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### An Analytic "Gap": The Perils of Relentless Enforcement of Payment-By-Underlying-Insurer-Only Language in Excess Insurance Policies

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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

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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.<sup>1</sup> 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 & THERESE 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.<sup>2</sup> 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,<sup>3</sup> 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. KNUITSEN, *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 & KNUITSEN, *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 & KNUITSEN, *supra* note 1, § 9.05[B]; STEMPEL, SWISHER & KNUITSEN, *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<sup>4</sup> and because the excess insurer need not provide coverage until underlying limits of insurance have been “exhausted”<sup>5</sup> and the “attachment point”<sup>6</sup> 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.<sup>7</sup> 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 underling 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

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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* STEMPER & 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),<sup>8</sup> 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,<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup>

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and Those Who Review Their Work 4–14 (2005) [hereinafter ALI HANDBOOK], <http://www.ali.org/doc/StyleManual.pdf>. To the extent the difference is meaningful, a Principles of insurance document is logically less cabined by the actual law than is a Restatement, although the difference is, as a practical matter, probably only one of degree. The Restatement was scheduled to be formally and finally approved at the May 2017 Annual Meeting, but in response to concerns expressed by insurer representatives, the Institute deferred final decision until 2018 to permit additional commentary on the document. Section 40, the topic of this article, was not discussed at the 2017 Meeting and, of course, is not a provision to which insurers would object.

10. See text and accompanying notes 43–49, *infra*, describing disagreement of some ALI members with § 40 and the failed amendment attempt.

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.

A. *Excess Insurer Arguments for Strict Enforcement of Payment-Only-by-Underlying-Insurer Provisions*

Excess insurers contend that a clear term of its policy (e.g., “the underlying limit must be paid by an underlying insurer”<sup>12</sup>) 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.<sup>13</sup>

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).<sup>14</sup>

As discussed below,<sup>15</sup> 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-

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*Comerica, Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1022 (E.D. Mich. 2007) (emphasis added).

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.

*Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 73 Cal. Rptr. 3d 770 (Ct. App. 2008) (emphasis in original).

[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.”).

13. *See Qualcomm, Inc.*, 73 Cal. Rptr. 3d 770 (the leading case); *Comerica, Inc.*, 498 F. Supp. 2d at 1022 (another prominent case in this line). *Accord*, *Ali v. Fed. Ins. Co.*, 719 F.3d 83, 91 (2d Cir. 2013) (applying New York law) (excess insurers had “good reason to require actual payment up to the attachment points of the relevant policies, thus deterring the possibility of settlement [of the underlying lawsuit] manipulation”); *Fed. Ins. Co. v. Srivastava*, 2 F.3d 98, 103 (5th Cir. 1993) (applying Texas law) (noting that unless amount of claim or loss is set, there is danger that primary insurers could, “contrary to the contracted-for risk,” shift part of their burden to excess carriers); *Quellos Grp. v. Fed. Ins. Co.*, 312 P.3d 734 (Wash. Ct. App. 2013).

14. *See, e.g., Qualcomm, Inc.*, 73 Cal. Rptr. 3d 770. *Accord Comerica, Inc.*, 498 F. Supp. 2d at 1022.

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.<sup>16</sup> 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,”<sup>17</sup> which have considerable force, do not

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16. See John F. O'Connor, *Caveat Settlor: Insurance Coverage Settlements and the Triumph of Policy Language over Precedent*, 79 ALB. L. REV. 101 (2015) [hereinafter O'Connor, *Caveat Settlor*]; John F. O'Connor, *Insurance Coverage Settlements and the Rights of Excess Insurers*, 62 MD. L. REV. 30 (2003) [hereinafter O'Connor, *Rights of Excess Insurers*] (arguing against considering underlying insurance to be exhausted solely by primary insurer's compromise of coverage dispute for amount below primary policy limits); see also Scott M. Seaman & Charlene Kirtledge, *Excess Liability Insurance: Law and Litigation*, 32 TORT & INS. L.J. 653 (1997); Thomas M. Bower, *Partial Settlements by Primary Insurers: The Law*, 29 TORT & INS. L.J. 536 (1994).

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 STEMPEL & 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. Pisciotto*, 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., *Schmitz 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.<sup>18</sup>

*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.<sup>19</sup>

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.<sup>20</sup> 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 & STEMPEL, *supra* note 3, at ch. 21 (discussing standards for determining bad faith and consequences); STEMPEL & 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); STEMPEL & 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 terms<sup>21</sup> 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.<sup>22</sup> As a matter of national judicial policy, settlement is generally encouraged.<sup>23</sup> 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 *Shugart*, 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 & KNUTSEN, *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.<sup>24</sup> Policyholders have raised this point with limited success.<sup>25</sup> 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,<sup>26</sup> 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

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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.

25. See RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 40; text accompanying note 13.

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 guaranty 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.*,<sup>27</sup> 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.<sup>28</sup>

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.<sup>29</sup>

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.”<sup>30</sup> 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.<sup>31</sup>

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.”<sup>32</sup>

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.”<sup>33</sup> But reading the exhaustion clause in the actual case makes it hard to imagine how excess carriers could have been any clearer.

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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 insufficient by the Second Circuit. In any event, *Zeig*’s statement regarding power to alter the default rule is arguably mere dicta. Further, its assumption appears to be that the default rule could be altered only if “the parties” 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”<sup>34</sup> 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.<sup>35</sup>

Regarding the importance of settlement in liability and insurance coverage litigation, the *Zeig* court observed that

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. 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 satisfied 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.<sup>36</sup>

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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 articulated 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 justify 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.<sup>37</sup> Many early twenty-first-century cases continued this pattern.<sup>38</sup> 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. 1955) (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).

38. See, e.g., *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, 629 F.3d 653, 658–59 (7th Cir. 2010) (applying Indiana law); *Waste Mgmt. of Minn., Inc. v. Transcont’l Ins. Co.*, 502 F.3d 769 (8th Cir. 2007) (applying Minnesota law); *Archer Daniels Midland Co. v. Aon Risk Servs., Inc.*, 356 F.3d 850 (8th Cir. 2004) (applying Minnesota and Illinois law); *Coffeyville Res. Refining & Mktg., LLC v. Liberty Surplus Ins. Corp.*, 714 F. Supp. 2d 119 (D. Kan. 2010); *Drake v. Ryan*, 514 N.W.2d 785, 786–87 (Minn. 1994); *Mass. Mut. Life Ins. Co. v. Certain Underwriters at Lloyd’s of London*, 2014 Del. Super. LEXIS 373 (June 6, 2014) (following *Zeig* approach where excess policy ambiguous as to whether satisfaction of underlying limit must be by particular payer; in case involving massive Bernard Madoff Ponzi scheme fraud, policyholder losses actually paid clearly exceeded tower of liability limits, a factor that minimizes risk that underlying insurer will unfairly compromise claim, causing premature attachment of excess policy); *Plantation Pipe Line Co. v. Highlands Ins. Co.*, 444 S.W.3d 307 (Tex. App. 2014); *HLTH Corp. v. Agric. Excess & Surplus Ins. Co.*, 2008 Del. Super. LEXIS 280 (July 31, 2008) (applying Delaware and New Jersey law) (expressly rejecting reasoning of *Qualcomm* and *Comerica* as unduly impeding settlement in litigation); *Reliance Ins. Co. v. Transamerica Ins. Co.*, 825 So. 2d 998, 999–1000 (Fla. Dist. Ct. App. 2001).

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.<sup>39</sup> Excess insurers began to insert such anti-*Zeig* clauses into their policies and began to have success enforcing such provisions.<sup>40</sup> 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

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 insurer, 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.”<sup>41</sup> Although embracing *Zeig* as a default approach, the Reporters and Council<sup>42</sup> accepted the excess insurer argument that an excess insurer could avoid *Zeig* 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.<sup>43</sup>

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

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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.

See RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 40 (Proposed Final Draft) (AM. LAW INST. Mar. 28, 2017).

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.<sup>44</sup> 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.”<sup>45</sup>

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<sup>46</sup> 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.<sup>47</sup> 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.<sup>48</sup>

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44. See Proposed Amendment to the excess attachment section of the Restatement (on file with author and available to ALI Members at [ali.org](http://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.<sup>49</sup> 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 issue)<sup>50</sup> 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.<sup>51</sup> Where policy language is unclear, of course, it is construed against the drafter (almost always the insurer) absent persuasive extrinsic evidence to the contrary.<sup>52</sup> 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.<sup>53</sup>

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.

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(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* STEMPEL & KNUTSEN, *supra* note 1, § 4.08; STEMPEL, SWISHER & KNUTSEN, *supra* note 3, §§ 2.01–2.11.

53. *See* *Maximus, Inc. v. Twin City Fire Ins. Co.*, 2012 U.S. Dist. LEXIS 32970 (E.D. Va. Mar. 12, 2012) (finding insufficient clarity in anti-*Zeig* clause that required "actual payment of the policy limit by the insurance carrier"); *Pereira v. Nat'l Union Fire Ins. Co.*, 2006 U.S. Dist. LEXIS 49263 (S.D.N.Y. July 12, 2006) (clause providing for attachment after "the underlying insurance policies have been exhausted by actual payment" does not clearly bar coverage where there is actual payment of underlying limits by entity other than underlying insurer).

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### 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)<sup>54</sup> 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.<sup>55</sup> 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.<sup>56</sup>

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

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55. See Barry Zaretsky, *Insurance Proceeds in Bankruptcy*, 55 BROOK. L. REV. 373, 386–87 (1989).

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),<sup>57</sup> 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,<sup>58</sup> 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](http://www.insurancejournal.com/news/national/2015/11/17/389153.htm).

58. The Restatement (Second) of Contracts is largely viewed as functionalist or instrumentalist 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 ali.org](http://available.at.ali.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.<sup>59</sup> Under these circumstances, it is not surprising that

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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-

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Trade Towers had been sold in July 2001, written policies had still not been issued by the time of the September 11 attack).

struction are often unclear about their definitional standard.<sup>60</sup> Decisions have a certain "I know it when I see it" quality.<sup>61</sup> But condemnation of *Qualcomm* treatment of Illustration No. 1 is more than consistent with many judicial decisions defining or finding an absurd result.<sup>62</sup>

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.<sup>63</sup> 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.<sup>64</sup> 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.<sup>65</sup> Because the claim presents obvious exposure to a damage award of more

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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 MANIHOFF & 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 MANIHOFF & 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 decisions 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.<sup>66</sup> 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.<sup>67</sup> 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.<sup>68</sup> 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 MANIHOFF & STEMPER, *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).

67. See, e.g., *Century Sur. Co. v. Casino W., Inc.*, 329 P.3d 614 (Nev. 2014) (carbon monoxide claim against hotel not barred by pollution exclusion); *MacKinnon v. Truck Ins. Exch.*, 73 P.3d 1205 (Cal. 2003) (same).

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.*,<sup>69</sup> which exhibits a *Qualcomm*-like literal approach to the issue that fails to even ask whether the policy text in question was really understood and agreed to by the policyholder or whether strict enforcement of the text runs counter to other important legal norms.<sup>70</sup>

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.<sup>71</sup>

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 proferentem 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.<sup>72</sup>

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.<sup>73</sup>

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.<sup>74</sup>

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.<sup>75</sup> 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.<sup>76</sup> 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).<sup>77</sup>

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75. See text accompanying notes 131–40.

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.

See also *id.* at 772 (treating the reader to exposition on the finer points of the meaning of terms such as “exhausted by actual payment,” “wholly exhausted solely due to actual payment,” “wholly exhausted,” and “partially reduced” as well as “all”).

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 *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.<sup>78</sup> 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.<sup>79</sup> 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.<sup>80</sup>

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.”<sup>81</sup> 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-

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78. See JOSEPH E. PERILLO, CALAMARI AND PERILLO ON CONTRACTS § 1.1 (6th ed. 2009) (aim of contract construction is to give effect to party intent, with contract defined as enforcement of promises); E. ALLAN FARNSWORTH, CONTRACTS § 1.1 (4th ed. 2004) (same).

79. See *Trident Ctr.*, 847 F.2d 564 (bemoaning California’s liberal attitude toward extrinsic evidence but feeling bound to apply pursuant to the *Erie* Doctrine); *Pac. Gas & Elec. Co. v. G.W. Thomas Drayage & Rigging Co.*, 442 P.2d 641 (Cal. 1968).

80. See text accompanying notes 101–75, *infra*.

81. *Martin Res.*, 803 F.3d at 769.

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.<sup>82</sup> 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.<sup>83</sup>

### 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,

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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.<sup>84</sup>

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.<sup>85</sup> 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*, LEXISNEXIS 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*, LEXISNEXIS 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.<sup>86</sup> This is a sound approach enshrined in the maxim that the “law abhors a forfeiture.”<sup>87</sup> 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.

87. See *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 370–71 (1999) (overruled on other grounds); *Hasper v. Ctr. Mut. Ins. Co.*, 723 N.W.2d 409, 415 (N.D. 2006); *Kershaw v. Kershaw*, 848 So. 2d 942, 955 (Ala. 2002).

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-

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88. 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.<sup>89</sup> 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.

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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.<sup>90</sup>

Although contract traditionalists might have little sympathy for policyholders and note that there is a "duty to read" the policy<sup>91</sup> (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.<sup>92</sup> 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.<sup>93</sup> 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-

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90. See *Granite Constr. Co. Inc. v. Bituminous Ins. Co.*, 832 S.W.2d 427, 430 (Tex. App. 1992); *J.A. Jones Constr. Co. v. Hartford Fire Ins. Co.*, 645 N.E.2d 980, 982 (Ill. App. Ct. 1995) (certificates of insurance may be used to confirm existence of a policy, but courts normally accord no weight to certificate language in conflict with policy language); *STEMPEL & KNUSTEN*, *supra* note 1, § 3.05[B][1].

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 & KNUSTEN*, *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, entrepreneurship, 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.<sup>94</sup> 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.<sup>95</sup>

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)<sup>96</sup> 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.<sup>97</sup> 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.<sup>98</sup>

i. MISTAKE, UNCONSCIONABILITY, OR CONTRACTS RESTATEMENT § 211 AS GROUNDS FOR AVOIDANCE OF ANTI-ZEIG LANGUAGE—Even in this “a deal’s a deal” atmosphere,<sup>99</sup> 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).

97. See E. ALLAN FARNSWORTH, CHANGING YOUR MIND: THE LAW OF REGRETTED DECISIONS 26–27 (1998) (“only rarely will a court allow you to change your mind and renege on a binding promise”).

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<sup>100</sup> but under certain circumstance it also relieves a party of its unilateral mistake, a principle adopted by the Restatement of Contracts.<sup>101</sup>

An unconscionable provision is one that is either sufficiently the product of bargaining misconduct or unreasonably favorable to a contracting party.<sup>102</sup> Where a contract provision is unconscionable, a “court may refuse to enforce the contract, or may enforce the remainder of the contract without the unconscionable term, or may so limit the application of any unconscionable term as to avoid any unconscionable result.”<sup>103</sup> Although

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100. A mistake is “a belief that is not in accord with the facts.” See 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 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 RESTATEMENT (SECOND) OF CONTRACTS § 152(2).

101. See RESTATEMENT (SECOND) OF CONTRACTS §§ 153 and 154:

**§ 153 When Mistake of One Party Makes a Contract Voidable**

Where a mistake of one party at the time a contract was made as to a basic assumption on which he made the contract has a material effect on the agreed exchange of performances that is adverse to him, the contract is voidable by him if he does not bear the risk of the mistake under the rule stated in § 154, and

- (a) the effect of the mistake is such that enforcement of the contract would be unconscionable or
- (b) the other party had reason to know of the mistake of his fault caused the mistake.

**§ 154 When a Party Bears the Risk of a Mistake**

A party “bears the risk of a mistake” when

- (a) the risk is allocated to him by agreement of the parties, or
- (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
- (c) the risk is allocated to him by the court on the ground that it is reasonable in the circumstances to do so.

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.” *Williams v. Walker-Thomas Furniture Co.*, 350 F.2d 445, 449 (D.C. Cir. 1965) (cited as a commonly accepted definition in FARNSWORTH, *supra* note 78, § 4.28 at 301). *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. *See, e.g.*, *Gonski v. 2d Jud. Dist. Ct.*, 245 P.3d 1164 (Nev. 2010); 8 RICHARD A. LORD, *WILLISTON ON CONTRACTS* § 18:10 (4th ed. 2010); *Armendariz v. Found. Health Psychcare Servs., Inc.*, 6 P.3d 669 (Cal. 2000).

103. RESTATEMENT (SECOND) OF CONTRACTS § 208.

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.<sup>104</sup>

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.<sup>105</sup>

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."<sup>106</sup>

In the absence of actual injury to excess insurers due to the absence of payment by an underlying insurer, anti-*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.<sup>107</sup>

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."<sup>108</sup>

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

104. See, e.g., *Gonski*, 245 P.3d 1164.

105. RESTATEMENT (SECOND) OF CONTRACTS § 155.

106. See PERILLO, *supra* note 78, § 9.27 at 321 (footnotes omitted).

107. 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., *Gonski*, 245 P.3d 1164; *Walker-Thomas Furniture Co.*, 350 F.2d 445.

108. 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.<sup>109</sup> 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-

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109. See, e.g., *Atwater Creamery Co. v. W. Nat'l Mut. Ins. Co.*, 366 N.W.2d 271 (Minn. 1985) (requirement that there be visible marks of entry in order to obtain burglary coverage not enforced because it contradicted policyholder reasonable expectations of coverage and was comparatively hidden from the policyholder in definitions section of policy rather than noted as an exclusion or express limitation of coverage. See MANILOFF & STEMPEL, *supra* note 3, at ch. 22 (reviewing concept, citing leading secondary literature, and reviewing state law on use of reasonable expectations approach in construing insurance policies); STEMPEL, SWISHER & KNUTSEN, *supra* note 3, § 2.09 (discussing reasonable expectations principle and application in cases of contested coverage).

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,<sup>110</sup> 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).<sup>111</sup>

In addition, rational policyholders would not knowingly agree to such draconian provisions unless required by a hard insurance market<sup>112</sup> or unless the policyholder made a conscious decision to accept the limitation

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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.<sup>113</sup>

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.<sup>114</sup> These victims of minor breach must still perform their contractual obligations.<sup>115</sup> 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. . . ."<sup>116</sup>

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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.*

116. See *id.* § 8.16 at 566–68 (footnotes omitted). Accord PERRILLO, *supra* note 78, § 11.18 at 375–77. See, e.g., *Fires Sec. Bank v. Murphy*, 964 P.2d 654 (Idaho 1998) ("breach of con-

The Restatement of Contracts adopts this view,<sup>117</sup> as do the Vienna Convention<sup>118</sup> and the UNIDROIT Principles.<sup>119</sup> 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.<sup>120</sup>

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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tract is not material if substantial performance has been rendered"); *Liddle v. Petty*, 816 P.2d 1066 (Mont. 1991) (where a party "materially breaches the contract, the injured party is entitled to suspend his performance") (purchaser's failure to pay was material breach). See also FARNSWORTH, *supra* note 78, § 8.16 at 567 n.3 ("Although usage is not uniform, there is a commendable tendency among courts and scholars to use substantial in the sense of 'almost complete' and material in the sense of 'more than just a little.'").

117. See RESTATEMENT (SECOND) OF CONTRACTS §§ 237–49.

118. See Vienna Convention on the Law of Treaties, art. 60, 1155 U.N.T.S. 331, 8 I.L.M. 679, entered into force Jan. 27, 1980.

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 plaintiff 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.<sup>121</sup> 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."<sup>122</sup> 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.<sup>123</sup>

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.<sup>124</sup> "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."<sup>125</sup> 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-

121. See generally MANILOFF & STEMPEL, *supra* note 3 (surveying state law regarding more than twenty areas of recurring coverage disputes reflecting insurer grounds for seeking to avoid coverage).

122. See *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665, 666 (2d Cir. 1928) (applying federal common law) (case decided prior to *Erie R.R. Co. v. Tompkins*, 304 U.S. 64 (1938)).

123. 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 779 (Ct. App. 2008).

124. See *supra* text accompanying note 36.

125. See *Zeig*, 23 F.2d at 666 (emphasis added).

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.<sup>126</sup> 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,<sup>127</sup> is unduly bound by text.<sup>128</sup> *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.<sup>129</sup>

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-

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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.”).

129. *See* Stempel, *The Insurance Policy as Social Instrument*, *supra* note 56; Jeffrey W. Stempel, *The Insurance Policy as Thing*, 44 TORT TRIAL & INS. L. J. 813 (2009); Daniel Schwarcz, *A Product Liability Theory for the Judicial Regulation of Insurance*, 48 WM. & MARY L. REV. 1389 (2007). In addition, insurance policies can be analogized to regulated industries (*see* Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653 (2013)) or standardized private legislation (although excess policies are generally less standardized than primary policies). *See* Jeffrey W. Stempel, *The Insurance Policy as Statute*, 41 MCGEORGE L. REV. 203 (2009).

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.<sup>130</sup> The problems of the *Qualcomm* approach have only solidified that view.

D. *Strict Enforcement of Anti-Zeig Clauses Erroneously Treats Policy Language as “The Contract” When a Better View Is That Policy Language Is Merely Memorialization of the Contractual Undertaking of the Parties*

The *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.<sup>131</sup>

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

130. See articles cited in note 129. See also STEMPEL, SWISHER & KNUITSEN, *supra* note 3, at ch. 2; STEMPEL & KNUITSEN, *supra* note 1, at ch. 4; Jeffrey W. Stempel, *Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role*, 5 CONN. INS. L.J. 181 (1998–99). Accord YONG Q. HAN, POLICYHOLDER’S REASONABLE EXPECTATIONS (2016); MALCOLM CLARKE, POLICIES AND PERCEPTIONS OF INSURANCE (1997).

131. See 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.<sup>132</sup>

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.<sup>133</sup> But an insurance policy differs in several ways from garden variety contracts,<sup>134</sup> although tradi-

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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 STEMPEL, 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.” STEMPEL, 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.<sup>135</sup>

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,<sup>136</sup> private legislation crafted by the insurance industry and essentially imposed on most policyholders,<sup>137</sup> and purposive instruments designed to accomplish particular functions in the real world.<sup>138</sup> Construction of insurance policies—and

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stantial 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.

135. See, e.g., Michael Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against the Drafter*, 30 GA. L. REV. 171 (1995); David S. Miller, Note, *Insurance as Contract: The Argument for Abandoning the Ambiguity Doctrine*, 88 COLUM. L. REV. 1849 (1988). But see Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1996) (ambiguity principle central to insurance law).

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 Lines 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.

138. See Stempel, *Insurance Policy as Social Instrument*, *supra* note 56.

the relationship among insurers, policyholders, claimants, and the public—can be substantially enriched by recognizing these alternative characterizations of insurance policies. The socioeconomic role of insurance, in particular, 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 interestingly as a “social instrument” or “social institution” that serves to facilitate socioeconomic activity.<sup>139</sup> For that reason, various issues of insurance 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 parties and in relation to society at large.<sup>140</sup>

#### 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.<sup>141</sup> Sometimes courts are not particularly 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.<sup>142</sup> 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 unreasonable 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 provisions are “grammatically severable”); *Hanks v. Powder Ridge Rest. Corp.*, 885 A.2d 734 (Conn. 2005) (refusing to enforce waiver of liability for negligence clause skiing/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 INTERPRETATION* 17–18 (2008); WILLIAM D. POPKIN, *A DICTIONARY OF STATUTORY INTERPRETATION* 3–8 (2007).

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.<sup>143</sup> One strains to find a reasonable basis for giving strict enforcement to an anti-*Zeig* 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.<sup>144</sup> 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.<sup>145</sup> 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 & STEMPER, *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 & STEMPER, *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 & STEMPER, *supra* note 3, at 57–58, 71–72.

language.<sup>146</sup> 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.<sup>147</sup> 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.<sup>148</sup> The ALI also adopts this position in § 37 of the Restatement.<sup>149</sup>

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 MANILOFF & 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. MANILOFF & 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.<sup>150</sup>

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.<sup>151</sup> 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 where 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<sup>152</sup> and may attack and avoid a settlement that is unreasonable or collusive,<sup>153</sup> 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.<sup>154</sup> But after the event has taken place, the relative risk presented by the original policyholder and the assignee is irrelevant.<sup>155</sup> 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).

153. See RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 37.

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.<sup>156</sup>

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.<sup>157</sup>

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.*,<sup>158</sup> but more recently correctly rejected in *Fluor Corporation v. Superior Court*,<sup>159</sup> 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.”<sup>160</sup>

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*).

160. RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 37(2) (Proposed Final Draft) (AM. LAW INST. Mar. 28, 2017).

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.<sup>161</sup>

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.<sup>162</sup>

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.<sup>163</sup>

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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.

162. See *Cisneros v. UNUM Life Ins. Co. of Am.*, 134 F.3d 939, 945 (1998).

163. See RESTATEMENT (SECOND) OF CONTRACTS § 356(1) (AM. 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.<sup>164</sup> "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."<sup>165</sup>

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.

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able on grounds of public policy as a penalty."); UCC § 2-718(1) ("Damages for breach by either party may be liquidated in the agreement but only at an amount which is reasonable in the light of the anticipated or actual harm caused by the breach, the difficulties of proof of loss, and the inconvenience or nonfeasibility of otherwise obtaining an adequate remedy."); FARNSWORTH, *supra* note 78, § 12.18; PERILLO, *supra* note 78, § 14.33. *See, e.g.*, Carr-Gottstein Props., Ltd. P'ship v. Benedict, 72 P.3d 308 (Alaska 2003) (upholding \$25 per day specified damages for delay in finishing construction as reasonable in light of amount and purpose of protecting aesthetics of neighborhood that would be compromised by prolonged construction in residential area); Nohe v. Roblyn Dev. Corp., 686 A.2d 382 (N.J. Super. Ct. App. Div. 1997) (prohibiting retention of nearly \$80,000 deposit as liquidated damages for breach of sale contract for residential property); Kvassey v. Murray, 808 P.2d 896 (Kan. 1991) (refusing to enforce liquidated damages clause where amount deemed well in excess of actual loss), *reprinted in* EPSTEIN, MARKELL & PONOROFF, *supra* note 94, at 823–35.

One can criticize this approach as overly paternalistic, at least where the contracting parties are sophisticated and the specified damages provision was negotiated and understood. *See* Lake River Corp. v. Carborundum Co., 769 F.2d 1284, 1288–90 (7th Cir. 1985) (applying Illinois law) (per Judge Richard Posner); Charles Goetz & Robert Scott, *Liquidated Damages, Penalties and the Just Compensation Principle*, 77 COLUM. L. REV. 554 (1977). But it is nonetheless well-established law. And it is law that results in courts refusing to give literal enforcement to textual provisions with economic consequences far less severe than the forfeitures created by anti-*Zeig* provisions in excess policies.

164. *See* FARNSWORTH, *supra* note 78, § 5.3; 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. *Compare Valley Medical Specialists*, 982 P.2d 1277 (modifying offending clause), *with Islam*, 376 P.3d 151 (refusing to rewrite clause and striking it). *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).

165. *See* 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." *Id.* at 325. *Accord* 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.<sup>166</sup> Although there is a split of authority, many courts take a similar attitude toward waivers of liability<sup>167</sup> and disclaimers or limitations of remedies.<sup>168</sup>

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.

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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.

167. See FARNSWORTH, *supra* note 78, §§ 4.26–4.27, 5.2, 11.8; PERILLO, *supra* note 78, § 14.22; C. Connor Crook, *Validity and Enforceability of Liability Waivers in Ski Lift Tickets*, 28 CAMPBELL L. REV. 107 (2005). See, e.g., *Hanks v. Powder Ridge Rest. Corp.*, 885 A.2d 734 (Conn. 2005) (refusing to enforce waiver of liability signed by patron as condition of skiing); *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 445–46 (Cal. 1963) (refusing to enforce hospital's waiver of liability for negligence); *Henningsen v. Bloomfield Motors*, 161 A.2d 69, 87–94 (N.J. 1960) (refusing to enforce warranty disclaimer).

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).

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## V. CONCLUSION

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.

