to object and cancel the policy if the insurer will not delete the clause, forcing the policyholder to again shop the market for excess coverage?

Placing this sort of burden on the policyholder is particularly unfair in light of rather consistent evidence in the cognitive science literature of a natural human tendency toward “optimism bias”—a tendency to overly discount the risk of a negative development (e.g., insolvency of an underlying insurer or a coverage dispute with an underlying insurer).

In addition, rational policyholders would not knowingly agree to such draconian provisions unless required by a hard insurance market or unless the policyholder made a conscious decision to accept the limitation

110. See explanation of duty to read, supra note 91.

111. Optimism bias is the “inclination of individuals to believe that there is an above-average chance of good things happening to them and a below-average chance of bad things happening.” See David Adam Friedman, Debiasing Advertising: Balancing Risk, Hope, and Social Welfare, 19 J.L. & Pol’y 539, 586 (2011).

112. A “hard” insurance market is one in which, due to adverse underwriting and claims conditions, insurance coverage is hard to obtain and tends to be expensive, often being accompanied by relatively low policy limits, high retentions, or particularized limits on coverage. By contrast, a “soft” market is one in which relatively broad coverage with high policy limits is available in the marketplace at comparatively low premium. See generally Sean M. Fitzpatrick, Fear Is the Key: A Behavioral Guide to Underwriting Cycles, 10 Conn. Ins. L.J. 255, 257 (2004).
on coverage in return for a lower premium or some other countervailing favorable policy provision. This would appear to make Contracts Restatement § 211 applicable.113

Rational policyholders, if not mistaken as to the presence of anti-Zeig language in a policy form, would not accept the provision in light of the risk (reflected in this article's three Illustrations) of underlying insurer insolvency or coverage disputes. Only if it received a significant premium discount would a rational policyholder accept a policy provision that effectively gave any insurer in the coverage tower veto power over settlement of coverage disputes.

ii. The Material Breach Concept as Grounds for Declining to Enforce Anti-Zeig Text—Another aspect of mainstream contract doctrine counsels in favor of Zeig-like treatment of these issues rather than the Qualcomm approach. Pursuant to longstanding contract law, the victim of material breach of a contract may lawfully repudiate the contract (as well as collect damages suffered prior to repudiation), while victims of minor breach can collect damages due to the breach but may [not] avoid the contract.114 These victims of minor breach must still perform their contractual obligations.115 As explained by Professor Farnsworth:

In order for a breach to justify the injured party’s suspension of performance, the breach must be significant enough to amount to the nonoccurrence of a constructive condition of exchange. Such a breach is termed “material.” . . .

The doctrine of material breach is simply the converse of the doctrine of substantial performance. Substantial performance is performance without a material breach, and a material breach results in performance that is not substantial. . . .

[The most significant fact in determining the existence of material breach] is the extent to which the breach will deprive the injured party of the benefit that it justifiably expected. . . .”116

113. RESTATEMENT (SECOND) OF CONTRACTS § 211 provides:

(1) Except as stated in Subsection (3), where a party to an agreement signs or otherwise manifests assent to a writing and has reason to believe that like writings are regularly used to embody terms of agreements of the same type, he adopts the writing as an integrated agreement with respect to the terms included in the writing.

(2) Such a writing is interpreted wherever reasonable as treating alike all those similarly situated, without regard to their knowledge or understanding of the standard terms of the writing.

(3) Where the other party has reason to believe that the party manifesting such assent would not do so if he knew that the writing contained a particular term, the term is not part of the agreement.

114. See FARNSWORTH, supra note 78, §§ 8.15–8.16.

115. See id.

The Restatement of Contracts adopts this view, as do the Vienna Convention and the UNIDROIT Principles. Restatement § 241 lists the “Circumstances in Determining Whether a Failure Is Material” as

- The extent to which the injured party will be deprived of the benefit which he reasonably expected;
- The extent to which the injured party can be adequately compensated for the part of the benefit of which he will be deprived;
- The extent to which the party failing to perform or to offer to perform will suffer forfeiture;
- The likelihood that the party failing to perform or to offer to perform will cure his failure, taking account of all the circumstances, including any reasonable assurance;
- The extent to which the behavior of the party failing to perform or to offer to perform comports with standards of good faith and fair dealing.

Applied to excess insurance attachment, the material breach concept augers in favor of treating payment by a policyholder or third party (rather than an underlying insurer) as only a minor breach rather than a material breach. Unless the source of payment defeats the purpose of the attachment point—limiting the excess insurer’s coverage responsibility to only claims over a minimum amount—the source of payment does not operate to deprive the excess insurer of the benefit of its bargain to begin providing insurance coverage at a certain level, particularly when the excess insurer retains all of its nonattachment/anti-Zeig defenses. Where payment by the policyholder or entity other than an underlying insurer is not accompanied by fraud, collusion, self-dealing, or inadequate vetting of a claim sufficient to harm the excess insurer, enforcement of an anti-Zeig clause is inconsistent with basic contract law.

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117. See Restatement (Second) of Contracts §§ 237–49.
119. See UNIDROIT Principles of International Commercial Contracts, art. 6 (2010).
120. See Restatement (Second) of Contracts § 241(a)–(e).
3. The *Qualcomm* Approach Impedes Settlement of Claims and the Risk Management Function of Insurance, Creating Increased Litigation, Inefficient Resolution of Claims, and Insufficient Compensation of Victims

The practical effect of a *Qualcomm*-style approach is to make settlement of complex cases involving towers of insurance much more difficult. Excess insurers are given an incentive to sit on the sidelines if they think an underlying carrier will not be forced to pay full policy limits. When settlement is hindered, informal dispute resolution costs (e.g., negotiation, mediation) increase. Litigation costs also increase when settlement cannot be attained. These negative outcomes in turn increase the workload of courts and the costs paid by parties to a dispute. Systemic social costs thus increase.

In addition, to the extent that the *Qualcomm* approach permits excess insurers to avoid their coverage responsibility on this “exhaustion technicality,” insurance funds are taken out of the pot otherwise available to compensate victims. Undercompensated victims in turn are more likely to seek and obtain public assistance benefits, imposing additional social costs and taxation—all for risks that were supposed to have been shifted to the excess insurer, spread throughout the excess insurer’s risk pool, and funded by policyholder premium payments rather than tax dollars.

4. Requiring Excess Insurance to Attach When Underlying Limits Are Paid Without Regard to the Source of Payment Is Not Unfair to Excess Insurers—They Retain All Other Coverage Defenses That May Legitimately Be Available

As previously noted, excess insurers may argue that language requiring underlying limits to be paid by an underlying insurer is necessary to protect the excess insurer from “sweetheart” deals between an insured (or the plain-tiff to whom the insured has transferred its rights) and a relatively low limit insurer (such as a primary insurer eager to cease paying defense costs).

This is a legitimate concern *if* the underlying loss amount does not in fact legitimately exceed the excess insurer’s underlying limit or *if* no one is actually paying the balance of that underlying limit amount. But it is a concern that can be (and often is) addressed by a direct attack on a suspect settlement, rather than by permitting an across-the-board forfeiture of excess coverage, even for insureds who in good faith pay a portion of actual liability losses from their own pockets in an effort to settle underlying litigation and to avoid coverage litigation.

If a settlement is suspect because of collusion or unreasonableness, or because the insured’s “payment” of a share of the underlying limit is illu-
sory, the excess insurer retains the right to challenge coverage on that basis. There is no need to give the excess insurer the blanket protection of the Qualcomm approach where it suffers no economic detriment.

In addition, general liability excess insurers have available all other nonfrivolous defenses available under the facts of a particular case: pollution exclusion, own work, own property, impaired property, expected or intended injury, lack of an occurrence, late notice, failure to cooperate, rescission based on fraud or misrepresentation, and so on.121 Under these circumstances, there is no need to provide excess insurers with another defense to coverage that bears no realistic connection to the risk assumed for which the excess insurer has received and enjoyed earnings on premiums, often for years, before it is asked to provide coverage.

C. Warring Visions of Contract and Insurance: The Textualism Overkill of Qualcomm and the Pragmatic Purposivism of Zeig

The Zeig approach has been relegated by some courts and the ALI to a mere default rule because it stated that it was “doubtless true that the parties could impose [an underlying-insurer-must-pay requirement as a] condition precedent to liability upon the policy, if they chose to do so.”122 Seizing upon this language, courts like Qualcomm concluded that when an excess insurance policy does contain underlying-insurer-must-pay language, the insurer has altered the default rule of Zeig and that the policy language controls, no matter how pernicious its effect.123

However, as noted in the discussion of Zeig above, Zeig also stated that any particularized exhaustion language in an excess policy should “demand” a result.124 “A result [loss of all coverage where all of an underlying limit is not paid by the underlying insurer alone] harmful to the insured, and of no rational advantage to the insurer, ought only to be reached when the terms of the contract demand it.”125 One can thus interpret Zeig as not only requiring particular—and particularly clear—exhaustion language to avoid the Zeig approach but also as requiring that the application of such a policy provision be consistent with other aspects of con-
tract law such as avoiding absurd results; avoiding undue forfeitures; avoiding unfair windfalls to one contracting party, particularly when based on a textual provision that was not obvious or expressly discussed or understood; or rendering a result consistent with public policy and the larger goals of contract and insurance.

So interpreted, and of course as a default rule, Zeig reflects an emphasis on contract purpose and function as well as pragmatic application and overall fairness. Zeig did not say that the policyholder automatically could collect from the excess insurer. Rather, the case was remanded to the trial court so that the policyholder could be given the opportunity to prove that its loss reached the excess layer of insurance. The excess insurer retained the right to contest the amount of loss and presumably any other coverage defenses, including collusion between the policyholder and any underlying insurer.

By contrast, the Qualcomm approach, although not devoid of functional analysis, is unduly bound by text. Qualcomm and like cases reflect a highly textual, highly formalist approach to contract. Zeig, despite characterization as a default rule case, reflects a functional and purposive view, one that implicitly recognizes that in addition to being contracts, insurance policies have aspects of products designed to fill a particular function as part of a risk management and socioeconomic system.

The contrasting Zeig and Qualcomm approaches reflect a significant fault line in contract jurisprudence and insurance law. One approach treats the text of contract documents and insurance policies almost as sacred text that must be strictly enforced according to its verbiage, not-

126. See id.

127. For example, Qualcomm notes in the excess insurer argument that it included the underlying-insurer-must-pay language into the policy in an attempt to achieve greater assurance that the claim was sufficiently vigorously vetted and defended so as to reduce the risk that the attachment point would be reached. See Qualcomm, 73 Cal. Rptr. 3d at 784. However, Qualcomm gives relatively little consideration to the strong functional arguments against enforcement of the underlying-insurer-must-pay clause at issue. See id. at 785–86. In essence, as discussed above, it is good enough for the Qualcomm court that the policy contains language requiring payment by all underlying insurers as a prerequisite to attachment of the excess policy.

128. See id. at 772 (court concluded “that the literal policy language in this case governs”), 777 (“As to the exhaustion [anti-Zeig] clause, we cannot detect ambiguity” and “[u]nder these circumstances, Qualcomm’s objectively reasonable expectations as the insured were that primary insurance would have to be exhausted before excess coverage would attach.”).

withstanding that agreement regarding textual clarity is often illusive. The other approach treats contracting, including the purchase of an insurance policy, as a purposive endeavor designed to fulfill a function. I long ago cast my lot with the functionalists.\textsuperscript{130} The problems of the \textit{Qualcomm} approach have only solidified that view.


The \textit{Qualcomm} approach rests on the proposition that where language in an excess insurance policy text states that all payment must be made by the underlying insurer, this language must be enforced because it definitively represents the deal made between the policyholder and excess insurer, regardless of fairness, function, or public policy concerns.

But despite thousands of cases referring to a written instrument (e.g., insurance policies, apartment leases, sale invoices, bills of lading, construction agreements) as “the contract,” this characterization is oversimplified. It may be handy shorthand to refer to the writing as the “contract” between the parties, but that is not technically accurate and may lead to mischievous results. A leading contract law textbook explains as follows.

People often use the word “contract” to refer to the writing that embodies the agreement or deal. . . .

But the piece of paper is not a “contract.” At least it is not a “contract” as we will be using the word “contract.” At most, the piece of paper is a memorialization of the contract. . . .

In law school (and usually in the practice of law), a contract is a promise or set of promises that the law will enforce. . . .

At bottom, contract law exists to satisfy the basic impulse—to which most people subscribe—that the reasonable expectations excited by a promise, if and when disappointed without legal excuse, are entitled to recompense in a court of law.\textsuperscript{131}

Under this view, an excess insurance policy may (despite the importance of its textual content) be seen as embodying a basic agreement. When underlying insurance is no longer available, the excess insurer will respond, as

\textsuperscript{130} See articles cited in note 129. See also \textsc{Stempel, Swisher & Knutsen, supra} note 3, at ch. 2; \textsc{Stempel & Knutsen, supra} note 1, at ch. 4; Jeffrey W. Stempel, \textit{Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role}, 5 \textsc{Conn. Ins. L.J.} 181 (1998–99). Accord Yong Q. Han, \textsc{Policyholder’s Reasonable Expectations} (2016); Malcolm Clarke, \textsc{Policies and Perceptions of Insurance} (1997).

\textsuperscript{131} See \textsc{Epstein, Markell & Ponoroff, supra} note 94, at 12–13.
long as it receives the protection it would have had from full performance by an underlying insurer so that the excess policy will not attach at a monetary level lower than the underlying limit stated in the policy.

Seen in this way, it would appear that defense and settlement payments (or payment of a judgment) by the policyholder up to the level of the underlying limit would be sufficient to protect the excess insurer from responding below its agreed attachment point, regardless of whether the policyholder was paying the underlying limit because of insolvency of the underlying insurer or because a coverage dispute at the underlying level had been compromised.

Even if the excess insurance policy contains a clearly worded anti-Zeig clause, one can question whether this is really the “contract” made by the excess insurer and the policyholder, which reasonably expected that if its liability reached the attachment point of the excess insurer, the excess insurer would respond. 132

If the excess insurer can demonstrate that there was specific agreement that only payments by an underlying insurer exhaust the underlying limit or that the excess insurer was substantially prejudiced by payment of the underlying limit through alternative means, the excess insurer would then—like the insurer prejudiced by late notice—be able to avoid coverage on that basis. Absent such a showing by the excess insurer, it is unwise to incur the detrimental aspects of literal enforcement of an anti-Zeig clause.

To a degree, the clash over whether to allow policyholders to satisfy the underlying limit and eliminate any gap (due to insolvency, settlement, or more restrictive coverage in an underlying policy) between recovered insurance and the attachment point of excess insurance reflects a broader division in law concerning apt construction of insurance policies.

Insurance policies are, of course, contracts. 133 But an insurance policy differs in several ways from garden variety contracts, 134 although tradi-

132. Once again, it is important to stress that even if an excess insurer is not permitted to enforce “underlying limits can only be paid by an underlying insurer” language in its policy, the excess insurer would retain any other defenses to coverage it may have—not only sweeping defenses such as fraud, collusion, and an unreasonable settlement amount, but also specific coverage defenses based on a failure to satisfy a condition or the applicability of an exclusion, such as the pollution exclusion.

133. See Stemple, Swisher & Knutsen, supra note 3, at 99; Robert H. Jerry II & Douglas S. Richmond, Understanding Insurance Law § 25A (4th ed. 2012) (treating insurance policies as contracts). Typical of judicial pronouncements on the topic is Good v. Krohn, 786 N.E.2d 480, 485 (Ohio Ct. App. 2002), in which the court stated: “It is well-settled that an insurance policy is a contract and that the relationship between the insured and the insurer is purely contractual in nature.” However, “[t]his statement, although basically correct, glosses over a host of complexities of both insurance and contract.” Stemple, Swisher & Knutsen, supra note 3, at 99.

134. Among the differences between insurance and a typical purchase are that the insurance policy is an aleatory contract in which the contractual exchange cannot be deemed equal, even if one accepts each party’s valuation as conclusive. A policyholder may pay sub-
tionalists do not see these differences as supporting any departure from standard contract theory in assessing insurance policies. 135

In addition, courts and commentators differ in their deference to the text of an insurance policy or other written instrument. Reduced deference to policy text can be justified not only by public policy concerns or greater recognition of the limits of language, but also by greater appreciation of the other identities of insurance policies, which not only are contracts but also operate in the nature of products, 136 private legislation crafted by the insurance industry and essentially imposed on most policyholders, 137 and purposive instruments designed to accomplish particular functions in the real world. 138 Construction of insurance policies—and substantial premiums for decades and never submit a claim, while, conversely, an insurer may be required to pay for catastrophic loss only days after a policy takes effect that far exceeds the premium paid. See Edwin W. Patterson, Essentials of Insurance Law 62 (2d ed. 1957).

In addition, insurance policies are generally dramatically longer and more complex than most written instruments, even the occasionally baroque leases and chronically impenetrable credit card and mobile phone “agreements” inserted into monthly billings. The insurance policy is typically received weeks or even months after the contract was made. In most cases, the insurer also has dramatically more bargaining power and expertise than the policyholder. Policyholders are also generally more vulnerable than other contracting parties in the event of breach. Where the insurer is charged with defending a suit against the policyholder, most jurisdictions regard the insurer as acting in a fiduciary capacity. See Stempel & Knutsen, supra note 1, at 99–107. Insurance appears to exhibit these departures from the classic bargaining model more often than most contractual agreements.


136. See Stempel, Insurance Policy as Thing, supra note 129; Schwarcz, supra note 129.

One court decision invoking a strong form of the reasonable expectations approach to resolving insurance coverage disputes noted the product-like nature of insurance by using an implied warranty analogy, but this metaphor failed to catch on. See, e.g., C & J Fertilizer, Inc. v. Allied Mut. Ins. Co., 227 N.W.2d 169, 177–79 (Iowa 1976) (suggesting that an insurance policy may be in breach of an implied warranty of fitness for a particular purpose where text in the policy would reduce coverage below what is reasonably expected by the typical policyholder) (“[P]olicy [of burglary insurance with requirement of visible marks of forced entry] provided by defendant in this instance breached the implied warranty of fitness for its intended purpose. It altered and impaired the fair meaning of the bargain these parties made for plaintiff’s insurance protection.”). Only a handful of cases have cited C & J Fertilizer’s warranty language. Most decisions in this vein do not expressly invoke the breach-of-warranty concept, although it is certainly consistent with the reasonable expectations principle. See, e.g., Great Lakes Chem. Corp. v. Int'l Surplus Llins Ins. Co., 638 N.E.2d 847, 850 (Ind. Ct. App. 1994) (where policy text is seemingly clear but results only in illusory coverage, court will construe policy to comport with policyholder’s reasonable expectations); Prudential Ins. Co. v. Lamme, 425 P.2d 346, 347 (Nev. 1967) (complexity of insurance policies and comparative expertise and sophistication of insurer may require that courts not be bound by “strict legal [contract] doctrine” in construing a policy or conditional receipt); Robert E. Keeton, Insurance Law Rights at Variance with Policy Provisions (Part I), 83 Harv. L. Rev. 961, 967 (1970).

137. See Stempel, Insurance Policy as Statute, supra note 129.

the relationship among insurers, policyholders, claimants, and the public—
can be substantially enriched by recognizing these alternative characteriza-
tions of insurance policies. The socioeconomic role of insurance, in particu-
lar, can be a valuable lens for assessing insurance policies and adjudicating
their operation.

In addition to being a contract between policyholder and insurer, the
insurance policy has a number of other important identities, most inter-
estingly as a “social instrument” or “social institution” that serves to facil-
itate socioeconomic activity.\(^{139}\) For that reason, various issues of insur-
ance policy construction should be addressed not only according to the
text of the insurance policy at issue or any specific documented intent
of the parties, but also according to the overarching purpose of the policy
and the socioeconomic role played by the policy, both as between the par-
ties and in relation to society at large.\(^{140}\)

E. Insurance Law’s Modern Tradition of Refraining from Literal
Enforcement of Potentially Problematic Policy Provisions

There are many instances when courts refuse to give strict enforcement to
seemingly clear contract language when this would lead to a result that
conflicts with the purpose, function, or underlying intent of a contractual
instrument, such as an insurance policy.\(^{141}\) Sometimes courts are not par-
ticularly explanatory on this point and simply state that they are refusing
to enforce language that would make for an “absurd result.” Courts often
take a similar approach to statutory interpretation.\(^{142}\) Insurance coverage
disputes are no exception.

Requiring an insurer to prove substantial prejudice from late notice in
order to use this defense is an example of this sort of judicial overriding of

\(^{139}\) See id. at 1512–16 (describing socioeconomic functions of insurance).

\(^{140}\) See generally id.

\(^{141}\) See, e.g., Golden Road Motor Inn, Inc. v. Islam, 376 P.3d 151 (Nev. 2016) (refusing
to enforce clear text of noncompete agreement in worker’s contract because it was unreason-
able in scope, exceeded what was necessary to protect the employer’s interests, and placed an
undue burden on the employee); Valley Med. Specialists v. Farber, 982 P.2d 1277 (Ariz.
1999) (same but unlike Nevada, Arizona law permits a court to “blue pencil” the problematic
clause and edit it to meet the parameters of reasonableness as long as unreasonable provi-
sions are “grammatically severable”); Hanks v. Powder Ridge Rest. Corp., 885 A.2d 734
(Conn. 2005) (refusing to enforce waiver of liability for negligence clause/snow tubing
facility required as a condition of use); R.R. v. M.H., 689 N.E.2d 790 (Mass. 1998) (refusing
to enforce clear terms of surrogate birth agreement on public policy grounds); In re Baby M,
537 A.2d 1227 (N.J. 1988) (refusing to enforce surrogacy agreement on public policy
grounds); Williams v. Walker-Thomas Furniture Co., 350 F.2d 445 (D.C. 1965) (refusing
to enforce terms in lending agreement deemed unconscionable).

\(^{142}\) See William Eskridge Jr., Philip Frickey & Elizabeth Garrett, Legislation and
Statutory Interpretation 260–63 (2000); Linda D. Jellum, Mastering Statutory Inter-
pretation 17–18 (2008); William D. Popkin, A Dictionary of Statutory Interpreta-
policy language—what one might call “super-functionalism” in that it goes beyond merely construing policy language in a functionalist manner. Instead, it effectively rewrites the text of the insurance policy to better fit the purposes of insurance and to prevent the policyholder from suffering the disproportionate forfeiture of losing all the insurance protection it purchased simply because it was tardy giving notice even when the late notice appears not to have harmed the insurer.

The clear majority rule is that late notice to the insurer of a loss or claim under the policy will not result in a loss of coverage (even though the policy states that prompt notice is a “condition precedent” to coverage) unless the insurer is substantially prejudiced by the late notice, with the burden to prove prejudice ordinarily placed upon the insurer.\(^{143}\) One strains to find a reasonable basis for giving strict enforcement to an anti-Zieg clause while refusing to give the same strict enforcement to prompt notice provisions. The prompt notice requirement is arguably more compelling in that an insurer has good reasons for wanting to know about a loss or claim sooner than later in order to better investigate and defend the matter. While requiring that the underlying insurer payment provides some increase in excess insurer assurance of proper vetting of claims, one is hard-pressed to say it is a more compelling need than notice.

Under these circumstances, it is hard to justify strict application of payment-by-underlying-insurer-only clauses in the same judicial system that denies strict enforcement to prompt notice requirements. California, home to Qualcomm’s adherence to payment-by-underlying-insurer-only clauses, is a state well-known for enforcing prompt notice clauses only when the insurer can demonstrate that it has been unduly prejudiced by late notice.\(^{144}\) Although recent cases have moved Michigan (the home state of Comerica) back toward the traditional but now minority view that late notice bars coverage, California continues to apply the notice-prejudice rule that bars coverage when notice is late only if the insurer can demonstrate that it was actually harmed by the late notice.\(^{145}\) And the ALI Restatement of the Law of Liability Insurance reflects a similar view of late notice and hence an inconsistency as compared to anti-Zieg

\(^{143}\) See Maniloff & StempeL, supra note 3, at ch. 4.

\(^{144}\) See, e.g., Purefoy v. Pac. Auto. Indem. Exch., 53 P.2d 155 (Cal. 1935); Travelers Prop. v. Centex Homes, No. C 10-02575, 2011 U.S. Dist. LEXIS 36128 (N.D. Cal. Apr. 1, 2011); Slater v. Lawyers’ Mutual Ins. Co., 227 Cal. App. 3d 1415 (Ct. App. 1991); see also Maniloff & StempeL, supra note 3, at 57–58. California’s notice-prejudice rule is so well established that it was recognized by the U.S. Supreme Court and applied over insurer objections in a case subject to the Employee Retirement Income Security Act (ERISA), even though ERISA coverage disputes are generally subject to federal common law.

\(^{145}\) See Maniloff & StempeL, supra note 3, at 57–58, 71–72.
Courts were correct to begin moving away from strict application of notice requirements, a trend begun roughly fifty years ago. There remain only a handful of hold-out states adhering to the traditional formalist rule. Rather than reversing field on late notice, it would obviously make more sense to adjudicate anti-Zeig clauses in the same manner as late notice cases and to require excess insurers to show prejudice in order to avoid otherwise available coverage merely because some or all of the underlying limit was paid by an entity other than an underlying insurer.

The clearly dominant judicial approach to notice of claim requirements is the functionalist approach known as the “notice-prejudice” rule, meaning that a late notice defense was effective to deny coverage only if the lateness of the notice had caused substantial prejudice to the insurer. This approach had become the established approach in all but a handful of states. The ALI also adopts this position in § 37 of the Restatement.

A major impetus for requiring prejudice to the insurer as a prerequisite for enforcing a notice condition was that enforcing the condition to bar coverage when the insurer had not suffered harm would be an unfair result, leading to disproportionate forfeiture of contract benefits by the policyholder. In spite of the importance of notice, courts have concluded that notice conditions should be enforced only when the lateness of the notice diminishes the insurer’s rights in some substantial degree.

One can readily analogize prompt notice provisions to anti-Zeig clauses. But as with late notice that does not cause prejudice to the insurer, satisfying the requirement of exhaustion through payments that come from sources other than an underlying insurer would appear not

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146. Compare Restatement of the Law of Liability Insurance § 36(1) (adopting rule that late notice bars coverage only if insurer substantially prejudiced), with Restatement of the Law of Liability Insurance § 40 (providing for enforcement of payment-by-underlying-insurer-only clauses).

147. See Manilloff & Stempel, supra note 3, at 51–54 (describing evolution from strict application of prompt notice conditions precedent in policies to modern majority rule that late notice bars coverage only if prejudicial to insurer).

148. Manilloff & Stempel, supra note 3, at ch. 4 (finding only Alabama, Arkansas, the District of Columbia, Georgia, Idaho, and Virginia to expressly embrace the traditional rule that a showing of late notice alone, even without a showing of prejudice to the insurer, bars coverage). In the more than forty states that require prejudice as a prerequisite to enforcing a late notice requirement, all but a few states require the insurer to shoulder the burden of proof to demonstrate prejudices, although a few states require the policyholder that gave late notice to prove the absence of prejudice to the insurer.

149. For occurrence-based liability policies, “[t]he failure of the insured to satisfy a notice-of-claim condition excuses an insurer from performance of its obligations under a liability insurance policy only if the insurer demonstrates that it was prejudiced as a result. . . .” See Restatement of the Law of Liability Insurance § 36(1).
to harm the excess insurer as long as the settlement was reasonable, non-fraudulent, and not a collusive effort to unfairly trigger excess coverage prior to actual payment of the requisite underlying amount to settle lawsuits or pay judgments.

These similarities between the requirements of prompt notice and payment of underlying limits undermines the literalist Qualcomm approach. So does the similar treatment of policy provisions requiring a policyholder to cooperate with the insurer in responding to claims. Courts will only strip a policyholder of coverage if the policyholder’s failure to cooperate prejudices the insurer’s ability to respond to the claim.150

In similar fashion, courts have tended not to give literal enforcement to insurance policy provisions requiring that the insurer consent to any settlement with the claimant. In cases where an insurer has breached its duty to defend or its duty to make reasonable settlement decisions, policyholders have been permitted to settle claims without insurer consent without losing coverage.151 Although the insurer in most states may continue to

150. See Restatement of the Law of Liability Insurance § 30 (“An insured’s breach of the duty to cooperate relieves an insurer of its obligations under an insurance policy only if the insurer demonstrates that the failure caused or will cause prejudice to the insurer); Stempel & Knutsen, supra note 1, § 9.02; Allan D. Windt, Insurance Claims and Disputes § 3:2 (6th ed. 2012). Restatement of the Law of Liability Insurance § 30(2) also provides that there has been “collusion with a claimant” that is discovered before prejudice occurs, “the prejudice requirement is satisfied as long as the collusion would have caused prejudice to the insurer had it not been discovered.” Courts typically require a fairly significant failure to cooperate before even considering the issue of prejudice to the insurer. See, e.g., Home Indem. Co. v. Reed Equip. Co., 381 So. 2d 45 (Ala. 1980) (failure to cooperate must be both “material and substantial” before coverage lost); Hartschorn v. State Farm Ins. Co., 838 N.E.2d 211 (Ill. App. Ct. 2005) (breach and prejudice sufficient to deny coverage found where property insurance policyholder, apparently intentionally, failed to provide documentation and failed three times to appear for examination under oath).

151. See Thomas, supra note 37, § 17.07[1] (2012) (“If an insurer breaches its duty to defend, however, the insured may enter into a reasonable, non-collusive settlement without the consent of the insurer and without forfeiting coverage.”); Restatement of the Law of Liability Insurance § 19 (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” and may lose the right to contest coverage if the breach is “without a reasonable basis”). See, e.g., Risely v. Interinsurance Exch. of Auto. Club, 107 Cal. Rptr. 3d 343, 350 (Ct. App. 2010) (“Where the insurer denies its insured a defense for covered claims, the insured may make reasonable, noncollusive settlement with the third party, without the insurer’s consent.”). However, depending on the applicable state law, the nondefending insurer may contest coverage of the settlement on other grounds. See Stempel, Enhancing the Socially Instrumental Role of Insurance, supra note 65. See also Restatement of the Law of Liability Insurance § 25(3):

When an insurer has reserved the right to contest coverage for a legal action, the insured may settle the action without the consent of the insurer and without violating the duty to cooperate or other restrictions on the insured’s settlement rights contained in the policy, provided that certain requirements are met, including providing the insurer with notice, a chance to withdraw its reservation, and that the settlement is reasonable.
dispute coverage and may attack and avoid a settlement that is unreasonable or collusive, the insurer may not avoid coverage simply because it withheld consent to the settlement.

Policy provisions concerning notice, cooperation, and consent-to-settlement serve important purposes—at least as important as the “adequate vetting” purpose used to justify anti-Zeig clauses. But these important notice, cooperation, and consent provisions are not given the literal enforcement that Qualcomm accords to seemingly less important underlying-insurer-must-pay provisions. This asymmetry should trouble Qualcomm enthusiasts, including the ALI.

Judicial treatment of anti-assignment clauses (also discussed above) provides a similar example of courts refusing to give literal application of clearly written insurance policy/contract text when this would defeat the purpose of insurance or work a disproportionate forfeiture upon the policyholder. Anti-assignment clauses are enforced if a policyholder assigns a policy to another prior to a liability-creating event because this may increase the insurer’s risk. But after the event has taken place, the relative risk presented by the original policyholder and the assignee is irrelevant. Enforcing the anti-assignment clause if the assignment comes after the loss makes even less sense than enforcing a prompt notice provision when the insurer has not been harmed in its ability to respond to the lawsuit due to late notice.

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152. See Stempel, Enhancing the Socially Instrumental Role of Insurance, supra note 65 (noting that this is the majority rule but that a substantial number of states follow the arguably better rule of precluding a breaching insurer from contesting coverage).


154. The typical anti-assignment clause is not a flat ban on assignment but rather requires the insurer to consent to the assignment if it is to be effective. In this way, the insurer can assess whether the transfer of the policy from one policyholder to another will increase risk.

155. Prior to a loss, an anti-assignment clause makes sense in that it prevents a relatively low-risk policyholder (e.g., a clothing retail shop) from assigning its general liability or property policies to a higher-risk policyholder (e.g., a chemical or munitions manufacturing plant). By reserving the right to approve any assignments, the insurer protects itself from having its risk exposure increased and may refuse assignment and insist on new underwriting and premium increases as a condition of taking on the new, riskier policyholder. However, after a loss involving the original policyholder has taken place, the insurer’s coverage responsibilities are fixed and are not increased when the original policyholder merely assigns its right to payment of policy proceeds to a second policyholder. For this reason, courts have traditionally refused to enforce anti-assignment clauses in post-loss situations. See, e.g., Ocean Accident & Guar. Corp. v. Sw. Bell Tel. Co., 100 F.2d 441 (8th Cir. 1939) (applying Missouri law). See Stempel & Knutsen, supra note 1, § 3.15[D]. See also Restatement (Second) of Contracts § 317 (Am. Law Inst. 1981) (assignment of contractual right generally permitted unless it materially increases risk, burden, or duties; is prohibited by law or public policy; or is “validly precluded by contract”). Because enforcement of an anti-assignment clause post loss would deny payment of insurance proceeds for no good reason, this would not be a valid preclusion and would work an undue forfeiture of insurance coverage that has been purchased.
Anti-Zeig language in an excess policy, although perhaps “plain” in meaning, could be treated like anti-assignment clauses. Such clauses clearly prohibit assignment, but courts routinely refuse to give them effect when assignment post-dates loss because strict enforcement of an anti-assignment clause at that juncture does not serve the purpose of the clause and results in disproportionate forfeiture of the insurance for which a policyholder has paid.\(^{156}\)

Courts for decades have refused to strictly enforce anti-assignment clauses (which are often more clearly written than the anti-Zeig clauses in excess policies) to prevent assignment of rights to an insurance policy as long as the assignment takes place after a covered event and does not increase the hazard to the insurer or otherwise implicate the risk assumed by the insurer.\(^{157}\)

Although policy text is, of course, important, use of policy text in the literalist Qualcomm manner is reminiscent of the now-discredited approach strictly enforcing an anti-assignment clause that was taken in Henkel Corp. v. Hartford Accident & Indemnity Co.,\(^ {158}\) but more recently correctly rejected in Fluor Corporation v. Superior Court,\(^ {159}\) In Henkel-like fashion, the Qualcomm approach (and ALI Restatement § 40) elevates textual form over insurance operation substance and should be revised by striking this portion of the draft.

Ironically, the Restatement, despite supporting enforcement of anti-Zeig language in excess policies even without a showing of prejudice to the insurer from exhaustion via other means, adopts the Fluor majority rule in § 37(2), which states that “[r]ights of an insured under an insurance policy relating to a specific claim that has been made against the insured may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments.”\(^ {160}\)

Restatement § 38 (which provides for disregarding an unfair policy text at odds with the apt operation of liability insurance) is thus in considerable tension with Restatement § 40 (which would permit excess insurers to avoid proper operation of liability insurance through policy text). The tension can be rectified to a degree in that although literal enforcement of underlying-insurer-must-pay language is problematic, the policy provision makes some sense. All other things being equal, full payment by

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156. See Fluor Corp. v. Superior Court, 354 P.3d 302 (Cal. 2015) (summarizing traditional treatment of anti-assignment clauses and justifying permitting assignment of policy benefits where loss precedes assignment).

157. See, e.g., Ocean Accident & Guar. Corp., 100 F.2d 441.

158. 62 P.3d 69 (Cal. 2003).

159. 354 P.3d 302 (overruling Henkel).

an underlying insurer increases the odds that a claim has been fairly thoroughly tested and thus gives the excess insurer some protection against its attachment point being reached too easily because of insufficient defense of claims at lower levels of the liability insurance tower.

Those protections are not worth the costs imposed by way of disproportionate forfeiture, unfair windfall, impeded settlement, and collateral costs, but there is at least a basis for the presence of the underlying-insurer-must-pay requirement. By contrast, there is arguably no basis for enforcing an anti-assignment clause after a loss has occurred. At that point, the identity of the policyholder is irrelevant. And, of course, the purpose of the anti-assignment clause was fully met in that the policyholder who bought the policy was the policyholder at the time of loss. There was no increase of risk due to any change in the identity of the policyholder prior to the events creating the claim.161

Although imperfect, the analogy to anti-assignment clauses nonetheless provides a good example of where courts have properly declined to give literal enforcement to policy text. As noted above, insurance law doctrine provides similar illustrations of situations where literal textual enforcement has properly been rejected by the courts. In addition to judicial modification of notice and cooperation policy provisions, proof of claim requirements have not been strictly enforced.162

Non-insurance law provides additional examples of judicial refusal to give literal enforcement to contract text that is considered unnecessary to vindicate the legitimate interests of the party seeking to enforce the text. For example, contracts frequently contain liquidated damages provisions setting a specific amount of compensation to be paid in the event of breach. Even as between two sophisticated contracting parties with similar bargaining power, courts will not enforce liquidated damages provisions unless the actual damages for breach are difficult to calculate and the amount of the liquidated damages is not so excessive as to amount to a penalty.163

161. See Fluor Corp., 354 P.3d 302. However, Henkel, although wrongly decided, articulated a rationale for its resistance to post-loss assignment based on the purported risk that liability insurers could be saddled with multiple defense and indemnity obligations (or at least uncertainty regarding those obligations) due to changes in corporate form that accompanied transfer of policy rights. The concern, although overdone, had some plausibility. On close enough empirical analysis, excess insurer justifications for needing the protection of requiring that payment come only from underlying insurers could prove as exaggerated as the concerns of the Henkel insurers that were used initially to persuade the California Supreme Court.


163. See RESTATEMENT (SECOND) OF CONTRACTS § 356(1) (A.M. LAW INST. 1981) (“Damages for breach by either party may be liquidated in the agreement but only at an amount that is reasonable in light of the anticipated or actual loss caused by the breach and the difficulties of proof of loss. A term fixing unreasonably large liquidated damages is unenforce-
Similarly, even clear contract document text subjecting an employee or business partner to restrictions on competition after practice are not given literal enforcement where the noncompete clause constitutes too great a restriction on the departing employee or partner.\textsuperscript{164} “In general . . . post-employment restraints are sustained only if the employer stands to lose its investment in confidential information relating to some process or method—sometimes loosely called a ‘trade secret’—or in customer lists or similar information.”\textsuperscript{165}

Judicial attitudes toward liquidated damages and covenants not to compete share a kinship with judicial attitudes toward late notice, failure to cooperate, proof of claim, and assignment in the insurance context.

\textsuperscript{164} See \textsc{Farnsworth}, supra note 78, § 5.3; \textsc{Perillo}, supra note 78, § 14.31. See, e.g., Golden Rd. Motor Inn, Inc. v. Islam, 376 P.3d 151 (Nev. 2016) (refusing to enforce covenant not to compete that barred departing casino worker from finding work at other casinos on the Las Vegas Strip); Valley Med. Specialists v. Farber, 982 P.2d 1277 (Ariz. 1999) (refusing to enforce covenant not to compete of a medical practice group because enforcement would effectively prohibit physician leaving group from practicing anywhere in the Phoenix metropolitan area for three years). Courts divide somewhat on whether an overreaching noncompete clause is to be given no effect or whether the court may modify the clause to eliminate unconscionable provisions or terms in violation of public policy. \textit{Compare} Valley Medical Specialists, 982 P.2d 1277 (modifying offending clause), \textit{with} Islam, 376 P.3d 151 (refusing to rewrite clause and striking it). \textit{But see} id. at 163 (Pickering, Hardesty, and Parraguirre, JJ., dissenting) (arguing for modification or “blue-penciling” of such clauses rather than total elimination from the contract and noting that this is the majority approach).

\textsuperscript{165} See \textsc{Farnsworth}, supra note 78, § 5.3 at 324–25. “Against this interest in a workable relationship, courts balance the public interest in individual economic freedom, free dissemination of ideas, and reallocation of labor to areas of greatest productivity. Because post-employment restraints are often the product of unequal bargaining power and may inflict unanticipated hardship on the employee, they are scrutinized with more care than are covenants in the sale of a business.” \textit{Id.} at 325. \textit{Accord} \textsc{Perillo}, supra note 78, § 16.19.
Collectively, these sub-doctrines demonstrate that it is not at all uncommon for courts to refuse to give literal application to the text of an insurance policy or contract document where such literal enforcement undermines the goals and purpose of the instrument or other public policy goals.  

Although there is a split of authority, many courts take a similar attitude toward waivers of liability and disclaimers or limitations of remedies.

As these instances show, literal application need not bring absurd or unconscionable results to be eschewed by a court. It is sufficient to defeat strict enforcement if such literal application brings unwise deleterious effects. And as demonstrated by the liquidated damages and noncompete clause cases, courts deny literal enforcement of problematic text even in cases where the aggrieved party was almost surely aware of the term and where the term was in all likelihood specifically discussed and negotiated.

166. For more than thirty years, the American Law Institute has taken the position that

(1) A promise or other term of an agreement is unenforceable on grounds of public policy if legislation provides that it is unenforceable or the interest in its enforcement is clearly outweighed in the circumstances by a public policy against the enforcement of such terms.

(2) In weighing the interest in the enforcement of a term, account is taken of

(a) The parties’ justified expectations,
(b) Any forfeiture that would result if enforcement were denied, and
(c) Any special public interest in the enforcement of the particular term.

(3) In weighing a public policy against enforcement of a term, account is taken of

(a) The strength of that policy as manifested by legislation or judicial decisions,
(b) The likelihood that a refusal to enforce the term will further that policy,
(c) The seriousness of any misconduct involved and the extent to which it was deliberate, and
(d) The directness of the connection between that misconduct and the term.

See RESTATEMENT (SECOND) OF CONTRACTS § 178.


168. See FARNSWORTH, supra note 78, §§ 4.26–4.27, 5.2, 11.8; PERILLO, supra note 78, § 14.22. See, e.g., Diamond Fruit Growers, Inc. v. Krack Corp., 794 F.2d 1440 (9th Cir. 1986) (applying Oregon law and refusing to enforce clause eliminating consequential damages for breach but conducting unconscionability/public policy analysis in the context of UCC § 2-207).
Measured against well-established principles of both general contract law and insurance contract law as well as the important function of excess insurance, the Qualcomm approach of literal enforcement of anti-Zeig language should be treated as an erroneous aberration rather than something to emulate. By supporting Qualcomm, the ALI has taken the wrong fork of the road to follow a direction at odds with both its own professed insurance and contract values of nonforfeiture, purposive construction, and sound public policy.
DEFENDING THE INDEFENSIBLE: NAVIGATING THE STRATEGIC AND ETHICAL LANDSCAPE OF DEFENDING CLIENTS WHO HAVE ENGAGED IN INDEFENSIBLE CONDUCT

Michael S. Ross and Peter J. Biging

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I. INTRODUCTION

As an attorney asked to provide a defense to a prospective client, you may be confronted with claims involving gross negligence, palpably credible allegations of fraud, intentional misconduct, or otherwise overtly malicious and utterly indefensible behavior. Indeed, there may be times when the conduct at issue has led to enormous losses in terms of money, reputation, and sometimes even life and limb. When presented with these claims, you will immediately face questions about whether the case is something you feel comfortable defending. It even may present a practical business issue; i.e., can my firm or I afford to be associated with the defense of this client, or the defense of this type of behavior? Assuming you have sufficient comfort level in taking on the matter, you will have to navigate potential coverage issues, regulatory concerns, and ethical concerns, and, where insurance is available to fund the cost of the defense, considerations with regard to the tripartite relationship, as well as moral concerns with regard to defending and protecting from exposure the individuals/entities alleged to have been involved. Managing these various issues and concerns can be a delicate balancing act, requiring careful consideration of the issues presented on multiple levels and creative litigation strategies. In the following discussion, we will explore the moral, ethical, and strategic considerations to be balanced in successfully defending “indefensible” conduct and navigating a path to successful resolution of the claims.

A. Identifying/Defining the “Indefensible” Claim

1. When There Is Clear-Cut, Indisputable Liability on the Facts and Law

One of the most difficult circumstances presented to defense attorneys is what to do with a case that exhibits clear liability under both the facts and the law. This can be presented in many different ways. Often, unfavorable documents may evidence the “bad facts” at issue. Even more troublesome, there are times where the defendant has actually confessed liability. This can take many different forms: for example, an apology to the injured party; a revelation to a business partner or colleague; or even in a formal proceeding, such as a disciplinary action against a professional. Today, with a smartphone in every hand, there is often the potential for incriminating texts, voice mails, and video.

2. When the Case Is Theoretically Defensible, but There Are Big Obstacles to Surmount

More complex circumstances can arise when the case is theoretically defensible under the facts or law, but other factors make the case extremely
difficult to defend. This can occur in cases where one of the following may exist:

- The defendant’s story simply does not add up due to inconsistencies in his/her own recitation of the facts or comparison of the story with those of other involved parties.
- The defendant has made prior sworn statements compromising, but not completely eviscerating, his/her defense position.
- The defendant or corporate representative is thoroughly unlikable or presents badly.
- The defendant is unable to participate in the defense due to death, mental incompetence, or inability on the part of counsel to locate him/her.
- The legal rationale on which the defense relies is tenuous at best.
- The defendant or a critical witness has engaged in outrageously objectionable, weird, or otherwise offensive conduct, even if tangential to the matter at hand.
- The defendant or the principal is under indictment or criminal investigation and will not attest to anything under oath.

Additionally, numerous other factors can create obstacles in the defense of a claim. For example, high-profile cases with negative publicity tend to be more difficult to defend. A video of a fireball caused by your client’s alleged negligence, accompanied by cries of despair, may appear on the nightly news and other media outlets. How do you defend a case where the entire nation has been emotionally agonizing over the events giving rise to the claims? Alternatively, unreasonable defendants who either push for settlement or want their day in court at any cost can create significant hurdles for lawyers to overcome. Cases venued in states or brought under theories of recovery where attorney fees are recoverable and the amounts dwarf the actual damages at issue can incentivize plaintiff’s counsel to make extreme demands and actually show disinterest in even good faith settlement discussions while they build up their attorney fees. Cases where there is discoverable information that, when revealed, has the potential for exponentially increasing the value of the case can be problematic. Parallel criminal proceedings or investigations may interfere with the ability to mount a defense, or other circumstances may exist that render defendants unable to defend themselves or participate in their defense. Finally, there are circumstances, even if none of these factors is immediately apparent, where seasoned defense counsel can instinctually feel that the case will be difficult to defend.
B. Ethical Concerns

Defending truly difficult cases typically requires an attorney to think creatively and sometimes to engage in aggressive legal tactics and litigation strategies that implicate important ethics rules, including conflict-of-interest rules. Those strategies also may involve activities by lawyers and their agents that may be viewed, rightly or wrongly, as triggering the crime-fraud exception to the attorney-client privilege; exceeding the bounds of proper witness preparation; and receiving and utilizing what some lawyers describe as “bootleg” evidence. This article briefly touches upon the American Bar Association Model Rules of Professional Conduct\(^1\) and case law relating to these topics.

The use of the term “aggressive” to describe a lawyer was once more kindly received because lawyers were, as a matter of “ethics,” urged to be “zealous” on behalf of their clients. Professor Charles W. Wolfram in his seminal treatise on ethics\(^2\) explained the importance of the zealousness mandate in the ABA’s former Model Code: “The heading of [ABA Disciplinary Rule (‘D.R.’)] 7-101 [i.e., ‘Representing a Client Zealously’] assumes that a lawyer will ‘represent a client zealously,’ repeating the axiomatic message of Canon 7 of the [ABA] Code that ‘a lawyer should represent a client zealously within the bounds of the law.’”\(^3\)

In the current ABA Model Rules, the notion of zealousness—as a stated goal of advocacy on behalf of a client—plays a much more muted role, at least in the context of the language of the Model Rules and their commentary. Now, the notion of zeal is mentioned only in Comment 1, which notes, in part, that “[a] lawyer must . . . act with commitment and dedication to the interests of the client and with zeal in advocacy upon the client’s behalf.” Some rules and commentary in some states do not mention the terms “zealousness” or “zeal” at all. Nonetheless, it is important to remember that the motto of many fine and decent lawyers is that “I will advance my client’s interests within the bounds of the law.”

But what are the bounds of the law? The answer, as discussed below, is often measured in terms of the crime/fraud exception to the attorney-client privilege and related issues of improper handling of witnesses and evidence.

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1. The former ABA Model Code has been superseded by the ABA Model Rules of Professional Conduct. Although the Model Rules do not govern in any state (because each state has its own version of the rules governing attorneys), many states have patterned their ethical rules after the ABA Model Rules. The ABA Model Rules, particularly as they relate to ethics opinions issued by the ABA, have been relied upon and cited on numerous occasions by courts, disciplinary committees, and ethics scholars in various jurisdictions.


3. Id. (citations omitted; emphasis added).
II. ZEALOUS ADVOCACY FOR TRIAL LAWYERS

A. Introduction

Understanding the principles relating to, for example, the offering of questionable testimony and documents, lawyer deceit, the duty to correct false testimony, witness coaching, etc., requires an understanding of the sometimes murky application of the relevant provisions of the applicable Rules of Professional Conduct of the lawyer’s state of admission or the venue in which the lawyer practices.

B. Ethical Advocacy and Its Limits

1. Significance of the Crime-Fraud Exception to the Attorney-Client Privilege

The attorney-client privilege, although the oldest privilege for confidential communications, is a limited one that must be proven to exist by the person asserting the privilege.4 As United States v. Roe explains, the privilege applies

(1) where legal advice of any kind is sought
(2) from a professional legal adviser in his or her capacity as such
(3) so that the communications relating to that purpose
(4) made in confidence
(5) by the client
(6) are at his or her instance permanently protected
(7) from disclosure by himself or herself or the legal adviser,
(8) except that the protection can be waived.5

Communications are not considered to be within a legitimate attorney-client relationship if the attorney is wittingly or unwittingly being used to commit a crime or fraud. Thus, communications that would otherwise be protected by the attorney-client privilege or the attorney work-product privilege are not protected if they relate to client communications in furtherance of contemplated or ongoing criminal or fraudulent conduct.6

The Fifth Circuit adopted the view of the Second Circuit and various other courts in In re Grand Jury Subpoena7 when it held that the crime-

6. See, e.g., In re Grand Jury Subpoena, 745 F.3d 681, 689 (3d Cir. 2014); In re Grand Jury Proceedings, 417 F.3d 18, 28 (1st Cir. 2005); Intervenor v. United States (In re Grand Jury Subpoenas), 144 F.3d 653, 663 (10th Cir. 1998); In re Grand Jury Subpoena Duces Tecum (Marc Rich), 731 F.2d 1032, 1038 (2d Cir. 1984); Amusement Indus. Inc. v. Stern, 293 F.R.D. 420, 441 (S.D.N.Y. 2013).
7. 419 F.3d 329 (5th Cir. 2005).
The attorney-client privilege does not apply to a communication occurring when a client:

1. Consults a lawyer for the purpose, later accomplished, of obtaining assistance to engage in a crime or fraud or aiding a third person to do so, or
2. regardless of the client’s purpose at the time of the consultation, uses the lawyer’s advice or other service to engage in or assist a crime or fraud.8

When a client consults a lawyer with the intention of violating elemental legal obligations, there is less social interest in protecting the communication. Over the years, some litigants have argued that there is a public policy exception to the attorney-client privilege that allows the piercing of the privilege based upon a balancing test of the public good. In an excellent analysis of the issue, Southern District of New York Judge Sweet thoroughly addresses the issue in G-I Holdings, Inc. v. Baron & Budd.9 The court found that the public policy exception to the attorney-client privilege has rarely been utilized and can rarely be justified.10 In rare situations, New York courts have applied the exception to allowing the court to require an attorney to disclose the client’s address where doing so was necessary for the safety and welfare of a young child. But other attempts to expand the public policy exception have been rejected.

The client need not specifically understand that the contemplated act is a crime or fraud. The client’s purpose in consulting the lawyer or using the lawyer’s services may be inferred from the circumstances. It is irrelevant that the legal service sought by the client, such as drafting an instrument, was itself lawful.11

2. The Crime-Fraud Exception

Pursuant to ABA Model Rule 8.4(c) (and its counterpart in most states), “it is professional misconduct for a lawyer to . . . engage in conduct involving dishonesty, fraud, deceit or misrepresentation.”12 Pursuant to

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8. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 82 (AM. LAW INST. 2000).
10. Id. at *11–12.
11. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 82 cmt. c.
12. MODEL RULES OF PROF’L CONDUCT r. 8.4(c) (AM. BAR ASS’N 2015). Needless to say, conduct may be deceitful even in the absence of affirmative acts by the lawyer. For example, In re Forrest, 265 A.D.2d 12, 13–14 (N.Y. App. Div. 2000), the court imposed reciprocal discipline based, in part, upon a disciplinary finding in New Jersey that a lawyer had failed to inform both the arbitrator and opposing counsel that his client had died.
ABA Model Rule 3.3(a)(1) (and its counterpart in most states), “a lawyer shall not knowingly . . . make a false statement of fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer.”

Pursuant to ABA Model Rule 3.4(b) (and its counterpart in most states), “[a] lawyer shall not . . . falsify evidence, counsel or assist a witness to testify falsely, or offer an inducement to a witness that is prohibited by law.”

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These articles notwithstanding, one federal district court judge has ruled that he would not permit a defense lawyer to introduce evidence either on cross-examination or during direct examination of the defense witnesses that was inconsistent with evidence that had been suppressed in a pretrial hearing. United States v. Lauersen, 2000 U.S. Dist. LEXIS 16404, at *24 (S.D.N.Y. Nov. 13, 2000). In Lauersen, Judge Pauley found that a pretrial “proffer” of the defendant could not be used by the government to impeach the defendant’s testimony, should she testify, because the defendant had not knowingly waived her rights. On the other hand, the court would not allow defense counsel to cross-examine witnesses or introduce affirmative evidence on the defense case in a manner that would be inconsistent with the proffer. The court took this position because it felt that it was “duty bound to protect the integrity of the proceeding and to ensure that matters presented to the jury are grounded in good faith. Id. at *23–24; see, e.g., N.Y. COMP. CODES R. & REGS. tit. 22, § 1200.33 [D.R. 7-102] (2000).

In contrast to the reasoning of the Lauersen court, Justice White’s dissenting opinion in United States v. Wade, 388 U.S. 218, 258 (1967), an opinion joined in by Justices Harlan and Stewart, expressed this view of the legitimate role of defense counsel:

If he can confuse a witness, even a truthful one, or make him appear at a disadvantage, unsure or indecisive, that will be his normal course. . . . [D]efense counsel will cross-examine a prosecution witness, and impeach him if he can, even if he thinks the witness is telling the truth, just as he will attempt to destroy a witness who he thinks is lying. In this respect, as part of our modified adversary system and as part of the duty imposed on the most honorable of defense counsel, we countenance or require conduct which in many instances has little, if any, relation to the search for the truth.


14. MODEL RULES OF PROF’L CONDUCT r. 3.4(b).
Pursuant to ABA Model Rules 8.4(a) and 1.2(d) (and their counterparts in most states), “[i]t is professional misconduct for a lawyer to: violate or attempt to violate the Rules of Professional Conduct, knowingly assist or induce another to do so, or do so through the acts of another; and shall not counsel a client to engage, or assist a client, in conduct the lawyer knows is illegal or fraudulent.”

ABA Model Rule 3.3 provides that

(a) A lawyer shall not knowingly:
   (1) make a false statement of fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer;
   (2) fail to disclose to the tribunal legal authority in the controlling jurisdiction known to the lawyer to be directly adverse to the position of the client and not disclosed by opposing counsel; or
   (3) offer evidence that the lawyer knows to be false. If a lawyer, the lawyer’s client, or a witness called by the lawyer, has offered material evidence and the lawyer comes to know of its falsity, the lawyer shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal. A lawyer may refuse to offer evidence, other than the testimony of a defendant in a criminal matter, that the lawyer reasonably believes is false.

(b) A lawyer who represents a client in an adjudicative proceeding and who knows that a person intends to engage, is engaging or has engaged in criminal or fraudulent conduct related to the proceeding shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal.

(c) The duties stated in paragraphs (a) and (b) continue to the conclusion of the proceeding, and apply even if compliance requires disclosure of information otherwise protected by Rule 1.6.

Tempering these “protective” ethical mandates is the uncertainty of other seemingly nonmandatory ABA Model Rules:

(1) ABA Model Rule 1.6(b)(2)—“A lawyer may reveal confidential information . . . to prevent the client from committing a crime . . .”

(2) ABA Model Rule 1.6(b)(3)—A lawyer may reveal or use confidential information to withdraw a written or oral opinion or representation previously given by the lawyer and reasonably believed by the lawyer still to be relied upon by a third person, where the lawyer has discovered that the opinion or representation was based on materially inaccurate information or is being used to further a crime or fraud.

15. MODEL RULES OF PROF’L CONDUCT r. 8.4(a), r. 1.2(d).
16. MODEL RULES OF PROF’L CONDUCT r. 3.3 (emphasis added).
ABA Model Rule 1.16(b)(2) and (3)—A lawyer may, but is not required to, withdraw from a matter when “the client persists in a course of action involving the lawyer’s services that the lawyer reasonably believes is criminal or fraudulent” and when “the client has used the lawyer’s services to perpetrate a crime or fraud.” It is important to remember that under notions of agency law, a “lawyer may . . . be liable under civil or criminal law for aiding and abetting a client’s misrepresentation.” A lawyer’s transmission of information on behalf of a client, even on a matter seemingly as removed as transmitting a letter given to him or her by a client, can be viewed as making the attorney subject to the duty to correct. This reflects the engrafting of the law of “agency” on the duties of attorneys, which, at the same time, must be tempered with an analysis of the relationship between the attorney and the client. As one group explained:

Undertaking to transmit information does not necessarily involve an undertaking to do anything more, and it is important to identify the characteristics that will signal both when a lawyer has become the alter ego of the client and how becoming an alter ego affects his professional responsibilities and his professional liabilities.

These disciplinary rules contain problematic definitions of a lawyer’s mental state; i.e., “knows,” “information clearly establishing,” and “believed.” The Second Circuit and other courts have held that the language in D.R. 7-102(B) (the predecessor to ABA Model Rule 3.3(a)(3)), which uses the language “a lawyer comes to know of [the evidence’s] falsity . . . referring to ‘information clearly establishing that’ means “actual knowledge.” In an interesting article, Rebecca Roiphe suggests that because ethics rules require “actual knowledge” before most sanctions are triggered, lawyers are permitted to hide behind “willful ignorance”—a somewhat dubious position. Indeed, ABA Model Rule 1.0(k) defines “[k]nowingly,” “known,” “know,” or “knows” as “denot[ing] actual knowledge of the fact in question. A person’s knowledge may be inferred from circumstances.”

17. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 98 (Statement to Non-Client), Reporter’s Note, cmt. c (AM. LAW INST. 2000); see also cmt. d, cmt. e.
19. Doe v. Fed. Grievance Comm., 847 F.2d 57, 62 (2d Cir. 1988); see, e.g., United States v. Parse, 789 F.3d 83, 115–16 (2d Cir. 2005) (“suspicion” that statements are false not equivalent to “knowledge” that statements are false); United States v. Shaffer Equip. Co., 11 F.3d 450, 459 (4th Cir. 1993); Addamax Corp. v. Open Software Found., 151 F.R.D. 504, 510 (D. Mass. 1993); United States v. Del Carpio-Cotrina, 733 F. Supp. 95, 99 (S.D. Fla. 1990). It is important to emphasize that “know” or “knowledge” does not mean “reasonably should know.” In re Lucarelli, 611 N.W.2d 754, 761 (Wis. 2000) (in rejecting the claim that a prosecutor knowingly brought a case unsupported by probable cause, the court rejected the argument that “knowledge” can be satisfied by a finding of “reasonably should know”).
21. MODEL RULES OF PROF’L CONDUCT r. 1.0(k) (emphasis added).
The Supreme Court in *Nix v. Whiteside* held that in applying the ethical rule’s “knowledge” standard, a lawyer was permitted to advise the court of what he believed would be perjurious testimony by a client based solely upon the client indicating he would testify on his own behalf in a manner inconsistent with the version he had previously told the attorney.

The knowledge/belief dichotomy—that is, the dichotomy between the attorney’s mandatory duties as opposed to discretionary duties—goes to the heart of decisions that lawyers must make every day, both in and out of the litigation context. Indeed, in *Shade v. Great Lakes Dredge & Dock*, a federal district court in Pennsylvania was faced with whether a lawyer violated ABA Model Rule 3.3’s proscription against intentionally presenting false testimony based upon the fact that the attorney called a witness to testify to a version of facts that was completely contrary to the version the witness had given under oath in another proceeding on both direct and cross-examination. When accused of this misconduct, the attorney defended his conduct by explaining that the prior inconsistent testimony was merely peripheral evidence and that it had been offered in the prior proceeding to explain the witness’s own subjective beliefs.

The *Shade* court explained that even the outright inconsistency was not enough to support the conclusion that the attorney had knowingly presented false testimony:

“Even the slightest accommodation of deceit or lack of candor in any material respect quickly erodes the validity of the [adversarial system of justice] process.” That is, the overall duty of truth “takes its shape from the larger object of preserving the integrity of the judicial system.” However, it is important to emphasize that a mere suspicion of perjury is not enough to require disclosure to the court. As [ABA Model Rule 3.3(a)(4) and (c)] indicates, an attorney’s duty to inform the court does not arise unless the attorney knows that false testimony has been elicited; an attorney has the option of refusing to offer testimony she believes to be false.24

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22. 475 U.S. 157 (1986); see also Frank S. Finnerty Jr. & Robert P. Guido, *Ethical Considerations in the Defense of a Criminal Case*, CRIMINAL TRIAL ADVOCACY 17 (Ronald E. Cohen & James C. Neely eds., 8th ed. 1999) (arguing that, in their view and based on their analysis of the law, including *Nix*, the standard for revealing the intention of a client to commit perjury is “what a reasonable attorney would believe under the circumstances”).
24. Id. at 523 (emphasis added; internal citations omitted). In fact, it is this elastic concept of “knowledge” versus “belief” that permits a prosecutor to use inconsistent factual theories of a crime in successive criminal trials. Cf. Michael English, *A Prosecutor’s Use of Inconsistent Factual Theories of a Crime in Successive Trials: Zealous Advocacy or a Due Process Violation?*, 68 FORD. L. REV. 525, 541 (1999) (because a prosecutor is limited only by the proscription of not knowingly presenting false testimony, “ethical codes suggest that the prosecutor’s personal opinion is irrelevant”). N.Y. Cty. Lawyers’ Ass’n Comm. on Prof’l Ethics, Op. No. 698 (attorney not obliged to produce medical information that would be detrimental to the client’s claims as long as no specific request is made for those documents). But see Smith v. Groose, 205 F.3d 1045 (8th Cir. 2000) (Due Process Clause forbids state from
For a discussion of the how state courts across the country have defined the level of information that constitutes “knowledge” under the ethical rules, see Witness Testimony and the Knowledge Requirement: An Atypical Approach to Defining Knowledge and Its Effect on the Lawyer as an Officer of the Court by Erin Jaskot and Christopher Mulligan.25 Jaskot and Mulligan note:

Those courts adopting standards have articulated definitions of knowledge ranging from circumstantial evidence and a good faith belief to a more stringent definition of proof beyond a reasonable doubt. The majority of courts have required at the very least “some corroboration . . . more than unsubstantiated rumor” before an attorney may invoke Model Rule 3.3 [the duty to correct witness perjury]. Other courts have defined the standard as “firm factual basis.” But these vague and varying standards have done little to clarify the issue for practicing attorneys, and leave scholars to question “[h]ow can a lawyer recognize when she has a firm factual basis rather than a reasonable doubt of a client’s intention to commit perjury while on the witness stand.”26

Finally, it must be emphasized that the “knowledge” requirement does have teeth and cannot be sidestepped by the willful ignorance of the facts. “[A] lawyer’s denial of knowledge is not conclusive on the question. And, as in criminal law, a lawyer’s conscious avoidance of knowledge of the falsity of evidence should not prevent a finding of actual knowledge.”27 On the other hand, a lawyer acts improperly when he or she seeks to withdraw from a case simply to avoid the “danger” inherent in a client’s possible perjury or involvement in presenting false evidence. This flows from the fact that such action harms the client, and therefore, a lawyer will be punished for acting without the necessary factual basis.28 As one writer cautioned:

using inconsistent, irreconcilable theories to secure convictions against two or more defendants in prosecutions for the same offense arising out of the same event). For a discussion concerning how various state courts have addressed the issue of whether, or under what circumstances, prosecutors can lie, see Thomas Moore, Can Prosecutors Lie?, 17 GEO. J. LEGAL ETHICS 961 (2004).


26. Id. at 847 (footnotes and citations omitted).

27. Charles Wolfram, What Lawyers Know, MODERN LEGAL ETHICS § 12.5.1 (1986); see also RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 120, Reporter’s Note, cmt. c (AM. LAW INST. 2000) (the concept of conscious avoidance, a concept applied generally in criminal law, also applies to the notion of when a lawyer knowingly uses false evidence); ABA Formal Op. No. 353 n.9 (1987) (a lawyer who does not ask his or her client questions about certain facts of the case to avoid the ethical dilemma may be violating the duty to provide competent representation).

If the lawyer’s disquietude about a client’s intended testimony is the result of mere conjecture or an unsubstantiated opinion, however, the lawyer should present the testimony. Importantly, even if the lawyer’s suspicion permits formation of a reasonable belief that the evidence is false—and thus permits its non-introduction under D.R. 7-102 (A)(4) and Model Rule 3.3(c)—this does not entitle, or require, the lawyer to make disclosure or take other remedial action under [Model] Rule 3.3(a)(4) [mandating that a lawyer take remedial measures when the lawyer knows that he or she has previously offered evidence that the lawyer knows to be false].

The “teeth” of the “knowledge” requirement is reflected in the manner in which courts have applied the knowledge standard case and in the way they have articulated an attorney’s obligation to question what a client claims to be true. For example, in Manhobhan v. Rome Developmental Disabilities Services Office, Senior Federal District Court Judge Munson considered the question of whether defense counsel in a civil case had properly and ethically signed a response to interrogatories based upon what his client had told him. Judge Munson explained that “[s]o long as the attorney does not have obvious indications of the client’s fraud or perjury, the attorney is not obligated to undertake an independent determination before advancing his client’s position.”

Similarly, a federal district court judge in Georgia in Knox v. Hayes considered the claim that a lawyer had allowed a witness to an accident to sign an affidavit even though the attorney knew that it contained material falsehoods. The judge found that based upon the witness’s prior deposition testimony, it was “crystal clear” that the witness actually disagreed with the contents of the affidavit he was signing. In rejecting the lawyer’s claims that he had acted in good faith, the judge explained:

All jurists know that the line between advocacy and falsehood is blurry. Lawyers pursue many cases and within each and every case the opportunities for crossing the line are many. Lawyers, both plaintiffs and defendants, in daily competition, will often position themselves as close to the line as possible; it is for the Court to sift the facts from strategic characterizations and word choices, and to carefully decide what is good lawyering and what is fraud.

29. Modern Legal Ethics § 12.5.1, supra note 27, at 656; see also Legal Background, ABA Model Rule 3.3, Annotated Model Rules of Professional Conduct 328 (4th ed.) (1999) (a lawyer’s reasonable belief that a client intends to testify falsely must be based on independent investigation of the evidence or on distinct statements made by the client).
31. Id.
33. Id. at 1582; see also In re Colvin, 336 P.3d 823 (Kan. 2014) (imposing discipline upon an attorney for his failure to correct an omission in demand letters that were relevant in subsequent motion practice); In re Johnson, 641 S.E.2d 535 (Ga. 2007) (imposing discipline upon an attorney who, among other things, failed to take remedial measures upon learning a client testified falsely).
This raises the question of whether a lawyer has a duty to correct false testimony elicited by another attorney. In considering this, it is noteworthy that the prohibition of ABA Model Rule 3.3(a)(3) against offering or using false evidence reaches those situations in which perjurious testimony is not elicited on direct examination but rather on cross-examination by an opposing lawyer.34

Thus, the responsibility extends to any false testimony elicited by the lawyer as well as such testimony elicited by another lawyer questioning the lawyer’s own client or another witness favorable to the lawyer’s client.35 Additionally, a lawyer with actual knowledge that a client intends to commit perjury has a duty to attempt to persuade that person not to do so, i.e., remonstrate.36 The same Rule is applicable for a witness that the client intends to call.37

The lawyer’s obligations are often viewed as a remonstration requirement: to urge the client or the witness not to testify falsely and to explain the consequences and dangers (such as criminal liability, the lawyer’s responsibility to disclose, etc.) of doing so. After such admonitions, the lawyer may reasonably expect that a client will testify truthfully.38 And when a lawyer knows that the witness will testify truthfully as to some questions but not to others, the lawyer may call the witness but may not put a question to that witness knowing that the witness will respond with false testimony.39

34. See, e.g., Restatement (Third) of the Law Governing Lawyers § 120, cmt. d (Am. Law Inst. 2000) (“A lawyer’s responsibility for false evidence extends to testimony or other evidence in aid of the lawyer’s client offered or similarly sponsored by the lawyer. The responsibility extends to any false testimony elicited by the lawyer, as well as such testimony elicited by another lawyer questioning the lawyer’s own client, another witness favorable to the lawyer’s client, or a witness whom the lawyer has substantially prepared to testify. A lawyer has no responsibility to correct false testimony or other evidence offered by an opposing party or witness.”).

35. See Modern Legal Ethics § 12.5.1, supra note 27, at 659; In re Janoff, 242 A.D.2d 27, 30 (N.Y. App. Div. 1998) (upholding finding of misconduct where attorney failed to correct false deposition testimony by his client that was adduced by his adversary); In re Friedman, 196 A.D.2d 280, 290 (N.Y. App. Div. 1994) (upholding finding that attorney violated D.R. 7-102[B][2], the predecessor to Rule 3.3[a][3], because he failed to correct false testimony by his witness elicited on cross-examination); San Diego Cty. Bar Ass’n Advisory Op. No. 1983-8 (1983) (where witness testifies falsely on cross-examination, the lawyer who called that witness must nonetheless attempt to rehabilitate, correct, or impeach the witness); see also Mackler v. Turtle Bay Apparel Corp., 1999 U.S. Dist. LEXIS 16164, at *12 (S.D.N.Y. Oct. 21, 1999), rev’d in part, vacated in part (on procedural grounds), 225 F.3d 136 (2d Cir. 2000) (imposing $45,000 in sanctions on an attorney who knew his client testified falsely but did nothing to correct that testimony).


37. See Modern Legal Ethics § 12.5.1, supra note 27, at 657.


Assuming remonstration is unsuccessful and the client insists on presenting false testimony at a trial, the lawyer may not call the client or witness to testify or must make efforts to address the specific testimony that will be false. A lawyer must refuse to present false testimony in a civil or criminal case even over the objection of the client. A lawyer may also refuse to offer evidence, other than the testimony of a defendant in a criminal matter, that the lawyer reasonably believes is false.40

Assuming the client or witness surprises the lawyer and testifies falsely, ABA Model Rule 3.3 requires that a lawyer take reasonable remedial measures when false evidence has been offered. Those remedial measures are required for “materially” false evidence.41 The ABA Model Rule, unlike, for example, the New York Rule, provides that the duty to take remedial measures terminates at the conclusion of the proceeding.42 The New York Rule, by contrast, does not identify a cutoff point when the duty to correct terminates. But certainly, the duty to take remedial measure would not terminate prior to the conclusion of the proceeding at issue.43

The lawyer’s first obligation is, of course, to remonstrate with the witness/client and strongly urge him or her to correct the testimony. In addition to the issues mentioned above, the lawyer should discuss with the witness/client the lawyer’s duty to disclose the perjurious testimony to the tribunal.44 If the remonstration is unsuccessful, the attorney “shall

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40. ABA MODEL RULES OF PROF’L CONDUCT r. 3.3(a)(3) (AM. Bar Ass’n 2015).
41. ABA Model Rule 3.3(a)(3)’s duty to correct mandate has a materiality requirement. Interpreting New York’s counterpart to Model Rule 3.3(a)(3) (which also contains a materiality requirement), the Departmental Disciplinary Committee of the Appellate Division expressed the view more than two decades ago that the duty to correct would not apply to trivial errors, such as what a witness might have eaten for breakfast.
42. See ABA MODEL RULES OF PROF’L CONDUCT r. 3.3(c).
43. MODERN LEGAL ETHICS § 12.5.1, supra note 27, at 660.
44. Comments 10 and 11 to Rule 3.3 provide the following guidance:

[10] A lawyer who has offered or used material evidence in the belief that it was true may subsequently come to know that the evidence is false. Or, a lawyer may be surprised when the lawyer’s client or another witness called by the lawyer offers testimony the lawyer knows to be false, either during the lawyer’s direct examination or in response to cross-examination by the opposing lawyer. In such situations, or if the lawyer knows of the falsity of testimony elicited from the client during a deposition, the lawyer must take reasonable remedial measures. The advocate’s proper course is to remonstrate with the client confidentially, advise the client of the lawyer’s duty of candor to the tribunal, and seek the client’s cooperation with respect to the withdrawal or correction of the false statements or evidence. If that fails, the advocate must take further remedial action. If withdrawal from the representation is not permitted or will not undo the effect of the false evidence, the advocate must make such disclosure to the tribunal as is reasonably necessary to remedy the situation, even if doing so requires the lawyer to reveal confidential information that otherwise would be protected by Rule 1.6. It is for the tribunal then to determine what should be done, such as making a statement about the matter to the trier of fact, ordering a mistrial, taking other appropriate steps or doing nothing.
take reasonable remedial measures, including, if necessary,” disclosure to the tribunal.

Assuming the client or witness refuses to rectify the fraud and correct the false testimony, Rule 3.3(a)(3) requires that the lawyer take action because there is no issue of attorney-client privilege. In short, the duty to correct and notify the tribunal of the fraud is now clear.

In the event that a lawyer moves to withdraw from representing a client, the lawyer should move to withdraw in camera and ex parte. The reasons underlying this practice were clearly set forth in Ficom International, Inc. v. Israeli Export Institute,\(^\text{45}\) where the court noted that because withdrawal motions often rely on documents and other information protected by the attorney-client privilege, “the proper practice for an attorney in applying for an order relieving him from responsibility in a case is to serve opposing counsel with a ‘bare bones’ notice of motion, but being careful to submit the supporting documents to the trial court for inspection in camera.”\(^\text{46}\)

3. Limitations on Witness Preparation

Having discussed some of the basic ethics issues relating to the issue of candor by attorneys and the offering of questionable evidence, it is now helpful to consider how courts, ethics committees, and scholars articulate their views concerning the limits of witness coaching. Indeed, of all of the issues involving aggressive litigation, perhaps none is more fascinating and challenging than understanding the ethically acceptable limits of witness preparation (often referred to as witness coaching). Proper witness preparation is the sine qua non of success in litigation.

In considering a lawyer’s conduct in witness preparation, one must understand that a lawyer operates under the combined directives of various ethical rules that parallel ABA Model Rules 8.4(a) and 1.2(d). Those Rules

\[11\] The disclosure of a client’s false testimony can result in grave consequences to the client, including not only a sense of betrayal but also loss of the case and perhaps a prosecution for perjury. But the alternative is for the lawyer to cooperate in deceiving the court, thereby subverting the truth-finding process, which the adversary system is designed to implement. See Rule 1.2(d). Furthermore, unless it is clearly understood that the lawyer will act upon the duty to disclose the existence of false evidence, the client can simply reject the lawyer’s advice to reveal the false evidence and insist that the lawyer keep silent. The client could therefore in effect coerce the lawyer into being a party to a fraud on the court.

\[46\] Id. at *6, n.1; see also Team Obsolete, Ltd. v. A.H.R.M.A., Ltd., 464 F. Supp. 2d 164, 164–65 (E.D.N.Y. 2006) (“documents in support of motions to withdraw as counsel are routinely filed under seal where necessary to preserve the confidentiality of the attorney-client relationship between a party and its counsel, and that method is viewed favorably by the courts”).
collectively provide that “a lawyer shall not knowingly engage in illegal conduct”\textsuperscript{47} or conduct contrary to the Rules; shall not violate or attempt to violate the Rules, “knowingly assist or attempt to induce another to do so, or do so through the acts of another”\textsuperscript{48}; and shall not counsel a client to engage, or assist a client, in conduct the lawyer knows is illegal or fraudulent. Previously, in some states, including New York, this duty of diligence combined with a respect for lawfulness was expressed in Canon 7 of the New York Lawyer’s Code of Professional Responsibility, which required a lawyer to represent a client “zealously within the bounds of the law.”\textsuperscript{49}

As discussed above, ABA Model Rule 3.3(a)(3) is the Rule that expressly prohibits an attorney from offering or using false evidence and contains its own “knowledge” element. There can be no question that the term “knowing” is strictly construed to mean actually that a guess or even a mere suspicion is not equivalent to actual knowledge of participation in fraud, deceit, or other wrongdoing.

District of Columbia Bar Opinion No. 79 (December 18, 1979) blends the notion of knowingly introducing false testimony with the process of witness preparation, as was discussed in an article by James M. Altman.\textsuperscript{50} Altman notes that while former D.R. 7-102(A)(6) and (7), now Rules 3.4(a)(5) and 1.2(d), prohibits lawyers from participating in the creation of false evidence and counseling or assisting a client in conduct the lawyer knows to be illegal or fraudulent, these Rules do not give any advice on how to apply these truisms in the horseshed. And the only ethics committee opinion to comprehensively apply the Code’s general norms to attorney conduct during witness preparation likewise makes “truth” the sole touchstone without providing practical advice:

“[A] lawyer may not prepare, or assist in preparing, testimony that he or she knows, or ought to know, is false or misleading. So long as this prohibition is not transgressed, a lawyer may properly suggest language as well as the substance of testimony, and may—indeed, should—do whatever is feasible to prepare his or her witness for examination.”\textsuperscript{51}

Furthermore, Altman opines that as part of this witness preparation process, the attorney must educate the witness regarding how the witness’s testimony fits into the entire dispute:

\textsuperscript{47} Model Rules of Prof’l Conduct r. 1.2(d).
\textsuperscript{48} Model Rules of Prof’l Conduct r. 8.4 (a).
\textsuperscript{49} New York Lawyer’s Code of Professional Responsibility, Canon 7, EC-1 (“The duty of a lawyer, both to the client and to the legal system, is to represent the client zealously within the bounds of the law, which includes Disciplinary Rules and enforceable professional regulations”).
\textsuperscript{50} James M. Altman, Witness Preparation Conflicts, 22 Litig. 38, 43 (Fall 1995).
\textsuperscript{51} Id. at 38 (quoting D.C. Bar Formal Op. No. 79).
Most witnesses need to be oriented to the theory of the case and how their testimony fits into it. After giving the veracity admonition [i.e., telling the witness that he or she must tell the truth], then, the lawyers will need to orient the witness; to describe the dispute between the parties; each party’s primary legal contentions; the major factual issues in dispute; the material facts upon which each side will rely to make its case; the particular factual issues about which the witness probably will testify; and how the witness’s testimony fits into the big picture.  

Altman also recognizes what most lawyers and judges already know:

Those who regard a witness’s initial recollection as the truth (or at least the witness’s version of it) logically must regard any effort to change the initial recollection as unethical tampering with testimony, if not outright subornation of perjury. But common experience—not to mention several judicial decisions—suggest that such a conclusion evidences a naive view of human memory and knowledge.

In a law review article entitled *The Anti-False Testimony Principle and the Fundamentals of Ethical Preparation of Deposition Witnesses*, Stephen Goldman and Douglas Winegardner suggest that helping a witness think about the facts, consider word choice, and evaluate alternatives does not violate the ethical rules, provided that the lawyer keeps in mind what they call the “Anti-False Testimony Principle” and its underlying moral premise. The authors describe this principle as follows:

The fundamental ethical tenets affecting a lawyer’s witness preparation duties, which are equally applicable in deposition or at trial, are cast as two prohibitions on the introduction of “false” testimony. Rule 3.4(b) of the Model Rules of Professional Conduct (Model Rules) provides that “[a] lawyer shall not . . . (b) falsify evidence, [or] counsel or assist a witness to testify falsely,” and Rule 3.3(a) of the Model Rules requires that “[a] lawyer shall not knowingly . . . (3) offer evidence that the lawyer knows to be false.” Although Model Rules 3.4(b) and 3.3(a)(3) apply in different situations, their goal is the same—to prevent a lawyer from tampering (actively or passively) with the factual record. Together, these rules reflect a fundamental and underlying principle that aims to prevent lawyers from placing incorrect and dishon-
est testimony in the record. We call this underlying concept the “Anti-False
Testimony Principle.”

Inevitably, the line between acceptable and unacceptable witness prep-
aration is one that is intensively fact and context specific. The ethical rules
providing that a lawyer may not advise or assist a witness to give false tes-
timony, nor knowingly use perjured or false testimony, may be difficult to
apply in the fringe areas. For example, one writer aptly recognized that
showing a witness documents to see how it affects the witness’s recollec-
tion can be a valuable practice, but it is improper to do so in a manner
suggesting that the witness conform his testimony to what he has read
or so that the witness gives a consistent story that matches other evidence
in the case. Similarly, a lawyer who begins a witness prep session with the
words “Let me tell you what the law is. . . .” may—fairly or unfairly—be
viewed as having caused the witness to change his or her testimony. Sim-
ilarly, although it is acceptable to suggest different ways a witness can
phrase a response, coaching a witness to hedge testimony by saying “I be-
lieve” when in fact the witness has a clear recollection may be improper.
Finally, a lawyer may suggest to a witness a particular phraseology, but
not when it alters the substance or intended meaning of the witness’s tes-
timony. Similarly, a prep session may become improper when the attor-
ney makes excessive use of leading or suggestive questions and/or when
the intention or the consequence of the attorney’s conduct is to have
the witness parrot what the lawyer is saying or asking.

There is a significant and often-cited decision by the Fifth Circuit that
explains the broad discretion an attorney has to attempt to persuade wit-
nesses to change written statements. In Resolution Trust Corporation v.
Bright, two Resolution Trust Company (RTC) attorneys questioned
one of the bank’s former officers, Barbara Erhart, concerning issues relat-
ing to malfeasance by other former officers at the bank. After interviewing
Erhart three times, the RTC attorneys asked her to return to their office
to review and sign an affidavit. When she arrived, the attorneys ques-
tioned her again, made last minute revisions to an affidavit they prepared,
and told her that the affidavit she would be asked to sign had several state-
ments in it that she had not discussed with them, but which they believed
to be true. Erhart made semantic changes to parts of the affidavit but
disagreed with substantive statements that the two RTC attorneys had

55. Id. at 9–11.
For a discussion of the limits of witness preparation, as applied to the use of trial consultants
who interact with witnesses, see Nicole LeGrande & Kathleen Mierau, Witness Preparation
57. 6 F.3d 336 (5th Cir. 1993).
58. Id. at 338–39.
drafted. The RTC attorneys questioned her extensively about the changes she had made and asked her to reword some of them to “emphasize” the culpability of the other former bank officers in certain controversial cash transactions. Erhart refused to sign the affidavit because she did not have personal knowledge of the statements the attorneys wanted her to include. The RTC attorneys were not content to accept Erhart’s initial refusal to revise her changes; in an effort to have Erhart see things their way, the RTC attorneys described to her their understanding of how certain events transpired at the bank. Among other techniques, they aggressively challenged some of her assumptions about the conduct of the other officers. Erhart refused to alter the initial changes she had made.59

The district court judge concluded that the RTC attorneys were trying to “talk [Erhart] into those statements” and that their conduct concerning the draft affidavit was tantamount to “tampering with” or “attempting to manufacture evidence.”60 In addition to various financial sanctions, the court disbarred the RTC attorneys from practicing before it.61 On appeal, the Fifth Circuit rejected the notion that the attorneys, in essence, had sought to elicit or create false testimony. The court explained the boundaries of witness documentation creation: “It is one thing to ask a witness to swear to facts which are knowingly false. It is another thing for an attorney to attempt to persuade her, even aggressively, that her initial version of a certain fact situation is not complete or accurate.”62

Professor William Hodes, the author of various ethics texts,63 commented on the practice of attorneys showing deposition witnesses documents and other materials in order to refresh the witness’s recollection

59. Id. at 339.
60. Id. at 340.
61. Id.
62. Id. at 341; see also Fred Zacharias & Shaun Martin, Coaching Witnesses, 87 Ky. L.J. 1001, 1015 n.9 (1999) (“Lawyers in pretrial settings typically use preexisting documentary evidence to prepare clients and witnesses for their depositions. . . . Accordingly, it is common practice for such lawyers to encourage a witness to review key documents produced during discovery . . . before his deposition.” (citations omitted)); Richard Wydick, The Ethics of Witness Coaching, 17 CARDOZO L. REV. 1, 37 n.112 (1990) (The author describes the process of “Grade Three Coaching,” in which the lawyer does not knowingly induce the witness to testify to something the lawyer knows is false, but the lawyer’s conversation with the witness nevertheless alters the witness’s story. “By definition, grade three witness coaching does not involve knowing inducement of testimony the lawyer knows is false. It therefore does not violate [the ethical rules prohibiting the offering of false evidence or falsifying evidence, or assisting a witness to testify falsely or inducing a witness to testify falsely],”); Joseph Piorowski Jr., Professional Conduct and the Preparation of Witnesses for Trial: Defining the Acceptable Limitations of Coaching, 1 GEO. J. LEGAL ETHICS 389, 390 (1987) (explaining that one of the primary objectives of preparing witnesses is to refresh the witness’s recollection). Lawyers may or may not agree with such views.
63. For example, Professor Hodes is co-author, along with Peter R. Jarvis and Professor Geoffrey C. Hazard Jr. (original Reporter for the ABA Model Rules), of the treatise The Law of Lawyering: A Handbook on the Model Rules of Professional Conduct (2d ed. 2000) (with annual
in his article *The Professional Duty to Horseshed Witnesses—Zealously, Within the Bounds of the Law*. His view is that even the use of a “scripted” document to prepare witnesses for depositions, including the showing of key photographs to witnesses to refresh their recollections, is not suborning perjury. Professor Hodes views such witness preparation as ensuring that the witness

... would ... be able confidently and effectively to present their truthful testimony under pressure. ... “It is unlikely that [the rule against improperly influencing a witness’ testimony means] that any attempt to influence a witness’ testimony is improper, since the entire process of witness preparation is directed to some degree at influencing a witness’ testimony.”

Professor Hodes further explained that where a client is uncertain of certain facts, it is proper to show the client photographs, have discussions with others, and be prepped by the attorney in order to enable the client to make a “more confident statement.” Although there is always the risk that a witness may remember a fact because of the horsesheding process, and not because of any true recollection, the cure of prohibiting the refreshing of recollection “is a cure worse than the disease. In order to serve their clients with full vigor, lawyers must not be afraid to take ethical risks of their own.”

### III. STRATEGIC OPTIONS AND CONSIDERATIONS

Notwithstanding the seemingly “indefensible” nature of the conduct at issue, numerous strategies can be employed to provide a vigorous and potent defense to even the most challenging of claims presented, or at least offer a means of successfully managing and mitigating the risk presented.

#### A. Maneuver Case to Early Settlement

Early settlement may be the most utilitarian option if the plaintiff’s demand is relatively reasonable and the defendant is amenable to the options presented. This is often less complicated when there are no nonmonetary demands, counterclaims or fee disputes, or potentially uncovered claims. Moreover, where insurance is available, policy provisions, such as a reduction in a deductible or retention that kicks in if the case is settled in mediation, may make such a settlement even more valuable.
B. Defense Options

In the event that the case cannot be settled, numerous other strategies are available to mitigate or even obviate the risks presented by a seemingly indefensible claim. Initially, a host of technical defenses may be available. Each must be considered, and every available angle must be pursued. And if trial cannot be avoided, it is imperative to understand that every single phase of trial preparation and the trial itself provides an opportunity to reduce or even in some cases completely eliminate potential exposure.

1. Pursuing Technical Legal Defenses

Technical legal defenses to be explored include traditional legal defenses such as jurisdiction, standing to sue, failure to join indispensable parties, statutes of limitations, causation, ratification, unclean hands, or failure to comply with pre-suit requirements. Attacking damages also can be an enormously successful tactic. The following are some specific considerations that need to be made:

**Jurisdiction**

- Does the defendant have sufficient contacts with the forum state?
- Is the case a candidate for removal to federal court to achieve a more favorable venue?
- Was service proper (particularly as this may impact statute of limitations defenses)?

**Proper Parties**

Does the plaintiff have standing to sue? For example:

- A claim by a trust must be brought by the trustee, not the beneficiaries.67
- A decedent’s claim must be brought by the estate executor or administrator, not the heirs.68

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• A claim by a party plaintiff absolved of liabilities through bankruptcy may belong to the trustee in bankruptcy, not the party plaintiff.69

• Claims of children are assertable by their legal guardian, and not any family member.70

• Corporate entities generally must be in good standing, such as being current with corporate tax obligations, to enjoy the privilege of using state courts.71

• Has there been a failure to join indispensable parties, such as others who have a claim to disputed assets?72

• Is the plaintiff legally incompetent? If so, the court may need to appoint a guardian ad litem.73

Statute of Limitations

While the statute of limitations for professional negligence generally starts to run from the date the claim should have been discovered, in some circumstances it actually may begin to run at the time of the negligent act giving rise to the claim, regardless of when the injury or damage was discovered.74


Some claims, such as statutory and FINRA arbitration claims, are subject to an absolute time limit from the date of the transaction regardless when a claim may be discovered.75

_Causation_

Some claims essentially require “but for” causation, which may allow for an absolute defense, even in cases of clear negligence.76 For example, an insurance broker fails to place requested coverage, but the uncovered claim would have fallen outside of the claims made policy period in any event, or a lawyer misses the statute of limitation on the filing of a legally deficient claim.

_Ratification_

The plaintiff’s ratification of the defendant’s actions may completely defeat its claim.77 For example, a registered representative of a broker-dealer places an unauthorized trade. The client sees the trade on his activity statement but says nothing because the stock has increased in value. Later, when the stock drops and the client complains that the trade was not authorized, he will be deemed to have ratified the trade.78 Or a registered representative makes patently unsuitable investments and trades that are clearly contrary to the customer’s stated risk profile. Losses ensue over the next six months, and the registered representative doubles down on the strategy in an attempt to recoup


77. Calma v. Templeton, 114 A.3d 563 (Del. Ch. 2015) (In the corporate law context, stockholders (as principals) can, by majority vote, retrospectively and, at times, prospectively, act to validate and affirm the acts of the directors (as agents)); Saggese v. Kelley, 837 N.E.2d 699 (Mass. 2005) (attorney may obtain consent to fee-sharing arrangement by ratification); Spellman v. Am. Universal Inv. Co., 687 S.W.2d 27 (Tex. App. 1984) (lessors’ knowing receipt of royalty payments from mineral lease amounted to ratification of lease contract, thus barring lessors from claiming the allegedly fraudulent contract should be reformed or rescinded).

the losses—with the result of still greater losses. While the customer may have a valid unsuitability claim for the first month or two (or three), at some point the customer has to take responsibility for the risky investment strategy that he has ratified by not stopping it as losses were mounting and the riskiness of the strategy became apparent.79

Unclean Hands

Generally, a plaintiff who actively participates in wrongful conduct will not be rewarded.80 For example, a company engaged in fraudulent accounting cannot pursue a claim against the accountant for failing to uncover it.81 As another example, the perpetrator of a Ponzi scheme cannot sue other participants in the scheme for violations of RICO, nor can his creditors on his behalf in bankruptcy.82

Unavailable Damages

Some of the damages being claimed by a plaintiff may not be recoverable under the law, such as the case in New York, where recovery of lost profits arising from a fraudulent scheme that did not proceed as planned are barred.83 Claims for loss of reputation outside of a claim for defamation are generally not recoverable, and claims for emotional distress arising from property damage or economic loss are typically barred in most jurisdictions.84 Damages are also typi-


82. Official Comm. of Unsecured Creditors of PSA, Inc. v. Edwards, 437 F.3d 1145 (11th Cir. 2006).


84. Hustler Mag. v. Falwell, 485 U.S. 46 (1988) (plaintiffs must meet First Amendment standards of proof for defamation claims in order to recover reputation damages); Food Lion, Inc. v. Capital Cities/ABC, Inc., 194 F.3d 505 (4th Cir. 1999) (same); Exxon Mobil Corp v. Ford, 71 A.3d 105 (Md. 2013) (absent evidence of fraud or malice in underlying tort, emotional distress resulting from property damage not compensable); Blagrove v. JB Mech., Inc., 934 P.2d 1273 (Wyo. 1997) (homeowner’s emotional distress damages not compensable in connection with property damage arising from negligent installation of water
cally not available for lost profits from new business ventures with no history of profitability to draw upon in calculating damages.85

Failure to Comply with Pre-suit Requirements

Failure to comply with pre-suit requirements also may defeat all or a portion of a claim. For example, claims under consumer protection statutes may require a pre-suit demand letter, or in order to pursue a professional negligence claim in some jurisdictions, the plaintiff must obtain a certificate of merit from a qualified expert.86 For federal employment discrimination claims, you first must file a charge of discrimination with the EEOC and obtain a right-to-sue letter before you can pursue a civil claim in federal court.87 Even highly meritorious

85. MindGames, Inc. v. W. Publ’g Co., Inc., 218 F.3d 652, 658 (7th Cir. 2000) (newness of a business is a factor in applying damages standards); Mali v. Odom, 367 S.E.2d 166 (S.C. Ct. App. 1988) (attorney malpractice action; estimates of anticipated monthly income from new school held speculative and without reasonable basis where offered without reference to operational history or standard method for estimations). But see RESTATEMENT (SECOND) OF CONTRACTS § 352, cmt. b (AM. LAW INST. 1981) (update Oct. 2016) (lost profits damages for new business may be established by expert testimony, economic and financial data, market surveys and analyses, and business records of similar enterprises); W.W. Gay Mech. Contractor, Inc. v. Wharfside Two, Ltd., 545 So. 2d 1348, 1351 (Fla. 1989) (“A business can recover lost prospective profits regardless of whether it is established or has any ‘track record.’”); Super Valu Stores, Inc. v. Peterson, 506 So. 2d 317, 327 (Ala. 1987) (“Anticipated profits of an unestablished business [may be recovered], if proved with reasonable certainty.”); Olivetti Corp. v. Ames Bus. Sys., 356 S.E.2d 578, 585 (N.C. 1987) (“While we agree . . . that lost future profits are difficult for a new business to calculate and prove, we are persuaded that there should be no per se rule against the award of such damages where they may be shown with the requisite degree of certainty. Accordingly, we hold, along with what appears to be a majority of jurisdictions reaching the issue, that the new business rule is not the law of our state.”); Short v. Riley, 724 P.2d 1252, 1254 (Ariz. Ct. App. 1986) (“[W]hen evidence is available to furnish a reasonably certain factual basis for computation of probable losses, recovery cannot be denied even though a new business venture is involved.”).

86. See, e.g., MASS. GEN. LAWS ch. 93A, § 9(3) (requiring demand letter); TEX. BUS. & COM. CODE ANN. § 17.505(a) (Vernon Supp. 1992) (same); see also, e.g., Liggon-Redding v. Estate of Sugarman, 659 F.3d 258 (3d Cir. 2011) (Pennsylvania law requires plaintiff to file certificate of merit within sixty days after filing professional negligence complaint); CAL. CIV. PROC. CODE § 411.35 (West <<year?>>) (requiring certificate of merit in actions against architects, engineers, and land surveyors); N.Y.C.P.L.R. 3012-a (McKinney <<year?>>) (requiring certificate of merit in medical, dental, and podiatric malpractice actions); TEX. CIV. PRAC. & REM. CODE ANN. § 150.002 (West <<year?>>) (requiring certificate of merit in any action or arbitration proceeding for damages arising out of provision of professional services by licensed or registered professional); WASH. REV. CODE § 7.70.150 (<<year?>>) (requiring certificate of merit in actions against individual health care providers).

87. 42 U.S.C. § 2000e et seq.
claims can be dismissed for failure to comply with these absolute pre-suit obligations.

2. Defending the Claim Through Trial

Assuming there is no realistic possibility of settlement and the case cannot be disposed of through application of a technical legal defense, critical trial considerations must be made.

First, it is imperative to appreciate that big bad cases with ugly facts often are fought on two fronts—in public and in the courtroom. You must be cognizant of both fields of battle at all times and consider what can be done to mitigate the efforts of the plaintiff’s counsel to utilize media attention, sway a potential jury pool, and magnify damages. Where the case has received substantial media attention, to permit a fair trial for your client, efforts must be made to obtain a nondisclosure order by the court, directing that neither party make extrajudicial statements to the media concerning arguments, evidence, or settlement negotiations during the pendency of trial.

Second, it is imperative to realize that trial begins at the deposition stage. Your clients and your witnesses have to be thoroughly questioned and carefully prepared. Mistakes in testimony from careless preparation will be portrayed as a lack of candor or outright dishonesty. The stakes are much higher in these cases. Mistakes are that much more serious. You must strive to get the testimony you need, in the way it is needed, at the outset. So in this regard it is imperative as well to understand exactly what is being alleged, exactly what the fact issues are, each and every element of the claims being asserted, and what must be proven to establish or blunt the claims being made. You also must identify, articulate, and make sure that your witnesses, always truthfully, testify in a manner consistent with the themes you want to present to the jury.

Third, jury selection is critical. In this regard, it is important to note that during the deliberative process, the most critical factor is the juror’s long-standing predispositions.88

According to studies of juror biases, 76 percent of jurors believe that corporate executives lie and cover up, 30 percent believe that it takes “billions” to send a message to corporations, 71 percent do not believe there should be caps on juror awards, and 45 percent ignore a judge’s instructions.89 Develop a carefully considered questionnaire to uncover and identify potential juror biases. Get a jury consultant involved and make every effort to get a centrist jury selected. Further, do everything possible

89. Statistics based on data calculations suggested by DecisionQuest.
to get honest answers to your questions by letting the jury know at the outset that it is acceptable to have strong feelings and opinions; there are no right or wrong answers; and what is important, fair, and right is for everyone to be as honest as they can be.

It is also important to identify and weed out jurors who may have been influenced by media reports. The voir dire must be carefully crafted to identify not only traditional media, i.e., television and radio, potential jurors may watch or listen to, but also what websites they visit; what social media they use; and what they have seen, heard, or discussed about the facts in issue, as well as any opinions they may have developed. Additionally, it is important to determine if the potential jurors would be concerned about reactions to their verdict by anyone, including friends, family members, neighbors, acquaintances, or co-workers. It is important to ascertain if prospective jurors have any personal, moral, or religious beliefs and opinions that would influence or affect their ability to follow the law as it is explained to them and to render judgment.

Fourth, it goes without saying, but it still needs to be said: opening and closing statements are the ballgame. They must be compelling, set the themes of your defense, and comprehensively and compellingly present your version of the events. Volumes of treatises have been written on opening and closing statements, so no more will be said on this, except for this: in a case where indefensible conduct is involved, if the issue is solely about damages, and the objective is to get the jury to fairly and objectively focus on the actual damages and not be swayed by anger or a desire to punish your client, it is imperative that the themes designed to tamp down the anger and get the jury to focus on the actual damages incurred must be established during the opening and compellingly reaffirmed during the closing.

Fifth, focus must at all times be kept on developing key damage mitigation information. Remember, you are coming into this case with the understanding at the outset that the conduct is in many ways utterly “indefensible.” If liability is virtually a forgone conclusion, damages are the ballgame. Every effort must be made to build a defense to the asserted damages. In this regard, it is critically important to identify a damages expert early, identify the theory or theories by which you will be attempting to attack damages, and uncover every possible piece of information necessary to build the expert’s damages argument and provide support for his damages analysis. Further, the expert must be carefully vetted and his background thoroughly explored. Has the expert ever been fired? Has the expert ever been determined at trial to be presenting a flawed, unscientific, or otherwise insupportable argument? Has the expert testified 500 times and always for the defense? Has the expert authored papers, prepared reports in other cases, or given presentations on issues similar
to the issues before the court in your case that appear to contradict the positions he is taking for you? Does the expert assign all of the work to associates or does he actually work on the analysis? Does the expert sound credible or as someone who will literally say or do anything he is paid for? The time and attention spent on securing the right expert simply cannot be understated.

Sixth, again, where truly “indefensible” conduct is involved and horrific consequences have occurred, it is imperative to understand that the plaintiff’s attorney is going to be trying to stoke anger in the jury. The earlier you challenge the foundation for the anger, the better the chance for success in mitigating the exposure presented. This starts with the voir dire and continues into the opening statement and throughout the testimony of any defense witnesses. In fact, it is important that the corporate witnesses testifying in a case where an employee has engaged in indefensible conduct are carefully prepared in advance of their depositions to exhibit true contrition and sympathy where liability is not in dispute, and damages are what is going to be litigated at trial.

Seventh, where the case involves truly heinous conduct or tragic impacts—with the potential for imposition of emotionally charged compensatory and punitive damages—it is imperative that appropriate themes and defenses be presented to address these issues. In this regard, for example, it may be effective to own the misconduct—and even apologize for it—and in that way help steer the jury to an objective analysis of the actual damages incurred.

IV. CONCLUSION

When faced with the task of defending “indefensible” conduct, it is important to understand that the role of a lawyer is to provide an honest, ethical, and fulsome defense of the client, to the best of his or her ability. If for moral, business, or other reasons you feel uncomfortable representing a client in these circumstances, it is your obligation to pass on the representation. If you take it on, however, you need to understand the magnitude of the task you will be taking on and the holistic approach that must be taken to defend the claims asserted. Every possible angle for steering the case to early resolution must be considered, along with every possible option for achieving disposition on “legal” grounds. When trial cannot be avoided, every aspect of the trial must be carefully thought out, and the themes and issues that will be guiding your defense strategy must be employed at the outset and consistently throughout.

From an ethics standpoint, it is important to be cognizant of the fact that a lawyer who is attempting to defend the “indefensible” case may be tempted to consider pursuing strategies that are aggressive in nature.
This is fine, and lawyers have an obligation to advance their client’s interest zealously—but there are limits. In this regard, trial lawyers must have a keen understanding not only of what evidence is admissible, but also of the relationship between the rules of evidence, the rules governing conflicts of interest, the attorney-client privilege, and the principles governing questionable evidence.
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Negotiation, we may say, ought strictly to be viewed as a means to an end; it is the road the parties must travel to arrive at their goal of mutually satisfactory settlement. But like other means, negotiation is easily converted into an end in itself; it becomes a game played for its own sake and a game played with so little that those taken up with it will sacrifice their own ultimate interests in order to win it.¹

From the first step into law school and beyond, lawyers are taught to be zealous advocates for their clients, unwavering, and willing to do whatever necessary to win. Indeed, the preamble to the Model Rules of Professional Conduct explicitly states that “[a]s advocate, a lawyer zealously asserts the client’s position under the rules of the adversary system.”² This desire to

². MODEL RULES OF PROF’L CONDUCT (AM. BAR ASS’N 2016), Preamble [2]. Notably, comment 1 to Model Rule 1.3, which referenced a lawyer’s duty to act “with zeal in advocacy upon the client’s behalf,” was deleted because zealous advocacy is often invoked as an excuse for unprofessional behavior.

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win extends to lawyers’ behavior during negotiations. The preamble further states, “[a]s negotiator, a lawyer seeks a result advantageous to the client but consistent with requirements of honest dealings with others.”\(^3\) Whether attorneys employ truthful or deceptive negotiation tactics, however, largely depends on the individual.\(^4\)

Negotiation can best be described as “a consensual bargaining process in which the parties attempt to reach agreement on a disputed or potentially disputed matter.”\(^5\) Negotiation is used in almost all fields of law to resolve disputes in a variety of ways.\(^6\) Outside of a litigation context, negotiations are generally informal, less stressful, and cheaper than adjudication. Even if a lawsuit is pending, negotiations may still be taking place simultaneously to reach a mutually agreed-upon settlement.

This article discusses, in the context of negotiation, whether lawyers can lie, the scope and application of the rules with regard to express and implied misrepresentations of fact, and punishments for unethical deceitful behavior.

I. CAN LAWYERS LIE?

The laws governing lawyers’ conduct in negotiations have remained largely unchanged since their initial adoption in 1983 by the American Bar Association.\(^7\) In addition, the rules governing negotiations, as stated in the Model Rules of Professional Conduct, have been almost universally adopted by the highest courts in each state.\(^8\) A plethora of rules may govern negotiations in certain situations, including ABA Model Rules 1.2(a), 1.2(d), 1.3, 1.4, 1.6, 3.1, 3.3(a), 3.4, 4.1, 4.3, 4.4(a), and 8.4(c). The most relevant rules governing negotiation are 8.4(c), 3.3, and 4.1.

Rule 8.4(c) broadly prohibits dishonesty, fraud, deceit, or misrepresentation in any aspect of a lawyer’s professional life.\(^9\) Some might interpret

\(^3\) MODEL RULES OF PROF’L CONDUCT, Preamble [2].
\(^5\) Negotiation, BLACK’S LAW DICTIONARY (10th ed. 2014).
\(^9\) MODEL RULES OF PROF’L CONDUCT r. 8.4(c) (AM. BAR ASS’N 2016).
this broad prohibition on dishonesty to bar all lying in negotiations. However, a close look at the comments to the Model Rule seem to indicate that more wiggle room is allowed for when it comes to lying in negotiations.10

Rule 3.3, which overlaps with Rule 8.4(c), also may apply in some situations during negotiations. Specifically, Rule 3.3 may come into play where a judge is mediating settlement negotiations. Unlike Rule 4.1, discussed in detail below, Rule 3.3 prohibits a lawyer from knowingly making a false statement of fact or law or failing to disclose controlling legal authority to a tribunal.11 This rule does not require that the false statement of fact or law be material. If the judge, as mediator, asks a party a fact, the attorney’s options under Rule 3.3 are seemingly limited to either telling the truth or respectfully declining to answer.12

Rule 4.1 is narrower and states that “in the course of representing a client, while communicating to a third person, a lawyer shall not knowingly make a false statement of material fact or law or fail to disclose a material fact when disclosure is necessary to avoid assisting a criminal or fraudulent act by a client, unless disclosure is protected by [attorney-client privilege].”13 The prohibitions on misrepresentations of material facts or law apply equally in the context of all types of settlement negotiations, whether conducted privately by parties or with the assistance of a neutral.14 If the rules regarding misrepresentations applied literally, both parties would have a hard time doing anything but telling the whole truth during negotiations. However, the ABA, scholars, and case law have clarified the application of Rule 4.1 to allow for certain shades of gray in the negotiation context.

10. Model Rules of Prof’l Conduct r. 8.4 cmt. 2 (indicating that the rule is more about prohibiting conduct (including dishonesty) by an attorney that would reflect poorly on his or her fitness to practice law).
11. Model Rules of Prof’l Conduct r. 3.3(a)–(b). Before the 2002 amendments to the ABA Model Rules, Rule 3.3 prohibited lawyers from making false statement of “material” fact or law. Many states have opted to keep the language for their respective Rule 3.3 limited to only “material” facts or law.
12. See, e.g., Richmond, supra note 6, at 286 (“Judge, with all due respect, I don’t think I have to tell you my strategy. But, out of respect for you, I will say that I think we can settle this case for less than a million. My client and I would like to get this done now for $750,000. Please reiterate that offer to the plaintiff.”); see also A.B.A. Formal Op. 06-439 (2006).
13. Model Rules of Prof’l Conduct r. 4.1(a)–(b) (emphasis added).
14. ABA Comm. on Ethics & Prof’l Responsibility, Formal Op. 06-439 (2006) (stating that “the ethical principles governing lawyer truthfulness do not permit a distinction to be drawn between the caucused mediation context and other negotiation settings” and “[t]he Model Rules do not require a higher standard of truthfulness in any particular negotiation contexts; nor is a lower standard of truthfulness warranted because of the uniqueness of the mediation process”).
II. FALSE STATEMENTS OF MATERIAL FACT OR LAW, PROHIBITED

According to the “Ethical Guidelines for Settlement Negotiations” published by the ABA Litigation Section, “a lawyer must comply with the rules of professional conduct and applicable law during the course of settlement negotiations . . . and must not knowingly make a false statement of material fact (or law) to a third person [in the course of negotiating or concluding a settlement].” That said, the ABA guidelines allow for certain kinds of “puffery” or “posturing” during settlement negotiations. Statements about a party’s willingness to compromise or resolve a dispute, a party’s value placed on the subject of the case, the strength or weakness of a party’s factual or legal positions or case, and a party’s goals or objectives all qualify as allowable embellishments, not material misrepresentations, under Rule 4.1.17

The scope and application of the rules, and an attorney’s obligations thereunder, can vary depending on whether the misrepresentation was express or implied.

A. Express Misrepresentation of Fact

Model Rule 4.1(a) states: “In the course of representing a client a lawyer shall not knowingly . . . make a false statement of material fact or law to a third person.” In addressing express misrepresentations, the second comment to Model Rule 4.1 clarifies that whether a statement is one of material fact “depends on the circumstances” in which the statement was made. Rather than defining a statement of material fact, the comment instead gives examples of what a statement of material fact is not. The ABA notes several generally accepted conventions of negotiation that are not taken as statements of material fact, including estimated price or value on the subject of the transaction; the party’s intentions as to an acceptable settlement of a claim; and the existence of an undisclosed principal, except where nondisclosure of the principal would constitute fraud.

16. Id.; Model Rules of Prof’l Conduct r. 4.1 cmt. 2 (“Under generally accepted conventions in negotiation, certain types of statements ordinarily are not taken as statements of material fact. Comments which fall under the general category of ‘puffing’ do not violate this rule.”).
17. Richmond, supra note 6, at 268.
18. Model Rules of Prof’l Conduct r. 4.1(a).
19. Model Rules of Prof’l Conduct r. 4.1 cmt. 2.
20. Model Rules of Prof’l Conduct r. 4.1 cmt. 2.
21. Model Rules of Prof’l Conduct r. 4.1 cmt. 2.
Given that Model Rule 4.1 does not provide much additional guidance regarding the various elements of this provision, it is important in analyzing this provision to establish a basic understanding of the meanings that courts have given to these elements over time. This section addresses the way that courts have defined “material,” whether a statement was “knowingly made,” and who constitutes a “third person.” This section also considers a controversy in the courts regarding the disclosure of settlement authority.

Courts evaluate materiality on a case-by-case basis. In *Ausherman v. Bank of America Corp.*, the U.S. District Court for the District of Maryland defined “material” in its relation to Rule 4.1 as a statement of fact or law that “reasonably may be viewed as important to a fair understanding of what is being given up and, in return, gained” in the agreement or settlement. The court further posited, “it seldom is a difficult task to determine whether a fact is material.” In clarifying *Ausherman’s* definition of “material,” the federal district court in Maryland in *Hanlin-Cooney v. Frederick County* labeled a fact as “material if it is relevant to a person’s decision of how to act.” *Black’s Law Dictionary*, in line with the *Ausherman* definition, describes a statement as “material” if it is “significant” or “essential.”

In examining materiality, consider the following hypothetical. The plaintiff sprained his ankle in a premises liability case. May the lawyer representing the client describe the pain his client is experiencing as “the worst and most horrific pain imaginable”? Yes, a lawyer can exaggerate the extent of pain from an injury as well as the extent of the client’s ability to exert himself. But may the lawyer claim that the client’s sprained ankle is actually broken or that he needs to use special appliances to get around? No, both of those representations would be material misstatements of fact because such facts are significant and essential to the evaluation of the opposing party’s decision of whether to settle or for how much.

A violation of Rule 4.1 also will depend on whether the material fact or law was knowingly omitted or misrepresented by the attorney. Accordingly, after considering whether a misrepresented fact or law is material, the next consideration is whether that misrepresentation was knowingly made. According to Rule 1.0(f), “knowingly” denotes actual knowledge,

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23. *Id.*
24. *Id.*
which may be inferred from the circumstances. To satisfy this element of a Rule 4.1 violation, the lawyer does not need “evil intent or bad purpose.” Accordingly, innocent misstatements do not implicate Rule 4.1. If a lawyer makes an innocent misstatement of fact believed to be true and later learns the statement is false, however, the attorney must make the correction and notify the third person to whom the misrepresentation was made. And, as discussed above, if an attorney consummates a settlement without disclosing knowledge of that materially false fact or law, he has violated Rule 4.1. It remains debatable whether statements made with reckless disregard for the truth implicate Model Rule 4.1.

Curiously, neither Rule 4.1 nor its comments address what constitutes “material law,” leaving lawyers with only the following dictionary definition: “[L]aw that is either significant or essential to the negotiation.” Issues concerning whether to disclose material law also could occur during settlement negotiations. For instance, during settlement negotiations, opposing counsel has failed to find case law that would support his position. Do attorneys have an affirmative duty to tell their opponent about the case law they do not know about? The answer is no: it is well established that the lawyer “generally has no affirmative duty to inform an opposing party of relevant law.”

Rule 4.1 next requires the misrepresentation to be made to a “third person.” If the misrepresentation is not made to a third person, it will not trigger a Rule 4.1 violation. A “third person” is anyone other than the lawyer’s client. Opposing counsel, and other attorneys, qualify as third persons. However, other rules cover misrepresentations to clients.

28. MODEL RULES OF PROF’L CONDUCT r. 1.0(f) (AM. BAR ASS’N 2016).  
29. In re Edison, 724 N.W.2d 579, 584 (N.D. 2006).  
30. People v. Chambers, 154 P.3d 419, 425–26 (Colo. 2006) (holding that there was no Rule 4.1 violation for an innocent misstatement of the amount of previous claims and lawsuits).  
31. In re Carpentino’s Case, 651 A.2d 1, 4 (N.H. 1994) (relying on Rule 4.1(a)).  
32. Kath v. W. Media, Inc., 684 P.2d 98 (Wyo. 1984). Because the ABA Model Rules were not adopted in Wyoming until 1986, Rule 4.1 is not explicitly mentioned in this decision. However, this case is still relevant to this paper because the attorney in question knowingly omitted the fact that he represented multiple parties in a previous transaction and that omission was material to the settlement, which resulted in its invalidation.  
35. MODEL RULES OF PROF’L CONDUCT r. 4.1 cmt. 1 (AM. BAR ASS’N 2016). But note that, pursuant to Rule 3.3(a)(3), the lawyer would have a duty to disclose adverse law or statutes if the other side did not mention them in a court proceeding.  
36. Richmond, supra note 6, at 268.  
38. See e.g., MODEL RULES OF PROF’L CONDUCT r. 8.4(c).
In addition to defining “material,” “knowingly,” and “third person,” courts also have addressed an apparent controversy surrounding the disclosure of settlement authority. In at least two opinions—once in 1993 and again in 2006—the ABA has opined that misrepresenting one’s bottom line is a material fact and as such it should not be misrepresented.\(^{39}\) It should be noted, however, that the 1993 opinion further stated that it is never appropriate to disclose a client’s settlement authority without first obtaining informed consent.\(^{40}\) The ABA opinions, although persuasive authority, are certainly not binding on a court.

If the Model Rules prohibit an attorney from lying about the bottom line as a material misrepresentation and state that attorneys may not disclose their settlement authority without informed consent, the question becomes: why is the opposite practice so prevalent among attorneys? The State Bar of California, which is one of the only states that has refrained from adopting all of the ABA’s model rules, opined in its own Advisory Opinion that “[a]n intentional misstatement of a client’s ‘bottom line’ or other settlement goal is permissible posturing and is not an ethics rule violation . . . .”\(^{41}\) Chances are that the majority of attorneys—particularly those who regularly disclose or exaggerate their bottom line—would agree with the California advisory opinion. The practice has become so customary that lawyers practically expect such a misrepresentation from opposing counsel during negotiations and can hardly be said to rely on it to such a degree as to make it material. Therefore, in the highly unlikely event that opposing counsel finds out that an attorney misrepresented his settlement authority, it would be difficult to prove damages, even if the evidentiary hurdle of Rule 408, which prohibits the use of statements made in settlement negotiations, was met or if opposing counsel relied on that misrepresentation alone in choosing to settle (or not to settle) the case.

To gauge our understanding of the misrepresentation of an attorney’s settlement authority, consider the following hypothetical. The plaintiff’s attorney has settlement authority for anything over $100,000 and the defendant’s attorney has settlement authority for up to $130,000. The plaintiff demands $150,000 as its final offer and the defendant offers $70,000. The attorneys have not violated Rule 4.1 as long as neither attorney represented the actual limits of settlement authority to the other. If either attorney had made such a representation, the lawyer might have violated Rule 4.1(a) because the full value of settlement authority is a material

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\(^{40}\) Formal Op. 93-370.

statement of fact, at least according to the ABA. However, in another state, such as California, a misrepresentation of settlement authority would only amount to mere “puffery” and would not constitute a violation of Rule 4.1.

B. Implicit Misrepresentation of Fact—Failure to Disclose

Model Rule 4.1(b) states: “In the course of representing a client, a lawyer shall not knowingly . . . fail to disclose a material fact to a third person when disclosure is necessary to avoid assisting a criminal or fraudulent act by a client, unless disclosure is prohibited by Rule 1.6.”42 The first comment to Rule 4.1 addresses a lawyer’s failure to disclose material information that may amount to an implicit misrepresentation of fact.43 It states that although a lawyer is required to be truthful when dealing with others, a lawyer “generally has no affirmative duty to inform an opposing party of relevant facts.”44 However, a lawyer’s “knowing failure to disclose a non-confidential, material, and objective fact upon inquiry by opposing counsel is improper.”45

In Pendleton v. Central N.M. Correctional Facility, an attorney’s knowing failure to disclose a material fact led to court-imposed sanctions.46 During settlement negotiations with a magistrate judge as a mediator, the defendant agreed to settle the plaintiff’s discrimination claim.47 After the defendant executed the settlement agreement and release, but before the plaintiff fulfilled his portion of the deal, he filed a retaliation claim with the Equal Employment Opportunity Commission.48 The defendant discovered the claim and both parties moved for sanctions.49 The plaintiff’s motion for sanctions was denied because of his failure to notify the defendant during settlement negotiations of the impending retaliation claim.50 The court aptly penned,

[w]hat is particularly troubling in this case is that the second retaliation lawsuit arose directly and immediately out of efforts to settle the prior action. Holding back information that if divulged might have led to a quick low-cost resolution of this action without resort to additional litigation is exactly the type of conduct that the public finds abhorrent and that contributes to the low esteem that the bar currently is trying to reverse.51

42. MODEL RULES OF PROF’L CONDUCT r. 4.1(b).
43. MODEL RULES OF PROF’L CONDUCT r. 4.1 cmt. 1.
44. MODEL RULES OF PROF’L CONDUCT r. 4.1 cmt. 1.
46. Id. at 641.
47. Id. at 638.
48. Id. at 638–39.
49. Id. at 628.
50. Id. at 641.
51. Id.
In some situations, a lawyer’s silence may be the same thing as a knowing failure to disclose a material fact prohibited by Rule 4.1(b). The ABA Commission on Ethics and Professional Responsibility noted that a lawyer’s silence might equate to a positive misrepresentation. If the lawyer completes a settlement without disclosing a material fact or law, there is a violation of Rule 4.1. In *Kath v. Western Media, Inc.*, an attorney represented more than one defendant in a lawsuit during settlement negotiations and failed to disclose (before settlement) a letter showing that he had taken sides between the parties he represented jointly and that his representation was in the interest of one to the detriment of the other. The court found the nondisclosure improper. The Supreme Court of Wyoming found that the letter should have been disclosed to opposing counsel (and the court), and because it was not disclosed, it amounted to an affirmative misrepresentation. The settlement was vacated and the case reinstated for continued litigation.

Several exceptions to the general rule that lawyers have no affirmative duty to inform opposing parties of relevant facts have been revealed, including when (1) the client has passed away, (2) there is a writing that does not reflect the parties’ agreement, (3) there is clearly applicable insurance coverage and the attorney knew of opposing counsel’s mistaken belief that no such coverage exists, and (4) an attorney knows that an opponent is operating under a mistaken belief that will substantially decrease the benefit or deprive the opponent of the benefit of its bargain.

First, several courts have concluded that a lawyer has a duty to disclose the client’s death. In *Harris v. Jackson*, the Kentucky Supreme Court elaborated on a lawyer’s duty to disclose a client’s death. The client died after the action was filed and his attorney continued to litigate without advising opposing counsel or the court of the death. According to *Harris*, a lawyer must inform opposing counsel and the court during set-

52. ABA Comm. on Ethics & Prof’l Responsibility, Formal Op. 06-439 (2006); see also *Model Rules of Prof’l Conduct* r. 4.1 cmt. 1 (AM. BAR ASS’N 2016); Hinshaw & Alberts, *supra* note 34, at 104.


54. Id.

55. Id. at 100.

56. Id. at 101.

57. Id. at 102.

58. Richmond, *supra* note 6, at 281–82.


60. 192 S.W.3d 297.

61. Id. at 297–98.

62. Id. at 299.
tlement negotiations of his client’s death when he first learns of the fact.\textsuperscript{63} The court explained that “a lawyer acts on behalf of an identified client. When the death occurs, however, the lawyer ceases to represent that identified client.”\textsuperscript{64} Any representation after the client’s death that fails to disclose that the attorney no longer represents the client is a knowing misrepresentation.\textsuperscript{65} Because the attorney complied with an opinion from the state bar association ethics committee that he was not required to advise opposing counsel of the death absent fraud, the court did not sanction the attorney.\textsuperscript{66} However, the court clarified Kentucky law that an attorney must always disclose a client’s death to opposing counsel and the court at first notice.\textsuperscript{67}

The North Dakota Supreme Court also did not sanction an attorney for failing to disclose his client’s death where there was no evidence that the attorney knew the date of the client’s death, that he knew the manner of service of process (on the decedent’s husband), or that he knew of the opposing counsel’s lack of information regarding the client’s death.\textsuperscript{68} Therefore, even though a failure to disclose the client’s death is a misrepresentation that requires disclosure, the court found that the attorney did not intend to, or knowingly, deceive opposing counsel or the court.\textsuperscript{69} In Colorado, on the other hand, an attorney was suspended for six months for his failure to disclose his client’s death.\textsuperscript{70} The Colorado Supreme Court found in \textit{In re Rosen} that where an attorney refers to his client in the present tense during settlement negotiations, it implies that the client is still alive and constitutes a knowingly deceitful misrepresentation.\textsuperscript{71}

Compare failing to disclose a client’s death as the result of work injury in a workers’ compensation case. The plaintiff, your client, was injured on the job and now seeks workers’ compensation benefits. If your client has returned to work, do you have to disclose to the defense that the client returned to work? Maybe. Pursuant to Rule 4.1, comment 1, a lawyer is required to be truthful when dealing with others on a client’s behalf but generally has no affirmative duty to inform an opposing party of relevant facts. Upon inquiry, an attorney must certainly advise opposing counsel of the change in condition because it is material to any workers’ compensation benefits paid. However, in a workers’ compensation claim, medical and indemnity benefits are not material in the same way as a client’s death. If the client has died, the lawyer no longer

\textsuperscript{63} Id. at 305.
\textsuperscript{64} Id. (quoting Gailor v. Alsabi, 990 S.W.2d 597 (Ky. 1999)).
\textsuperscript{65} Id.
\textsuperscript{66} Id. at 300.
\textsuperscript{67} Id. at 305.
\textsuperscript{68} \textit{In re Edison}, 724 N.W.2d 579, 582 (N.D. 2006).
\textsuperscript{69} Id. at 584.
\textsuperscript{70} \textit{In re Rosen}, 198 P.3d 116, 121 (Colo. 2008) (en banc).
\textsuperscript{71} Id.
represents the client, but representation does not cease if the client merely returns to work. Therefore, a failure to make such a disclosure may violate Rule 4.1(b) depending on the factfinder.

Second, in at least one state, a lawyer owes a duty to disclose a writing that does not reflect the parties’ agreement that materially alters the agreement without the consent. In Attorney Grievance Commission of Maryland v. Trye, the Court of Appeals of Maryland disbarred an attorney for failing to disclose a writing that did not reflect the parties’ agreement. The attorney in Trye was going through a divorce and child custody proceedings and initially represented herself. Eventually, the attorney and her husband executed an agreement concerning the custody of their minor child. However, she redrafted the agreement prior to presenting it to the court to reflect different custody arrangements without opposing counsel’s or her husband’s consent. The opposing counsel found out about the changes and the attorney who changed the agreement was disbarred.

Third, a lawyer has a duty to disclose clearly applicable insurance coverage. The Nebraska Supreme Court suspended an attorney for his failure to disclose the existence of additional insurance coverage where he knew of the party’s false impression that there was no applicable insurance. In State ex rel. Nebraska Bar Association v. Addison, the attorney negotiated for a release of a hospital’s statutory liens. The hospital clearly did not know about a third insurance policy of $1,000,000 in excess coverage. After negotiating with the offending attorney, the hospital agreed to release the lien to recover less than half of its services based on its limited knowledge that only two policies were implicated in the action.

72. See Att’y Grievance Comm’n of Md. v. Trye, 118 A.3d 980 (Md. 2015) (finding that an attorney acting on her own behalf in divorce and custody proceedings fraudulently altered a negotiated draft settlement agreement and consent order before providing them to the opposing party and counsel for signature).
73. Id.
74. Id. at 993.
75. Id. at 984.
76. Id. at 986.
77. Id.
78. Id. at 993.
79. See State ex rel. Neb. State Bar Ass’n v. Addison, 412 N.W.2d 855, 856 (Neb. 1987) (failing to disclose existence of umbrella policy violates ethics rules); see also Slotkin v. Citizens Cas. Co. of N.Y., 614 F.2d 301 (2d Cir. 1979) (finding a misrepresentation where an attorney stipulated on the record that hospital only had $200,000 of insurance coverage when it actually had an additional $1,000,000 on an excess policy).
80. Addison, 412 N.W.2d at 857.
81. Id. at 586.
82. Id.
83. Id. at 586–87.
court suspended the attorney for failing to disclose the $1,000,000 policy during settlement negotiations because it was material and essential to reaching a desirable settlement.84

Fourth, a duty that rarely arises is the duty to disclose material facts (other than confidential client information) when an attorney knows that an opponent is operating under a mistaken belief that will substantially decrease the benefit or deprive the opponent of the benefit of its bargain.85 But with this last duty, note that a party is not required to rescue the opposing party from merely making a poor bargain.86 For example, in Stare v. Tate, during settlement negotiations between a divorcing husband and wife, the wife’s attorney made an obvious calculation error in a settlement agreement.87 The husband’s attorney took advantage of the miscalculation without informing opposing counsel about the mistake and was subsequently disciplined by the California Court of Appeal when opposing counsel found out.88

There are also several instances where various sources have opined that a lawyer’s failure to disclose does not constitute unethical conduct.89 For instance, a failure to disclose is not unethical conduct when a lawyer knows the opposing party will conduct its own investigation of the facts.90 In Statewide Grievance Commission v. Gillis, after the parties had entered into settlement negotiations, the plaintiff’s attorney’s initial correspondence did not mention a prior accident that occurred earlier in the year.91 However, the final demand letters sent to the opposing parties included reports that suggested that the accident in question was not the plaintiff’s first.92 The Gillis court held that the opposing parties were thereafter on notice of the existence of at least one prior incident and were free to inquire further or conduct their own investigations.93 The court also found that whether disclosure was material and required often depended on the opposing advocate’s reliance and whether the opposing party would conduct an independent investigation of those facts.94

84. Id. at 587.
85. Id.; Stare v. Tate, 98 Cal. Rptr. 264, 266 (Ct. App. 1971).
86. Richmond, supra note 6, at 281–82.
87. Stare, 98 Cal. Rptr. at 266.
88. Id. at 266, 269.
89. Christopher J. Brasco et al., Understanding Ethical Limits on Attorney Behavior in Settlement Negotiations: A Practical Approach, 45 BRIEF 12, 16 (2016).
91. Id. at *2.
92. Id. at *4.
93. Id. at *8.
94. Id. at *13.
The court concluded that because no evidence was provided that the opposing parties relied on the plaintiff’s attorney’s statements and because there was evidence that the opposing party had conducted its own investigation and already knew the opposite was true, there was no violation.95 The court stated, “[t]he Respondent is guilty of imprecision and exaggeration, traits that are not directly addressed by any of the Rules whose violation the petitioner alleges.”96

A failure to disclose an ongoing, ancillary dispute involving one of the parties and a third party regarding the same general subject matter also does not violate Rule 4.1(b).97 In Cedar Island Improvement Association v. Drake,98 a court ruled that an attorney did not violate Rule 4.1 where he did not disclose a lawsuit that occurred concurrently with the present suit but with another party.99 The court found that the ongoing dispute with the third party never arose during conversation between parties and thus no material misrepresentation existed.100

A lawyer’s failure to inform the other party that the statute of limitations has run on the client’s claim similarly does not violate the rule.101 In 1994, the ABA Committee on Ethics and Professional Responsibility concluded that during settlement negotiations, a lawyer has no duty to disclose weaknesses in the opponent’s case, including the expiration of the statute of limitations.102 The committee found that doing so would violate the lawyer’s obligation of diligent representation and possibly attorney-client privilege.103

Finally, a lawyer has no ethical obligation to prevent opposing counsel from relying on faulty information from another source.104 The New York County Lawyer’s Association found that this followed the idea that a lawyer is not required to disclose insurance coverage during a negotiation unless disclosure is required by law.105

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95. Id.
96. Id.
98. Id.
99. Id. at *3.
100. Id.
102. Id.
103. Id.
105. Id.
III. PUNISHING UNETHICAL DECEITFUL CONDUCT

The truth of the matter is that most attorneys expect a little deceit, bluffing, puffery, and embellishment in negotiations. Indeed, it would be difficult to find a lawyer who does not practice such embellishment, at least on occasion. However, if carried too far, deceitful negotiation tactics become unethical and can carry severe consequences if those tactics violate the Model Rules. They may result in settlements being set aside, litigation sanctions, malpractice or fraud suits, and disciplinary actions—even disbarment.

When unethical deceitful negotiations lead to a settlement, the party who later discovers the deceit has two choices: (1) set aside the settlement agreement and start anew or (2) uphold the agreement and file a separate action for fraud. Parties who have already accepted the agreement and received payment tend to choose the second option. Parties who choose to file a separate fraud action, however, are limited to recovering the fair compromise value of the settlement agreement had there been no deception by the opponent or opposing counsel. If a party wants to get the full award of what a jury may have awarded, the best choice is option one—to set aside the settlement agreement and start over.

An example of the court setting aside a settlement agreement took place in Spaulding v. Zimmerman. The plaintiff, a minor at the time, was involved in a severe car accident. The minor sued the driver (the defendant) of the car he was riding in. Both the plaintiff’s and the defendant’s doctors examined the plaintiff during discovery, but only the defendant’s doctor found an aortic aneurysm, which was causally related to the accident. The defendant’s attorney did not reveal to the other side (or even to his own client) that the doctor had discovered an aneurysm. The case settled. Two years later, when the plaintiff sought to join the army and got a physical exam, the aortic aneurysm was discovered and an emergency surgery was performed. The plaintiff thereafter filed a motion to reopen the previous case and set aside the settlement.
The trial court granted the motion and vacated the settlement because the aneurysm was causally related to the accident and the defendant’s counsel had reason to know that the plaintiff would not have agreed to the settlement had he known of it.118 Interestingly, the trial court failed to reprimand the lawyers for their failure to disclose this seemingly material fact. The case occurred before the creation of the Model Rules and there was no ethical obligation to disclose the plaintiff’s life-threatening condition. On appeal, the Minnesota Supreme Court found that the trial court did not abuse its discretion in vacating the settlement and affirmed.119

Notably, the court might have not set aside the settlement had the plaintiff not been a minor. According to the Zimmerman court, a settlement made on behalf of a minor may be vacated where it is shown that the minor sustained separate and distinct injuries, which were unknown or not considered by the court at the time the settlement was approved.120 However, the plaintiff may have still had a malpractice claim against his doctor and attorney for failing to discover the existence of the aortic aneurysm.

Even where the plaintiff is not a minor and there is a settlement on record, courts are more likely to set aside the negotiated instrument if no payment has been made in relation to that settlement.121 In one case settled before Michigan adopted the modern Model Rules, the court in Virzi v. Grand Trunk Warehouse & Cold Storage Co. set aside a judgment.122 In Virzi, the plaintiff died after the mediation occurred and the mediation statement was submitted to the court.123 The death was unrelated to the lawsuit.124 Counsel for the plaintiff found out about his client’s death but said nothing until after the settlement was put on record and counsel for both parties were walking to the elevator after the pretrial conference.125 The court set aside the judgment and held that the plaintiff had an ethical duty to disclose his client’s death because it had “significant bearing on defendants’ willingness to settle.”126 The defense attorney argued he agreed to settlement at least in part because he believed the plaintiff would be a successful witness at trial.127
In *Exotics Hawaii-Kona, Inc. v. E.I. DuPont De Nemours & Co.*, the party chose to affirm the settlement and sue for fraud.\(^{128}\) In *Exotics*, commercial growers settled claims against DuPont for selling fungicide that killed their plants.\(^{129}\) During negotiations, DuPont obtained and withheld scientific test results that could have made the growers’ claims more valuable.\(^{130}\) Instead of rescinding the settlement and attempting to start anew, the growers affirmed the agreement and sued for fraud.\(^{131}\) However, the growers were unable to provide the court with enough evidence to establish their damages in the fraud suit.\(^{132}\) The growers provided expert witnesses but failed to prove that they were damaged by the withholding of the test results.\(^{133}\) That is, the growers failed to prove the amount of money that they would have settled for had the test results been revealed to them during negotiations.\(^{134}\) Because the growers failed to carry their burden of proof, DuPont received summary judgment.\(^{135}\)

As mentioned above, unethical deceitful negotiation tactics also may result in sanctions leveled against the attorney. In *Ausherman*, the case where the court so famously outlined the meaning of Rule 4.1’s “material statements of fact,” the plaintiff’s attorney in a class action found himself facing sanctions from the court.\(^{136}\) In *Ausherman*, the plaintiff’s attorney initiated a class action based on an ambiguous report that the defendant’s bank employee (John Doe #1) sold credit reports through John Doe #2 in a scheme created by John Doe #3.\(^{137}\) The plaintiff’s attorney wrote to the bank with a settlement offer and claimed that he could provide the identity of John Doe #3 once a settlement had been reached.\(^{138}\) The bank declined the offer and discovery proved that the lawyer was lying, but the attorney said the lie was merely “settlement bluster.”\(^{139}\) He asserted that Federal Rule of Evidence 408, which prohibits the use of settlement evidence to prove liability or nonliability to the merits of a claim, protected him from the court’s use of the lie as a reason for monetary sanctions.\(^{140}\) The court held that the statements used by the attorney are admissible to evaluate an attorney’s conduct.\(^{141}\) Ultimately, the *Ausherman*
court referred the attorney’s conduct to the disciplinary committee rather than using it as a reason for imposing monetary sanctions.\textsuperscript{142}

Even if sanctions are not leveled for unethical deceitful conduct, attorneys are often subject to severe punishment by state disciplinary committees. In \textit{In re Nicholson},\textsuperscript{143} the Georgia Supreme Court disbarred an attorney for a Rule 4.1(a) violation (among other rule violations) occurring during negotiations.\textsuperscript{144} In Nicholson, the attorney facing disciplinary action represented a client who had been injured in an auto accident.\textsuperscript{145} The client died after the accident and the attorney was assigned as the temporary administrator of the deceased’s estate.\textsuperscript{146} On behalf of the client and his estate, the attorney asserted claims for injuries the client sustained and negotiated a settlement with two insurance companies.\textsuperscript{147} In order to facilitate the settlement, the attorney represented to the insurance companies by affidavit that all medical bills arising from the accident had been paid in full.\textsuperscript{148} In fact, the client’s attorney knew that the medical facility where the client was hospitalized had not been paid in full and had filed a statutory lien in the amount of $11,734 for medical services provided to the client.\textsuperscript{149} But the attorney’s misrepresentation induced the insurance companies to pay the settlement funds to the attorney on behalf of the estate and the attorney did not use the settlement funds to satisfy the hospital lien.\textsuperscript{150} The hospital sued the insurers, who impleaded the attorney, and a judgment was entered against the attorney for the full amount of the lien plus attorney fees.\textsuperscript{151}

The Nicholson court found that the attorney signed a false affidavit to induce settlement negotiations upon which the insurance companies reasonably relied and that he did so intentionally and to the detriment of others.\textsuperscript{152} Citing Rule 8.4(c), which encompasses Rule 4.1, the Georgia Supreme Court stated that it has “little tolerance for a lawyer who . . . engages in conduct involving dishonesty, fraud, deceit, or misrepresentation.”\textsuperscript{153} In fact, the court had so little tolerance for the attorney’s unethical deceitful negotiation tactics (as well as some other reprehensible conduct) that the attorney was disbarred.\textsuperscript{154}

\textsuperscript{142} Id. at 445.
\textsuperscript{143} In re Nicholson, 791 S.E.2d 776 (Ga. 2016).
\textsuperscript{144} Id. at 779.
\textsuperscript{145} Id. at 777.
\textsuperscript{146} Id.
\textsuperscript{147} Id.
\textsuperscript{148} Id.
\textsuperscript{149} Id.
\textsuperscript{150} Id.
\textsuperscript{151} Id.
\textsuperscript{152} Id. at 778–79.
\textsuperscript{153} Id. at 779 (quoting In re Friedman, 505 S.E.2d 727, 728 (Ga. 1998)).
\textsuperscript{154} Id.
Although there are many ins and outs of ethical negotiation practice, attorneys need not despair. Generally, as long as lawyers do what is right and try their best to follow the Rules as proscribed by the ABA, they will probably be fine. The issue of questionable ethics in negotiations will more often arise when attorneys do not know the rules or are tempted to do what they know to be inherently wrong.

In sum, lawyers can be guided by the following takeaway points:

- **Express and Implied Misrepresentations**—In negotiations, lawyers should not knowingly make material misrepresentations or knowingly fail to disclose a material fact or law.

- **Bottom Line**—According to ABA opinions, attorneys may violate the prohibition against material misrepresentations if they misrepresent their settlement authority or the client’s bottom line, but states may view such misrepresentations as mere puffery because materiality is decided on a case-by-case basis.

- **Generally No Affirmative Duty**—There is generally no affirmative duty to inform opposing counsel of relevant facts, unless the fact is material. Examples of material facts that may give rise to an affirmative duty to disclose include a client’s death, change in a client’s work status in a workers’ compensation case, applicable insurance coverage, a writing that does not conform to the parties’ agreement, or if opposing counsel is operating under a mistaken belief that will deprive his or her client of the benefit of the bargain if left uncorrected.

- **Penalties**—An attorney who violates Rule 4.1 by either express material misrepresentations or a failure to disclose material facts or law may face such penalties as settlements being set aside, litigation sanctions, malpractice/fraud suits, and disciplinary actions—even disbarment.
CRACKING THE MEDICARE SECONDARY PAYER ENIGMA CODE

Barron F. Dickinson

INTRODUCTION

“Picture a law written by James Joyce and edited by E.E. Cummings, such is the Medicare statute, which has been described [by judges] as ‘among

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the most completely impenetrable texts within human experience." Similarly, personal injury attorneys often find themselves engaging in a form of cryptanalysis when representing a client who is a Medicare beneficiary. This is because the Medicare Secondary Payer Recovery (MSPR) process suffers from imprecisely written rules and regulations, thereby placing an attorney in a situation similar to Alan Turing attempting to break the Enigma code without the bombe during World War II. The problem affects nearly all tort-related cases involving elderly clients because even if the attorney is reasonably certain that Medicare has not paid any portion of the client’s medical bills, the firm must nevertheless obtain confirmation from Medicare or risk liability for legal malpractice. As a result, lawsuits are unnecessarily dragged out and potential settlements are inevitably discouraged, much to the collective dismay of beneficiaries and their attorneys. Indeed, a University of Pennsylvania study found that the MSPR process delayed settlements in cases involving automobile accidents by an average of six months. The inefficiencies of the MSPR process hurt not only beneficiaries, but the overall financial health of Medicare as well.

Such inefficiencies are plainly unacceptable given the fact that under the current scheduled financing structure, the Medicare program is incontrovertibly unsustainable. Though the rate of general health care and Medicare-related spending has slowed considerably, “changing demographics, the aging of the baby boom generation, the growth in chronic illness, advances in medical technology and other factors will challenge the ability to achieve a sustainable level of health care spending.” According to the Board of Trustees of the Federal Hospital Insurance and Fed-

1. Catholic Health Initiatives Iowa Corp. v. Sebelius, 718 F.3d 914 (D.C. Cir. 2013) (quoting Rehab. Ass’n of Va., Inc. v. Kozlowski, 42 F.3d 1444 (4th Cir. 1994)).
2. See Andrew Hodges, ALAN TURING: THE ENIGMA 166, 179 (2012). Alan Turing was a British mathematician, who was largely responsible for breaking the code used by the German “Enigma” machine to send messages to Nazi troops during World War II. The bombe was an electromechanical device used to help decipher German encrypted secret messages. See Andrew Hodges, ALAN TURING—a short biography, ALAN TURING: THE ENIGMA, http://www.turing.org.uk/publications/dnb.html.
eral Supplementary Medical Insurance Trust Funds, the Medicare Trust Funds will be depleted by 2030. As it stands, Medicare’s fiscal outlook for future generations seems dire, giving rise to the age-old question of “what happens when an unstoppable force meets an immoveable object?” In the United States, as well as around the world, people are simply living longer. According to recent report from the Centers for Disease Control and Prevention, the average life expectancy for a U.S. citizen is 78.8 years. This represents a 9.1-year increase from the average life expectancy in 1960. However, while people may be living longer, studies have shown that the collective population suffers from a higher incidence of multiple chronic diseases and comorbidities. Further, as Medicare beneficiaries grow older, their complexity of care and associated costs exhibit an upward trend in terms of per capita expenditures. In addition, as the baby boom generation begins to become eligible for Medicare, program costs are expected to spike significantly. This is because the number of Medicare enrollees is projected to increase from 54 million participants to over 80 million by 2030. Substantive reform or a considerable infusion of funds seems inevitable. Proposals addressing these issues range

from increasing the age of eligibility to changing the investment procedures of the Trust Funds. While the best approach has yet to be decided upon, one aspect of the issue is clear: the MSPR process must be operated as efficiently as possible.

This paper makes several arguments: (1) attorneys must be aware of the Medicare Secondary Payer (MSP) laws to provide ethical and competent representation of Medicare beneficiaries; (2) Congress must pass additional MSP legislation that is designed to further accelerate the Medicare Secondary Payer Recovery (MSPR) process, given the financial health of the Medicare program; (3) Congress should also enact legislation mandating the development of a process pertaining to the submission, review, and approval of proposed liability medical set aside arrangements (LMSA); and (4) Attorneys must keep abreast of emerging MSP compliance tools because they both reduce the amount of exposure to all parties involved as well as help facilitate a successful conclusion to the client’s case.

Part I provides a general overview and history of the Medicare program. Part II describes the evolution of the MSP program and examines the different pieces of legislation that collectively represent the modern MSP laws. Part III discusses several specific criticisms of the MSPR process as well as Medicare’s responses to those criticisms. Part IV provides a step-by-step description of the current MSPR process. Part V examines the lack of regulatory guidance regarding the use of LMSAs in cases where the beneficiary will most likely require future medical treatment relating to the injuries sustained during the incident underlying the litigation. Part VI argues that significant improvements to the MSPR process are necessary and proposes several specific enhancements that could be implemented. Part VII concludes by explaining the importance of why the MSP laws must be understood by attorneys and provides useful attorney practice pointers on how to reduce one’s liability exposure.

I. OVERVIEW AND HISTORY OF THE MEDICARE PROGRAM

In July 1965, with former President Harry Truman at his side, President Lyndon B. Johnson signed the Medicare bill into law. As part of the Social Security Amendments of 1965, Title XVIII of the Social Security Act

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established the Medicare program in an effort to provide the elderly and disabled population of the United States with health insurance coverage.\textsuperscript{18} Prior to 1977, the Social Security Administration (SSA) was responsible for managing the Medicare program.\textsuperscript{19} The SSA then passed on the task to a newly formed agency called the Health Care Financing Administration, which was eventually renamed as the Centers for Medicare & Medicare Services (CMS) in 2001.\textsuperscript{20} Today, CMS administers all facets of the Medicare program and has ten regional offices throughout the United States.\textsuperscript{21}

Within CMS, the Coordination of Benefits and Recovery (COBR) program is responsible for determining the specific health benefits a beneficiary is entitled to, supervising the payment process and, most importantly, deciding whether a primary insurer exists.\textsuperscript{22} In February 2014, CMS created a branch called the Benefits Coordination & Recovery Center (BCRC) for the purpose of improving customer service and consolidating and expediting data collection and recovery operations.\textsuperscript{23} The BCRC and the Commercial Repayment Center both fall under the umbrella of the COBR program.\textsuperscript{24} In addition, CMS allocated the Coordination of Benefits Contractor responsibilities and MSPR Contractor operations to the BCRC.\textsuperscript{25} Knowledge of the transition is important because

\begin{footnotesize}
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\item[	extsuperscript{19}]. Id. at 3.
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the BCRC is the entity that attorneys primarily work with when representing Medicare beneficiaries.

The Medicare program is funded by two trust funds: (1) the Hospital Insurance (HI) trust fund; and (2) the Supplemental Medicare Insurance (SMI) trust fund. The HI trust fund derives the majority of its capital from a mandatory payroll tax. Alternatively, the SMI trust fund is primarily financed by contributions from the general fund of the U.S. Treasury.

The modern Medicare program has four parts: (1) Part A pertains to hospital insurance; (2) Part B covers medical insurance; (3) Part C addresses Medicare Advantage Plans; and (4) Part D adds prescription drug coverage for Part A and Part B insurance plans. Generally, to be eligible for Medicare coverage, an individual must be at least sixty-five years old and a citizen or permanent resident of the United States.

To receive Part A and Part B coverage, an individual must have paid federal insurance contribution (FICA) taxes for forty quarters of coverage, which is equal to about ten years of work. If an individual has worked fewer than forty quarters, then he or she will usually have to pay a premium. Part A is available premium-free if: (1) the beneficiary receives retirement benefits from Social Security or the Railroad Retirement Board; (2) the beneficiary is eligible to get Social Security or Railroad benefits but has not filed for them, or (3) the beneficiary or his or her spouse had Medicare-covered government employment. Beneficiaries pay a monthly premium for Part B that usually is deducted from the

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monthly Social Security payment. The premium amount depends on the beneficiary’s income the previous year. A Medicare Supplement Insurance (Medigap) policy, sold by private companies, helps pay some of the health care costs that Parts A and B do not cover, such copayments, coinsurance, and deductibles.

II. MEDICARE SECONDARY PAYER ACT OF 1980

Following Medicare’s enactment in 1965, the program’s costs began to grow at an alarming rate, which considerably outpaced Congress’s forecasts and estimations. In an effort to reduce the program’s annual costs, Congress passed the Medicare Secondary Payer Act (MSPA) as part of the Omnibus Reconciliation Act of 1980. Codified as 42 U.S.C. § 1395y, the Act amends the Social Security Act to render Medicare the secondary payer in cases where a primary plan exists. Medicare is prohibited by statute from paying for a beneficiary’s medical services in situations where payment has been previously paid or there is a reasonable expectation of payment by a primary plan. Thus, Medicare becomes secondary to the primary plan and is supposed to make payments only when the primary plan is completely exhausted. Pursuant to the MSPA, Medicare considers group health, workers’ compensation, liability insur-

35. Id.
39. Stalley, 517 F.3d at 915.
41. See id. at 1.
42. A group health plan is an insurance policy offered by an employer to a group of its employees and may offer coverage for employees’ dependents as well. See Health Plans & Benefits, U.S. Dep’t of Labor, http://www.dol.gov/dol/topic/health-plans/ (last visited on Nov. 30, 2015).
43. A worker’s compensation plan provides compensation to an injured employee when he or she suffers an accident or work-related injury or illness. See CMS, MEDICARE & OTHER HEALTH BENEFITS: YOUR GUIDE TO WHO PAYS FIRST 14 (Aug. 2015), https://www.medicare.gov/Pubs/pdf/02179.pdf.
ance,\textsuperscript{44} and no-fault insurance plans\textsuperscript{45} as primary plans.\textsuperscript{46} While the Act’s language is clear regarding payment where a primary plan exists, Medicare will nevertheless cover the costs of a beneficiary’s medical services in certain situations.\textsuperscript{47} For example, primary insurance carriers often contest a beneficiary’s claim when a lawsuit is filed.\textsuperscript{48} Because the primary insurance carrier usually denies liability, the beneficiary’s medical costs go unpaid.\textsuperscript{49} Thus, Medicare may issue conditional payments on the beneficiary’s behalf if the primary payer cannot be reasonably expected to provide payment within 120 days.\textsuperscript{50} These payments are considered conditional because they are predicated upon Medicare’s expectation of eventual reimbursement.\textsuperscript{51} An argument could be made that Medicare, by making such payment, is improperly risking non-payment given the program’s precarious financial position, the performance value of conditional payments is extremely important because it ensures that beneficiaries will receive access to the treatment they require.\textsuperscript{52}

Additionally, Medicare’s right of recovery of any conditional payments made on a beneficiary’s behalf is triggered upon its receiving notice that payment to the beneficiary has been made or could be made by a primary plan.\textsuperscript{53} If a primary plan fails to adequately reimburse Medicare, the government may bring suit in an enforcement hearing against the responsible primary plan, seeking double damages or twice the amount of the total

\textsuperscript{44} Liability insurance is typical in automobile accident cases where the injured party files a claim against the responsible party. See Liability, No-Fault and Workers’ Compensation Reporting, CMS, https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Liability-No-Fault-and-Workers-Compensation-Reporting/Liability-No-Fault-and-Workers-Compensation-Reporting.html (last accessed on Nov. 30, 2015). Traditional corporate insurance companies, such as State Farm, etc., usually offer these types of policies.

\textsuperscript{45} No-fault insurance provides compensation to a policyholder for health care services and costs resulting from an accident regardless of which party is at fault. See id.


\textsuperscript{49} See id.


\textsuperscript{53} See 42 U.S.C. § 1395y(b)(7)–(8).
conditional payments plus interest. This provision can cause problems for insurance companies because Medicare may still seek reimbursement regardless of whether payment was already transmitted to the plaintiff beneficiary. Another source of frustration for primary payers is the fact that Medicare does not consider itself bound by a release or indemnification agreement signed between the parties because it is not a party to the underlying action.

In the situation where a primary payer fails to repay Medicare for making conditional payments, the government has “a right to subrogation to step in and assume the Medicare beneficiary’s right for payment of medical bills that should have been paid by the primary payer.” Subrogation is the process of substituting a party for another party with regard to a legal claim or right. Because no contract exists between the parties, subrogation is considered an equitable remedy based upon the principle of unjust enrichment or that a party should not benefit from another’s loss. Used in this context, Medicare’s right to subrogation typically occurs where the primary insurance policyholder fails to reimburse Medicare after demonstration of the policyholder’s liability.

A. Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Although the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is primarily recognized for creating Part D of the Medicare program, the MMA also considerably expanded the scope of the MSPA. Specifically, Congress intended to address several adverse decisions handed down by several courts regarding the definition of a primary plan as well as clarify issues pertaining to the MSPR process. For example, although the original text of the MSPA specifically included self-insured insurance plans under the definition of a “primary plan,” multiple courts held that Medicare could not seek reimbursement

61. See id. at 16–17.
from an uninsured defendant who lacked formal insurance coverage. In response, Congress amended the MSPA by inserting the following language: “an entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.” As a result, defendants lacking formalized insurance could no longer use the absence of an existing insurance policy as a defense to Medicare’s right to reimbursement.

Congress also closed some important loopholes in the recovery process. First, Congress extended Medicare’s right to reimbursement to any entity that has received payment from a primary plan. Thus, where the parties reach a settlement in the underlying case, the payment to the beneficiary and his or her attorney renders them both potentially liable under the MSPA. Since Medicare is entitled to collect double damages, this addition has justifiably been of some concern to plaintiffs’ attorneys. In United States v. Harris, the plaintiff’s attorney was held liable to Medicare for over $11,000 because he failed to reimburse Medicare after securing a settlement for his client. Second, the MMA clarified that the duty to recompense Medicare occurs only when it is demonstrated that the primary plan bears legal responsibility to do so. Specifically, the MMA states that such responsibility is established when a settlement, judgment, or payment is made by the primary plan. Lastly, it is important to note that Medicare’s right of recovery does not require a finding or admission of liability. As a practical matter, the amendments

62. See Thompson v. Goetzmann, 315 F.3d 457, 462 (5th Cir. 2002) (“an alleged tortfeasor who settles with a plaintiff is not, ipso facto, a ‘self-insurer’ under the MSP statute”), reh’g, 337 F.3d 489 (2003); see also United States v. Baxter Int’l, Inc., 345 F.3d 866 (11th Cir. 2003); Mason v. Am. Tobacco Co., 346 F.3d 36 (2nd Cir. 2003).
65. See Franco & Signor, supra note 60.
71. See Glover v. Liggett Grp., Inc., 459 F.3d 1304 (8th Cir. 2006).
enacted by the MMA effectively “eliminated tort defenses as a barrier to Medicare reimbursement.”

B. Medicare, Medicaid, and SCHIP Extension Act of 2007

In an effort to increase Medicare’s ability to identify claimants who are also beneficiaries, Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). Section 111 does not alter or eliminate any existing statutory provisions, regulations, or processes, but instead mandates required reporting entities (RREs) to determine whether the injured party is a Medicare beneficiary. In effect, Medicare was able to outsource the process of identifying potential claims. Required reporting entities include liability, self, no-fault, and workers’ compensation insurance plans, also known as non-group health plans (NGHPs). Upon concluding that the insurance plan is subject to the MMSEA’s requirements, the RRE should register on COB’s Section 111 website. To aid potential RREs in making this determination, CMS has published two separate user guides to help both non-group and group health plans understand their individual reporting requirements. For example, RREs that carry a group health plan are required to submit employee and dependent entitlement information to CMS on a quarterly basis. Alternatively, RREs for non-group health plans must contact CMS if an injured employee or dependent requires medical treatment. However, prior to submitting a claim, NGHP required reporting entities may submit a query containing the injured party’s personal information to CMS to determine whether he or she is eligible for Medicare. If CMS finds that the claimant is a Medicare beneficiary, the RRE must provide infor-
tion relating to the claimant’s medical treatment, as well as any settlement, judgment, award, or other payment pertaining to the underlying suit.81 Should an RRE fail to report the required information to CMS, the consequences could be significant. RREs that fail to comply or report late may be fined up to $1,000 per day per individual.82

Although the MMSEA arguably improved Medicare’s ability to identify collectable funds, it also had an unintended chilling effect on the MSP settlement process.83 Due to the high penalty amounts Medicare may seek for failures to report, defendant insurance companies are usually overly cautious in reporting claim information.84 This can cause a delay in settlements for two reasons.85 First, the defendant’s insurance company will usually require the plaintiff to execute a release containing an indemnification clause that purports to absolve the company of any further liability arising from the claim.86 The language of the release is commonly a point of contention between the parties, often resulting in an extension of the settlement proceedings.87 Second, defendants sometimes improperly report inaccurate International Classification of Diseases (ICD) medical diagnosis code information concerning the injured party’s pre-existing or unrelated medical conditions to CMS.88 As a result, Medicare will conclude that the settlement compensated the beneficiary for all of the ICD-9 conditions reported by the defendant.89 This is important because should the beneficiary seek treatment for an unrelated condition in the future, Medicare may deny coverage.90 This may also occur if a defendant RRE provides insufficient settlement details to CMS because CMS will canvas the beneficiary’s entire medical history, using its discretion to determine which injuries are related to the accident or injury.91 These types

81. See id. at 3.
83. See Bradley v. Sebelius, 621 F.3d 1330 (11th Cir. 2010).
85. See Kuchel, supra note 55.
88. See id. at 40.
89. Id. at 25.
90. Id. at 5.
of situations demonstrate why it is crucial for the parties’ attorneys to work together throughout the entire settlement process.

C. **Strengthening Medicare and Repaying Taxpayers Act of 2012**

The Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act) represents Congress’s most substantive MSP reform effort. It was designed to streamline the MSPR process, while simultaneously preserving CMS’s control over the administration of the Medicare reimbursement program.\(^{92}\) Prior to the enactment of the SMART Act, CMS was experiencing numerous administrative issues stemming from inefficient rules and statutory obligations.\(^{93}\) Specifically, the resolution of MSP claims was a time-consuming and unpredictable process.\(^{94}\) Medicare beneficiaries were prevented from settling their claims within a reasonable amount of time because CMS was not required by law to notify parties of the total amount owed to Medicare.\(^{95}\) In addition, CMS inexplicably pursued all claims regardless of the amount owed, including cases where the cost of collection was outweighed by the amount ultimately recouped.\(^{96}\) As a result, many settlements fell through, beneficiaries failed to receive compensation for their injuries, and the Medicare Trust Funds never received reimbursement.\(^{97}\) The majority of attorneys, beneficiaries, and related parties felt it was “outrageous that seniors can’t even give money back to Medicare that the government is owed because the system is broken down.”\(^{98}\)

As a direct result, the purpose of the SMART Act was to ensure that CMS makes financially sound decisions in the quickest and most efficient manner possible.\(^{99}\) In furtherance of this objective, Congress directed CMS to promulgate rules that would improve the administration and efficiency of the MSPR system as well as accelerate reimbursement payments to the Medicare Trust Funds.\(^{100}\) Title II of the Act, entitled Strengthening Medicare Secondary Payer Rules, includes five sections that are designed to minimize waste of government resources and to pro-

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94. See id. at 6.
95. Id.
97. Id.
98. Id.
100. See id.
vide clarity to certain functional aspects of the MSPR system.\textsuperscript{101} Of the five, two sections are of particular importance to Medicare beneficiaries and their attorneys.

First, Section 201 charged CMS with creating and maintaining a website that would allow Medicare beneficiaries and their authorized users to access and manage their recovery cases.\textsuperscript{102} In addition, Section 201 contained eight subsections that implemented new procedures in regards to obtaining the total conditional payment reimbursement amount owed to Medicare.\textsuperscript{103} Although CMS had previously launched the Medicare Secondary Payer Recovery Portal (MSPRP) in July 2012, the website lacked functionality, thereby rendering it minimally useful at best.\textsuperscript{104} However, one of the clear benefits of the web portal is that attorneys are given the ability to access the details of their client’s claims much more quickly.\textsuperscript{105} These include dates of service, provider names, diagnosis codes, and conditional payment amounts.\textsuperscript{106} Finally and most important, the portal allows beneficiaries to submit required documentation and dispute unrelated posted costs electronically.\textsuperscript{107} Previously, claimants were required to submit physical copies of all documents and written correspondence, resulting in weeks or even months to receive a response from CMS. By submitting information electronically, beneficiaries now receive claims updates within a number of days and have the ability to view case details in real time.\textsuperscript{108}

Second, Section 202 requires CMS to publish an annual settlement threshold, which indicates the qualifying amount for whether a party is exempt from complying with the MSP laws, prior to November 15 of each year.\textsuperscript{109} The designated settlement amount represents the estimated cost of collection that would be incurred by CMS if reimbursement were pursued.\textsuperscript{110} In making this determination, CMS considers a vast amount of


\textsuperscript{107} Id. at 2-1.

\textsuperscript{108} See Benefits of Using the MSPRP, supra note 105, at 6.


data, including the annual outlay paid to the BCRC, the average final amount demanded in cases, and the average reduction applied for procurement. In practice, the minimum threshold ensures that CMS seeks reimbursement only in cases where it is economically beneficial to do so. In October 2014, CMS set the threshold for the fiscal year of 2015 at $1,000. For 2016, the threshold amount was once again $1,000.

III. RECENT CMS MSPRP UPDATES

One of the biggest criticisms of the MSPRP was the disparate treatment of beneficiaries and their attorneys. Specifically, beneficiaries could access all of the details related to their claims, yet their attorneys could not due to privacy and fraud concerns raised by CMS. Thus, even if attorneys completed the proper registration requirements and submitted the necessary client authorizations, CMS granted only frustratingly limited access to their client’s conditional payment information. This is no longer the case because CMS introduced Remote Identity Proofing (RIDP) and Multi-Factor Authentication (MFA) services to the MSPRP in July 2015. RIDP is the procedure by which CMS verifies and confirms the identity of the user seeking access to the beneficiary’s confidential information. Alternatively, MFA requires a user to successfully pass two or more authentication tests before gaining access to the information sought. While on its face this process may seem cumbersome, verified users enjoy the benefits of viewing “unmasked data,” which includes all of the

111. See id.
112. See id. at 1.
114. MSPRP USER GUIDE, supra note 106, at 2.
116. Id.
117. Id.
120. Id. at 3.
claim information in CMS’s possession. Therefore, the beneficiary’s attorney is able to resolve any existing liens with an increased level of precision and accuracy.

Another major criticism of CMS’s administration was its alleged reluctance to promulgate rules that enabled attorneys to obtain the exact amount of the final conditional payment amount (FCPA) prior to issuing a notice of settlement. The problem would arise where attorneys had to negotiate a settlement based upon a FCPA that may have been inaccurate at the time. On January 1, 2016, the MSPRP was updated to include new functionality that “will permit authorized MSPRP users to notify CMS that a recovery case is 120 days (or less) from an anticipated settlement and request that the recovery case be a part of the Final CP process.” Authorized users will also be able to request a FCPA through the portal, which may be relied upon as long as: (1) the case is settled within three days of making the request, and (2) the settlement details are submitted through the portal within thirty days of the date of the original request. The importance of this new functionality cannot be overstated because it allows attorneys to obtain the FCPA prior to entering into settlement negotiations with opposing counsel.

IV. NEGOTIATING THE MODERN MEDICARE SECONDARY PAYER RECOVERY PROCESS

The first step in every personal injury case is to determine whether the client is eligible for Medicare. If the client is at least sixty-five and has paid the requisite FICA taxes, there is a reasonable probability that Medicare provides coverage. Thus, the beneficiary’s attorney must contact the BCRC to notify Medicare, either by phone or letter, of the

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121. CMS, Multi-Factor Authentication Process, supra note 118.
122. Foley Letter, supra note 115.
123. See id.
125. Id.
126. See Linda Magruder & David Piatt, Relief from the Medicare Secondary Payer Headache the Smart Act Improves the Medicare Secondary Payer Process in Many Ways, but It Contains Some Limitations, TRIAL, Sept. 2013, at 40, 42.
pending claim against the defendant’s liability insurance company. The initial interaction, the BCRC will ask the attorney to submit information about the beneficiary, the case, and his or her representative. The beneficiary information requested includes the beneficiary’s personal information as well as his or her Medicare Health Insurance Claim Number (HICN). The relevant case information includes the date and description of the beneficiary’s accident and injury, the type of claim, and the insurer’s contact information. Finally, the beneficiary’s attorney’s contact information will suffice as the requisite representative information. The BCRC will then input this information into its system and will also begin to conduct its own investigation to determine whether another insurance company is primary to Medicare. Once it has been confirmed that a primary payer exists, the BCRC will create an “occurrence” in its system, signifying that the primary insurance company rather than Medicare should have paid the beneficiary’s bills. After a MSP occurrence is created, the beneficiary’s attorney should submit or upload a proof of representation authorization (POR) and a copy of the retainer agreement with the beneficiary as soon as possible because CMS may take up to forty-five days to review such documentation. The POR communicates to CMS that the beneficiary has authorized the attorney to represent his or her interests with respect to the underlying case, and once verified, the attorney will be able to obtain and receive important case information. Next, the BCRC will issue a Rights and Responsibilities (RAR) letter to all parties involved in the claim. A RAR letter contains information explaining the MSP recovery

129. Id.
130. Id.
131. Id. A HICN number is used by Medicare to identify beneficiaries receiving healthcare treatment; it is used to fulfill its responsibility to pay for healthcare costs and to administer the Medicare program. See CMS, Collection of Medicare HICNs, SSNs and EINs–ALERT (Apr. 6, 2010), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedCollectionSSNEINSpdf.
133. See id.
134. See MEDICARE & YOU, supra note 33.
137. See id.
process and is accompanied by a correspondence coversheet,\textsuperscript{139} an RAR brochure,\textsuperscript{140} and a Privacy Act enclosure.\textsuperscript{141} Most importantly, the RAR letter contains the beneficiary’s case ID, which is a fifteen-digit number that may be used to access important case information on the MSPRP.\textsuperscript{142} The transmittal of the RAR letter also commences the sixty-five day period after which CMS must issue the initial Conditional Payment Letter (CPL).\textsuperscript{143} During this period, CMS begins to compile all of the beneficiary’s health care costs related to the case paid by Medicare.\textsuperscript{144} The CPL contains CMS’s findings, including a detailed description of the various conditional payments made by Medicare and the total Current Conditional Payment Amount (CCPA), which represents the amount that must be ultimately repaid to Medicare.\textsuperscript{145} The CCPA is simply an interim amount that is posted on the MSPRP website and is subject to adjustment because CMS may continue to make conditional payments on the beneficiary’s behalf if he or she requires additional care prior to the lawsuit’s settlement.\textsuperscript{146} The CCPA is often mischaracterized as a lien; the correct term is a “recovery claim” because Medicare’s right to recovery allows it to seek reimbursement from several interested parties.\textsuperscript{147}

Next, not more than 120 days prior to an anticipated settlement, the beneficiary’s attorney must provide notification to Medicare through the MSPRP of the possibility of such a settlement.\textsuperscript{148} Within this time period, the beneficiary’s attorney should also dispute any claims that are unrelated to the case that have been included in the CCPA.\textsuperscript{149} The MSPRP allows the beneficiary’s attorney to select the unrelated claims from the claims listing page, provide a written explanation for the contention, and submit the dispute.


\textsuperscript{141} See CMS, \textit{supra} note 172 \textit{(AU: should refer to Privacy Act)}

\textsuperscript{142} See \textit{id}.


\textsuperscript{144} See \textit{id}.


\textsuperscript{146} See \textit{id}.


\textsuperscript{148} See \textit{Medicare’s Recovery Process}, \textit{supra} note 143.

\textsuperscript{149} \textit{Id}. 
and upload supporting documentation for the dispute.\textsuperscript{150} Pursuant to the SMART Act, CMS has eleven days to respond to the claims dispute.\textsuperscript{151} If CMS agrees with the dispute, an updated CPL will be sent to all parties and the disputed claims will be removed from the claims listing page.\textsuperscript{152} If CMS disagrees, the beneficiary may further challenge the determination through a multi-level appeal process, which includes opportunities for both administrative and judicial review.\textsuperscript{153}

Should the beneficiary’s attorney decline to dispute any included claims, the attorney’s focus should shift to obtaining a final conditional payment amount (FCPA).\textsuperscript{154} At least eight business days prior to an anticipated settlement, the beneficiary’s attorney should request a “claims refresh” through the MSPRP, which essentially gives CMS the opportunity to ensure that all claims related the beneficiary’s case are up to date.\textsuperscript{155} CMS then has five days to provide the beneficiary with a confirmation of a completed claims refresh.\textsuperscript{156} After receiving this confirmation, the beneficiary’s attorney should download a time-and date-stamped FCPA through the MSPRP.\textsuperscript{157} As long as the case settles within three days of the download date, the attorney may rely upon this amount as representing the total amount owed to Medicare, even if certain related claims were failed to be included.\textsuperscript{158} Within thirty days of the settlement date, the beneficiary’s attorney must enter a Notice of Settlement (NOS) through the MSPRP.\textsuperscript{159} The NOS requires the submission of certain settlement details as well as an upload of supporting documentation.\textsuperscript{160} CMS then has twenty days to review the settlement information before issuing its final demand letter, which represents the total amount owed to Medicare to resolve the case.\textsuperscript{161}

In determining the final demand amount owed, CMS will reduce the FCPA based upon a federally approved pro-rata formula.\textsuperscript{162} For example,


\textsuperscript{152} See Disputing a Claim, supra note 150.

\textsuperscript{153} See id.; 42 C.F.R. 405.947.

\textsuperscript{154} Medicare’s Recovery Process, supra note 143.

\textsuperscript{155} See id.

\textsuperscript{156} Id.

\textsuperscript{157} Coordination of Benefits & Recovery, supra note 124.


\textsuperscript{160} Id.

\textsuperscript{161} Id.

\textsuperscript{162} See 42 C.F.R. § 411.37.
if the FCPA is less than the settlement amount, then CMS will calculate a pro-rata reduction based upon Medicare’s share of the procurement costs. First, CMS will determine the total amount of procurement costs, which is based upon the attorney’s fee contract. Second, CMS must calculate the ratio of the procurement costs to the gross recovery. Third, CMS will calculate Medicare’s share of the procurement costs by multiplying the procurement ratio times the FCPA. Finally, CMS’s share of the procurement costs is subtracted from the FCPA to reach final demand amount owed to Medicare.

The attorney has sixty days after the issuance of the final demand letter to provide full repayment to Medicare. If full repayment is not delivered within this time period, interest begins to accrue and is assessed from the date of demand. Further, if CMS does not receive full repayment within 120 days, then CMS will issue an “Intent to Refer Letter,” which constitutes a threat to refer the unresolved debt to the Department of Treasury for collection proceedings.

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V. LIABILITY MEDICARE SET ASIDES

Although the client’s corresponding Medicare lien may have been successfully satisfied, the remainder of the settlement proceeds should not be disbursed until the attorney can determine whether the client will require future medical treatment directly related to the injuries underlying the litigation. Unfortunately, both Congress and CMS have failed to provide substantive guidance on the subject. CMS has interpreted the statutory language of § 1395y(b)(2)(A) to imply that Medicare’s future interest must be protected where a settlement is reached in a general liability case involving a Medicare beneficiary. CMS has deemed the medical set-aside arrangement as the instrument that “provides the best protection for the program and the Medicare beneficiary.” A set-aside is “a finan-

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163. 42 C.F.R. § 411.37.
164. 42 C.F.R. § 411.37.
165. 42 C.F.R. § 411.37.
166. 42 C.F.R. § 411.37.
167. 42 C.F.R. § 411.37.
169. See id. at 2.
170. Id. at 6. CMS will refer all debts greater than $25 to the Department of Treasury. Id. at 2.
172. Id.
cial agreement that allocates a portion of a [beneficiary’s] settlement to pay for future medical services related to the [beneficiary’s] injury, illness, or disease.” Further, CMS is of the opinion that a beneficiary must set aside a certain portion of the liability settlement to ensure that Medicare does not have to begin paying for costs related to the beneficiary’s injury until the set aside has been depleted.

How much of the settlement must be set aside for CMS to consider Medicare’s interests sufficiently protected? There are currently no rules or regulations in place that address this issue; however, CMS has carved out a single exception when a Liability Medicare Set-aside Arrangement (LMSA) is not necessary. In September 2011, CMS released a memorandum stating that where the Medicare beneficiary’s treating physician certifies in a written letter that the beneficiary will not require future medical care for the injuries suffered as a result of the underlying incident, Medicare will consider its interests satisfied. However, obtaining such a letter is often difficult because most injured beneficiaries will require further treatment.

CMS has also released several informal documents that have proven somewhat useful. For example, the CMS Office of Financial Management periodically conducts town hall teleconference events that address the general public’s policy and procedural questions regarding various provisions of the MSPA. During a teleconference in March 2010, CMS took the following positions in regards to LMSAs: (1) regional offices are under no legal obligation to review LMSAs, and (2) numerous CMS regional offices will not provide an approval letter regardless of the sufficiency of the LMSA. Although some attorneys have taken the position that a LMSA is never required given the lack of binding statutory authority passed by CMS, if there is a reasonable probability that the client will require future medical care directly related to the injury underlying the litigation, the beneficiary’s attorney should create a LMSA.

Since it is still unclear when CMS will formally release new regulations addressing LMSAs, attorneys should place the utmost importance upon fulfilling their duties required by the Model Rules of Professional Conduct.\(^\text{177}\) Attorneys have an ethical responsibility to understand the Medicare statutes and their legal effects when representing a Medicare beneficiary.\(^\text{178}\) As long as the attorney sets aside a reasonable amount of funds in proportion to the client’s injuries, it is highly unlikely that the attorney or beneficiary could be held liable for performing an inadequate LMSA, given the lack of statutory guidance available.\(^\text{179}\) Conversely, in cases where an attorney elects not to perform a set-aside, Medicare may refuse to pay future benefits to the client until the settlement is considered exhausted.\(^\text{180}\) In such a case, the client may have a cause of action against the attorney based upon a lack of advisement as to the consequences of disbursing the entire proceeds of the settlement.\(^\text{181}\)

### VI. PROPOSALS FOR IMPROVING THE MSP STRUCTURE

Although Congress and CMS have made significant improvements to the MSPR process over the last three decades, several key challenges remain that must be addressed. For example, CMS fails to acknowledge the principle of proportionality relating to liability settlements.\(^\text{182}\) This problem arises in situations where the insurer and the beneficiary settle a case for an amount that is less than the total amount of conditional payments made by Medicare on the beneficiary’s behalf.\(^\text{183}\) CMS could seek to recover the full reimbursement amount despite the fact that it may leave the beneficiary with nothing.\(^\text{184}\) Stakeholders view this as a serious problem because the MSP laws were intended to allow Medicare to recover funds related to compensation for past medical treatment and not to compensa-

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180. See *Model Rules of Prof’l Conduct* r.1.1 (Am Bar Ass’n 2015).


183. See *id*.

184. See *id*.
tion for a beneficiary’s pain and suffering. Conversely, CMS administrators believe that such a position is in conflict with Medicare’s right to full recovery up to the settlement amount. Unfortunately for beneficiaries, the only recourse offered by CMS in these situations is to attempt to negotiate for waiver or reduction of the final demand amount.

To remedy this issue, Congress should draft a new bill that limits Medicare’s right to recover compensation relating to past and future medical treatment. In the past, CMS has expressed concern that such a limitation would result in collusion between beneficiaries and insurers by characterizing settlement funds as compensation for the plaintiff’s pain and suffering. However, several safeguards exist that would deter attorneys from engaging in this type of conduct. First, attorneys have a financial incentive and professional responsibility to recover the maximum amount for the injured client. In addition, Medicare may choose to reduce the attorney’s portion of an award where evidence exists that the attorney attempted to subvert Medicare’s right to recovery. Second, Medicare has the ability to sue any entity that received compensation from a primary payer. Thus, attorneys have an incentive to avoid personal liability, which threatens damage to their personal finances and, more importantly, to their reputations. After careful study, Congress may elect to include a provision that also limits the amount of damages for pain and suffering if Medicare will not receive full reimbursement. Such a provision could cap pain and suffering compensation at no more than twice the amount of the compensation for past and future medical treatment. In effect, this would ensure that adequate damages would be apportioned for the beneficiary’s medical treatment.

Many stakeholders have also taken issue with Code of Federal Regulations § 411.39, which governs the process and time frame for obtaining FCPA via the MSPRP. The main contention is that many of the provisions ignore the purpose of the SMART Act by extending several CMS

186. GAO-12-333, supra note 182.
187. Id.
189. Miklos, supra note 185, at 316.
191. Miklos, supra note 185, at 315.
response deadlines beyond the time frame intended by Congress. Specifically, CMS has interpreted the SMART Act to require that beneficiaries notify CMS 185 days prior to a possible settlement, which includes the 65-day CPL issuance period plus the 120-day protected period. The stakeholders believe the 185-day period defeats the purpose of the SMART Act, which was to give beneficiaries the ability to obtain an accurate FCPA prior to entering into settlement negotiations with opposing counsel. Instead, stakeholders opined that the sixty-five day period should be included within the 120 day protected period. The stakeholders’ position seems to make the most sense given the intent of the SMART Act and the fact that it would also encourage settlement of cases because the parties could obtain the FCPA much more quickly.

Another way that Medicare could improve the current structure of the MSPR process is to decrease the amount of time health care providers have to submit claims to Medicare. When providers provide covered health care treatment to beneficiaries, they are required to submit claims for payment within one calendar year. This time period is arguably one of the main reasons CMS is prevented from operating more efficiently. If the beneficiary’s case settles in less than a year and CMS has yet to receive all of the outstanding claims, CMS could foreseeably end up holding the bill for services it should have been entitled to seek reimbursement for. Thus, Congress should also amend this portion of the statute to decrease the required claim submission period from one year to three months. This would still give providers more than enough time to submit claims and would enable Medicare to provide a more accurate representation of the final amount owed by the beneficiary.

Clear rules and a developed LMSA approval system would allow attorneys to prepare a set aside for clients without having rely on third-party lien resolution firms, which can be expensive. CMS has already promulgated rules, including an approval process, addressing workers’ compensation MSAs; therefore, the structure only needs to be adapted to reflect the unique issues that concern LMSAs. A set of practical rules regard-

194. Id. at 2.
196. Id. at 2.
198. See Workers Compensation Medicare Set Aside Arrangements, supra note 173.
ing LMSAs would also foreseeably eliminate the need for third-party lien resolution firms, which usually must be paid for out of the attorney’s fee.\textsuperscript{199} As a result, more attorneys might be willing to represent Medicare beneficiaries in tort-related lawsuits.

\section*{VII. CONCLUSION AND PRACTICE POINTERS}

Due to the complexity of the current MSP laws and related regulations, representing a client who is a Medicare beneficiary is anything but simple. Yet if one commits the requisite time to research and comprehend these laws, an opportunity to tap into a pool of under-represented plaintiffs awaits.\textsuperscript{200} Attorneys who wish to accept this challenge must continuously cultivate their understanding of the MSPR process due to the risk of professional liability and their ethical duty to provide effective representation to the client. The following are several general practice pointers that should help protect the attorney’s reputation as well as offer insulation from potential financial exposure from Medicare.\textsuperscript{201}

First, because attorneys may face potential malpractice claims for failing to inform the client of the different requirements mandated by the MSP laws, it is of the utmost importance to educate the client about the MSPR process and to memorialize all client conversations on the subject. Even prior to reporting the claim to CMS, the attorney should discuss with the client the obligations and potential liabilities that can arise during the MSPR process. This is especially important in situations where the client declines to approve the creation of a LMSA and demands disbursement of the remaining settlement proceeds. Attorneys only have the power to advise their clients of the legal consequences of their actions, and if the client chooses to disregard that advice, the attorney must carry out the client’s wishes or withdraw from representation.\textsuperscript{202} In this situation, the attorney should send two checks to the client. The first should be for the amount of the LMSA had it been actually performed; the check should be accompanied by a letter stating that the funds must be used to open an account to pay for future medical costs related to the beneficiary’s injuries claimed in the underlying case. The letter should again

\begin{footnotesize}
\footnote{202. See \textit{Model Rules of Prof’l Conduct} r. 1.16 (Am. Bar Ass’n 2015).}
\end{footnotesize}
warn the client of potential liability if Medicare’s interests are not ade-
quately considered, which may include liability under the MSPA and
the federal False Claims Act. The second check should be for the re-
mainder of the settlement funds. With adequate documentation, the at-
torney will be able to provide evidence in his or her defense that the client
was adequately advised and represented in the event of a lawsuit from the
former client or Medicare.

Second, attorneys need to be cognizant of the fact that CMS may open
multiple recovery claims pertaining to a single beneficiary and a single in-
cident if the defendant carries multiple primary insurance policies. Al-
though not common, this type of situation could end in disaster if the at-
torney disburses the settlement proceeds to the client under the mistaken
belief that the total amount owed to Medicare has been satisfied by full
payment of one recovery claim. Because attorneys are usually responsible
for resolving all liens on behalf of a client, the attorney could be held li-
able for legal malpractice. To avoid such a predicament, the attorney
and support staff must be proactive in terms of accounting for all of the
client’s medical expenses. Because health care providers have up to a
year to bill Medicare for services rendered to a beneficiary, attorneys
should contact the provider’s office and request a copy of the client’s in-
voices. In addition, if the client’s FCPA is suspiciously low given the
severity of his or her injuries, the attorney should contact Medicare to
confirm that the total amount owed is an accurate representation.

Finally, if the FCPA owed to Medicare is more than the total amount
of the settlement, the attorney should attempt to apply for a waiver or re-
duction of the final demand amount. Under the Federal Claims Collection
Act of 1966 and Sections 1862 and 1870 of the Social Security Act,
Medicare has the authority to waive its right to recovery where it exceeds
the settlement amount. When negotiating with Medicare, several third
party lien resolution specialists recommend pursuing a partial waiver
rather than a full waiver. The reasoning is most likely based upon
the Medicare Trust Funds’ approaching exhaustion date of 2030, and

203. See John Cattie, The MSP and the False Claims Act: The Government’s Most Potent Re-
204. See In Re: Amendments to the Rules Regulating the Florida Bar, supra note 196.
205. See Lazarus, supra note 87, at 12.
206. Id. at 14.
207. See CMS, MEDICARE FINANCIAL MANAGEMENT MANUAL, Ch. 3–Overpayments (Sept.
208. See Scott J. Corwin et al., The Medicare Lien Resolution Process, CAALA 31ST ANNUAL
the fact that partial recovery is more favorable than no recovery. This negotiating strategy has been reported as most effective when the beneficiary’s attorney initially offers Medicare a nominal amount, such as $1,000 for Medicare to consider its interests satisfied.\textsuperscript{209} Even if Medicare rejects the offer, it will provide a vital starting point for the dialogue between the two parties. It is important to note that once CMS calculates the final demand amount owed by the beneficiary, all future correspondence must be written, as CMS will remove all claims details relating to the case from the MSPRP.

In conclusion, although each attorney will have his or her own approach to settling MSP claims, the importance of competent representation of the client’s interests is indisputable. For the sake of younger generations, hopefully Congress will decide to pass legislation that calls for additional updates to both the financing structure of the Medicare program as well as the MSPRP process.
