The Restatement of the Law, Liability Insurance: Illustrative Issues

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As this paper is written, the ALI Restatement of the Law, Liability Insurance project is entering the final stages of review and approval by the American Law Institute. A new draft, addressing and implementing changes to at least Sections 3, 4, and 12 is expected, and changes to other sections also are possible in advance of a proposed final draft. The project, in its proposed final form, will be presented for approval at the upcoming ALI Annual Meeting in Washington, DC on May 22, 2018. This paper – setting out key areas of concern with the project -- is written based on Council Draft No. 4, which is the most current available draft of the Restatement as these materials are being prepared.

Section 1 –Definitions:

In Section 1(8) and (9), the Restatement introduces the concept of mandatory and non-mandatory (default) rules, an idea that is not generally recognized as an insurance law principle. As Comment (f) admits, "courts typically have not used the label 'mandatory rule' in the insurance context." Given this admission, this innovative concept of mandatory/default rule labels for insurance law principles should not be presented as a black-letter rule or formal Comment in the Restatement.

In Council Draft No. 4, Comment (f) proffers a list of rules that the Reporters characterize as mandatory or nonwaivable legal rules from which insurance agreements would not be permitted to depart, even by contractual agreement. The purported authority for this list is scant, and even the Reporters' Note acknowledges that "courts have not emphasized this point," that they are drawing indirect conclusions from opinions that do not state a rule is mandatory (e.g., "therefore it can be concluded that . . ." or "it is likely that it would not be permitted"), and that there is contrary authority. This effort to introduce mandatory and default rules to insurance law, and to characterize the camp into which insurance rules should fall, does not belong in this Restatement and is not fairly characterized as the law as it is or might be stated by a court. To the extent the mandatory/nonmandatory rules concept remains, it should reside wholly in the Reporters' Note.

Section 1(13) proposes a definition of a "standard form term" that is overly broad, vague and unsupported. It would define as a "standard form term" any term appearing in or taken from an insurance policy available in the market, regardless of whether the term is put to a unique use, whether the term was identified and proposed by a policyholder or broker, or whether the term was ever previously seen by the contracting insurer. This overreaching definition is without any legal support and should be deleted.

Section 3: Plain Meaning Rule:

Probably the most well-established and fundamental insurance law rule is that courts are to give an insurance contract its plain meaning. It would be a serious error for the ALI to publish the first ever Restatement devoted to any insurance law topic, and in doing so alter the most elemental rule found in insurance law. The plain meaning rule is critical to every insurance dispute. It lays the foundation for how all insurance policies are to be interpreted and therefore impacts all the remaining sections of the Restatement.

As a practical matter, judges in the overwhelming majority of jurisdictions have relied for decades on a rule permitting them to enforce clear policy terms without resort to extrinsic evidence. The overwhelming majority of American jurisdictions – more than 40 states that have considered the issue – requires courts to enforce unambiguous policy language and does not allow a party to use extrinsic evidence to alter the meaning of unambiguous policy terms. Further, even in those handful of minority jurisdictions where courts have permitted extrinsic evidence, the types of evidence and circumstances where such evidence may be admissible is far more circumscribed than what may be allowed under the draft's proposed rule. In Council Draft No. 4, under Section 3(2), in particular, an unambiguous insurance policy term will *not* be interpreted according to its plain meaning – or as written – if a "reasonable person in the policyholder's position would give the term a different meaning."

Discarding the settled "plain meaning rule" will bring uncertainty to widely-used terms in insurance agreements. Insurance terms will not be given their accepted and plain meaning, but will turn on different extrinsic evidence offered by each individual policyholder. Overall, this invites collateral litigation, uncertainty, and stunning new legal fees through the unavailability of summary judgment and the expansion of discovery and evidentiary disputes.

Section 4: Ambiguous Terms:

In Council Draft No. 4, the black letter rules in subsections 4(1) and 4(2) set out the general rule that an ambiguous term is interpreted in favor of the party that did not supply it, unless that interpretation is unreasonable. However, subsection 4(3) goes much further, is unsupported by any law, and should be deleted. Subsection 4(3) states that what the Restatement broadly defines as a "standard form insurance policy term" will *always* be interpreted against the insurer in a dispute with its policyholder. Council Draft No. 4 compels this result, unless the policyholder has agreed otherwise in writing, even if the term was supplied by the policyholder and never otherwise used by the individual insurer in the dispute.

This is because in Section 1(13), a "standard form term" is broadly defined as "a term that appears in, or is taken from an insurance policy form (including an endorsement) that an insurer [apparently meaning *any* insurer, not *the* insurer] makes available for a non-predetermined number of transactions in the insurance market." Thus, a term is deemed a "standard form term" to be interpreted against an insurer, even if the term was chosen by the policyholder and not written or even previously used by the insurer to the dispute. There is no basis in existing insurance law for this anti-insurer principle of interpretation in subsection 4(3) and it does not belong in the Restatement.

Section 8: Materiality Requirement:

Section 8 imposes a new "substantiality" requirement, not found in applicable statutes or prevailing common law, for determining whether an insured's misrepresentation was material, such that it may result in the denial of a claim or rescission of a policy. Under the prevailing common law test, if a fact would have influenced an insurer's decision whether or on what terms to accept the risk, it is material. A new "substantiality" test, requiring the insurer to show that a "reasonable insurer" in this insurer's position would not have issued the policy or would have issued it only under *substantially* different terms, is at odds with existing statutory and common law.

Section 12: Liability of Insurer for Conduct of Defense:

As it stands in Council Draft No 4, Section 12 is without judicial precedent in insurance law. Nor has there been a breakdown in the normal recourse against the negligent lawyer to justify this new "remedy" of insurer liability for counsel's malfeasance. Under Section 12(1), the Restatement seeks to introduce agent-principal concepts into the tripartite relationship among insurers, policyholders and their defense counsel, a result not accepted by any court.

Under Section 12, an insurer would become liable for the independent negligence of professional attorneys. Under professional responsibility standards, defense counsel must exercise independent professional judgment. An insurer cannot control the attorney's decisions. Despite numerous submissions showing the lack of any case law support for these positions, as well as the tension between these new rules and the *Restatement Third, Law Governing Lawyers* and the rules of professional conduct governing lawyers, the Reporters propose to alter the rules that govern a lawyer's professional conduct in representing a client and create a new paradigm that no court has adopted.

Section 13: Conditions Under Which the Insurer Must Defend:

In Section 13(2)(b), the Council Draft No. 4 includes a provision that a duty to defend attaches based on evidence (which is a basis for all or part of the action) which is known to the insurer and not contained in the complaint. Section 13(2)(b), however, changes "facts" outside the complaint that are known to the insurer to any "additional allegation" known to the insurer, suggesting that a duty to defend could be created by the mere allegation of the policyholder, a result wholly inconsistent with the law and very troubling in seemingly allowing the policyholder to manufacture a duty to defend based on allegations outside the complaint. The word "facts" should be reinstated in this subsection.

In Section 13(3), addressing an insurer's reliance on non-liability facts in determining the duty to defend, the Reporters forbid reliance on undisputed non-liability facts in determining the duty to defend, except in five cases. This would force a defense of uncovered claims. Existing law permits reliance on non-liability facts (such as date of notice) and prohibits reliance on facts that would contradict the complaint or that are at issue in the underlying claim, i.e., facts that are an element of either the cause of action or a defense in the underlying litigation.

Rather than follow the existing law, the Reporters propose to disallow consideration of facts not at issue in the underlying action against the insured in determining coverage, subject to five specific exceptions. No court has ever stated that only these five exceptions justify use of non-liability facts in determining a duty to defend.

The Reporters' proposal, moreover, creates a duty to defend where it otherwise would not exist particularly when the Restatement is taken as a whole. Section 18(8) would not permit withdrawal of a defense without court permission (or in certain limited circumstances), and Section 21 would not allow an insurer to recoup costs advanced for a defense even if a court later found no coverage. The combined effect of these Sections would be to force insurers to defend uncovered claims without appropriate recourse.

Section 18(8): Terminating the Duty to Defend a Legal Action:

In Section 18(8), the Restatement provides that, beyond limited circumstances principally involving final adjudication or settlement of the action, an insurer's duty to defend terminates only upon final adjudication (i.e., a court determination) that the insurer does not have a duty to defend the action. It mandates that a non-breaching insurer – who has accepted the duty to defend – can withdraw from the defense *if and only if* it satisfies one of the eight-prong tests set forth in Section 18. Under Section 18(8), if none of the other prongs apply, an insurer can *only* cease defending with a court's permission. In other words, this subsection requires judicial adjudication for the withdrawal of a defense, even if facts become evident which clearly place the claim outside coverage.

This new rule – another example of the Restatement's antipathy toward insurers – proposes to burden insurers with substantial, unjustified defense and coverage litigation costs. It would create a judicial nightmare by incentivizing policyholders to undermine an insurer's effort to obtain judicial guidance, thereby continuing the defense (without any later right on part of the insurer to recoup costs). This approach is unsupported by the law and would have the ALI place a burden on insurers that does not exist for any other party to a private contract.

Section 21: Insurer Recoupment of the Costs of Defense:

This Section discards the common law and Restatement Third, Restitution and Unjust Enrichment to forbid recoupment of defense costs advanced when it is subsequently determined that the insurer did not have a duty to defend, unless otherwise stated in the insurance policy or agreed by the insured. The Reporters argue that a "default rule" prohibiting recovery of defense costs advanced for what is determined to be an uncovered claim is appropriate when the policy does not explicitly provide for recoupment. However, when costs are advanced for what is an uncovered claim, then the payment is made outside the policy coverage and should be subject to existing legal principles regarding the right to recoupment. Those principles are the settled law of unjust enrichment, which allows for recovery, assuming the elements of unjust enrichment are shown. See, e.g., Restatement Third, Restitution and Unjust Enrichment Section 35. This is also the prevailing rule in insurance rulings.

Comment a characterizes the proposed Restatement rule with the contorted label of "the emerging state court majority rule" notwithstanding an admission that "about half the state courts that have considered the issue and a majority of federal courts making Erie predictions, have held to the contrary." In other words, a clear majority view rejects the Restatement rule, and this includes several very recent decisions such as those in Evanston Ins. Co. v. Bosski, Inc, 2017 WL 1158245 (D. Idaho 2017), James River Ins. Co. v. Arlington Pebble Creek, LLC, 188 F. Supp. 1246 (N.D. Fla. 2016), and the decision I submitted on December 21, Santa Clara Waste Water Company v. Allied World National Assur. Co., 2d Civil No. B279679 (Cal. App. 2d Dist. Dec. 20. 2017). This Restatement should not alter the existing law on recoupment, should not contradict the Restatement Third, Restitution and Unjust Enrichment, and should not camouflage the

innovation being proposed by calling it a "default rule," a concept not recognized in insurance law and inconsistent with the prevailing law.

Section 24: The Insurer's Duty to Make Reasonable Settlement Decisions:

Section 24 addresses the basis for liability for failure to settle, and adopts a standard of reasonableness. Putting aside other objections, one thing that is needed in this Section is a clear statement that an insurer cannot be liable when the insurer has behaved reasonably. Not acknowledging that limitation would be completely inconsistent with settled law.

The Restatement should emphasize that the question is not whether any ordinarily prudent insurer would have accepted a given settlement offer (creating the impression that failure to do so was unreasonable). Rather, the question is whether an ordinarily prudent insurer would have thought that the settlement decision made by the insurer in the case at bar (i.e., to try rather than settle) was too risky. An unreasonable risk is one involving a likelihood of an unfavorable outcome out of reasonable proportion to the chance of winning. Thus, if at the time the decision is made, there is a good likelihood of a favorable outcome, then the insurer cannot be held liable in hindsight for failing to anticipate an unpredictable result. Section 24, and particularly Comment d, should be revised to make clear that an insurer that acted reasonably will not be liable for failure to settle. Further, Section 24 should be amended to make clear that the reasonableness of the insurer's decisions must be measured in relation to the covered portion of the claim.

Section 25: The Effect of Reservation of Rights on Settlement Rights and Duties:

Section 25(2) proposes that, unless otherwise stated in an insurance policy or agreed to by the insured, an insurer may not demand recoupment of a settlement amount advanced on the ground that the action was not covered. In other words, this subsection reverses the law on recoupment of indemnity costs. As with Section 21, the rule advanced is contradicted by the prevailing common law approach and the Third Restatement, Recoupment and Unjust Enrichment. The comment (d) effort to distinguish the Third Restatement, Recoupment and Unjust Enrichment seems to be an imaginary wonderland in which the R3RUE's premise and conclusions "disappear once insurance law is understood to include a no-recoupment default rule." But, in reality, there is not a "no recoupment default rule" in the case law. Rather, prevailing law supports reimbursement of costs advanced by the insurer for indemnity subject to a reservation of rights, if it is later determined that no coverage exists. The attempt to distinguish R3RUE falls flat and the Restatement Section 25's rejection of the longstanding, equitable principles of unjust enrichment should be rejected.

Further, the new Council Draft No. 4 addresses, and undermines, the effect of consent to settle requirements in Section 25(3) and Comment b to Section 27. This new approach to consent requirements inappropriately dilutes the contract terms and creates unnecessary and undesirable risks of fraud, collusion, moral hazard, excessive settlements, satellite litigation, and increased premiums.

Section 27: Damages for Insurer Breach of Settlement Duties:

Under Section 27, an insurer that breaches its duties in regard to settlement becomes liable for all damages awarded to the claimant at trial, regardless of the insurer's policy limits, as well as for "any other foreseeable harm." Comment *d* specifically says that the insurer must pay for punitive damages awarded against its insured, even when the insurance policy specifically excludes

punitive damages from coverage or when jurisdictions forbid insurance coverage for punitive damages. States' approaches to insurability of punitive damages are sharply divided. Moreover, in many states, statutes govern whether punitive damages are insurable. The ALI should not attempt to overturn these statutes through a Restatement. Indeed, the Reporters acknowledge in Comment e (and corresponding Reporters' Note e) that there is *no* authority for their proposed position, which rests on two dissenting opinions and what is essentially dicta in a single 1990 intermediate court legal malpractice case.

Section 35(2): Notice and Reporting Conditions:

This Section proposes to change the terms of claims-made-and-reported policies: notice after expiration of the reporting deadlines in such policies will be excused if the claim is considered to be too close to the end of the policy term to permit reporting during the policy period and the policy does not contain an extended reporting period. Whether a late notice defense should be permitted in this context is a legislative judgment, or a matter of regulatory law. The ALI should not take a position on this point in a Restatement.

Sections 47(4), 48(3) and 50(1): Fee-shifting:

The ALI should not jettison the American Rule and broadly mandate that insurers pay insureds' legal fees in coverage cases. Doing so contradicts the ALI's oft-stated recognition that it is not competent to substitute its judgment in matters of public policy for the judgments made by state legislatures and courts. The Reporters have ignored numerous submissions on this issue, including the aforementioned letter from non-insurer general counsels. The ALI should not advocate one-way attorney fee shifting and Council Draft No. 4 should be amended accordingly.

Section 50(2): Remedies for Liability Insurance Bad Faith:

Section 50(2) adds a new open ended remedy for bad faith, providing for "other remedies as justice requires." Comment c, however, suggests the Reporters are attempting to salvage former Section 19(2), which would have estopped an insurer from asserting coverage defenses for an unreasonable denial of a defense. Numerous submissions to the Reporters have demonstrated that forfeiture penalties are contrary to the majority rule, which does not impose automatic forfeiture of coverage defenses for *any* breach of the duty to defend. Once again the Reporters would compel insurers to pay uncovered claims. The ALI should not endorse this unlegislated penalty on insurers.

The Sections above address bedrock principles of insurance law which serve as the foundation for insurance agreements and the insurance system. It is critical that these provisions be reviewed and the problems noted be corrected before the project is finalized. They are illustrative of the issues found in the project draft, although other areas of concern can also be identified.

EXCERPTED SECTIONS OF THE RESTATEMENT COUNCIL DRAFT NO. 4

RULES ON POLICY INTERPRETATION

§3 The Presumption in Favor of the Plain Meaning of Standard-Form Insurance-Policy Terms

(1) The plain meaning of an insurance policy term is the single meaning, if any, to which the language of the term is reasonably susceptible when applied to the claim at issue, in the context of the insurance policy as a whole, without reference to extrinsic evidence regarding the meaning of the term. If the term does not have a plain meaning, it is interpreted under the rules stated in §4.

(2) An insurance-policy term is interpreted according to its plain meaning … unless extrinsic evidence demonstrates to the court that a reasonable person in the policyholder's position would give the term a different meaning. That different meaning must be one to which the language of the term is reasonably susceptible.

Council Draft No. 4, §3(20-(3) (Dec. 4, 2017), subject to revision after Council vote Jan. 2018.

§4 Ambiguous Terms

(1) An insurance policy term is ambiguous if there is more than one meaning to which the language of the term is reasonably susceptible when applied to the claim in question, without reference to extrinsic evidence regarding the meaning of the term.

(2) When an insurance-policy term is ambiguous, the term is interpreted in favor of the party that did not supply the term, unless the other party persuades the court that this interpretation is unreasonable in light of extrinsic evidence.

Council Draft No. 4, §4(1)-(2) (Dec. 4, 2017), subject to revision after Council vote Jan. 2018.

§1 Definitions

(13) A standard-form term" is a term that appears in, or is taken from, an insurance-policy form (including an endorsement) that an insurer makes available for a non-determined number of transactions in the insurance market.

Council Draft No. 4, §1(13) (Dec. 4, 2017)(tent. approved May 23, 2017 in Proposed Final Draft No. 4).

RULES ON MISREPRESENTATION/RESCISSION

§7 Standard for Misrepresentation

(1) Any statement of fact made by a policyholder in an application for an insurance policy is a representation by the policyholder.

(2) Subject to the rules governing defense obligations, an insurer may deny a claim or rescind the applicable liability insurance policy on the basis of an incorrect representation made by a policyholder in an application for an insurance policy (hereinafter referred to as a misrepresentation) only if the following requirements are met:

(a) The misrepresentation was material as defined in §8; and

(b) The insurer reasonably relied on the misrepresentation in issuing or renewing the policy as specified in §9.

When the policy is rescinded under subsection (2), the insurer must return all of the premiums paid for the policy.

Council Draft No. 4, §7 (Dec. 4, 2017) (tent. Approved May 23, 2017, in Proposed Final Draft No. 4).

§8 Materiality Requirement

A misrepresentation by or on behalf of an insured during the application for, or renewal of, an insurance policy is material only if, in the absence of the misrepresentation, a reasonable insurer in this insurer's position would not have issued the policy or would have issued the policy only under substantially different terms.

Council Draft No. 4, §7 (Dec. 4, 2017) (tent. Approved May 23, 2017, in Proposed Final Draft No. 4).

LIABILITY OF INSURERS FOR CONDUCT OF DEFENSE

§12 Liability of Insurer for Conduct of Defense

(1) An insurer exercising its right to defend a legal action brought against an insured is subject to vicarious liability to the insured for defense counsel's negligence or other breach of professional obligation in the following circumstances:

(a) Defense counsel provided by the insurer to defend a legal action, who is an employee of the insurer, causes harm to the insured while acting within the scope of that employment; or

(b) Defense counsel provided by the insurer to defend a legal action is not an employee of the insurer, causes harm to the insured while acting with the apparent authority of the insured.

Council Draft No. 4 §12(1) (Dec. 4, 2017) (subject to revision after Council vote Jan. 2018).

SCOPE OF DUTY TO DEFEND

§13 Conditions Under Which the Insurer Must Defend

(2) (b) Any additional allegation known to the insurer, not contained in the complaint or comparable document stating the legal action, that a reasonable insurer would regard as an actual or potential basis for all or part of the action.

(3) The insurer must defend until its duty to defend is terminated under §18 by declaratory judgment or otherwise, unless facts not at issue in the legal action for which coverage is sought and as to which there is no genuine dispute establish that:

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

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

(c) The claim was reported late under a claims-made-and-reported policy such that the insurer's performance is excused under the rule stated in §35(2);

(d) The action is subject to a prior and pending litigation exclusion or a related claim exclusion in a claims-made policy; or

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

§18 Terminating the Duty to Defend a Legal Action

An insurer's duty to defend a legal action terminates only upon the occurrence of one or more of the following events:

* * * *

(8) Final adjudication that the insurer does not have a duty to defend the action.

Council Draft No. 4 §18 (Dec. 4, 2017; tent. approved May 23, 2017, in Proposed Final Draft No. 4).

§21 Insurer Recoupment of the Costs of Defense

Unless otherwise stated in the insurance policy or otherwise agreed to by the insured, an insurer may not seek recoupment of defense costs from the insured, even when it is subsequently determined that the insurer did not have a duty to defend or pay defense costs.

Council Draft No. 4 §21 (Dec. 4, 2017; tent. approved May 23, 2017, in Proposed Final Draft No. 4).

RULES RELATING TO SETTLEMENT RIGHTS AND OBLIGATIONS

§24 The Insurer's Duty to Make Reasonable Settlement Decisions

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 applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.

A reasonable settlement decision is one that would be made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment.

An insurer's duty to make reasonable settlement decisions includes the duty to make its policy limits available to the insured for the settlement of a covered legal action that exceeds those policy limits if a reasonable insurer would do so in the circumstances.

Council Draft No. 4 §24 (Dec. 4, 2017; tent. approved May 23, 2017, in Proposed Final Draft No. 4).

§25 The Effect of a Reservation of Rights on Settlement Rights and Duties

(2) Unless otherwise stated in an insurance policy or agreed to by the insured, an insurer may not settle a legal action and thereafter demand recoupment of the settlement amount from the insured on the grounds that the action was not covered.

(3) When an insurer has reserved the right to contest 1 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 the following requirements are met:

(a) The insurer is given a reasonable opportunity to participate in the settlement process;

(b) The insurer declines to withdraw its reservation of rights after receiving prior notice of the proposed settlement;

(c) It would be reasonable for a person who bears the sole financial responsibility for the full amount of the potential covered judgment to accept the settlement; and

(d) If the settlement includes payments for damages that are not covered by the liability insurance policy, a reasonable portion of the settlement is allocated to the insured component of the action.

Council Draft No. 4 §25 (Dec. 4, 2017; tent. approved May 23, 2017, in Proposed Final Draft No. 4).

§27 Damages for Breach of the Duty to Make Reasonable Settlement Decisions

An insurer that breaches the duty to make reasonable settlement decisions is subject to liability for any other foreseeable harm caused by the insurer's breach of the duty.

Council Draft No. 4 §27 (Dec. 4, 2017).

RULES RELATING TO EXHAUSTION AND ALLOCATION

§39 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 excess insurance policy:

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

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.

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.

Council Draft No. 4, §39 (Dec. 4, 2017).

§41 Allocation in Long-Tail Harm Claims Covered by Occurrence-Based Policies

(1) Except as stated in subsection (2), when indivisible harm occurs over multiple years, the amount of any judgment entered in or settlement of any liability action arising out of that harm is subject to pro rata allocation under occurrence-based insurance policies as follows:

(a) For purposes of determining the share allocated to any occurrence-based liability insurance policy that is triggered by harm during the policy

period, the amount of the judgment or settlement is allocated equally across years, beginning with the first year in which the harm occurred and ending with the last year in which the harm would trigger an occurrence-based liability insurance policy; and

(b) An insurer's obligation to pay for that pro rata share is subject to the ordinary rules governing any deductible, self-insured retention, policy limit, or exhaustion terms in the policy.

(2) When an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy that provides coverage for the claim.

(3) Defense obligations relating to multiple triggered policies are subject to the rules in §20.

Council Draft No. 4, §3 (Dec. 4, 2017), subject to revision after Council vote Jan. 2018.

REMEDIES, INCLUDING HANDLING OF FEE-SHIFTING

§48 Damages for Breach of a Liability Insurance Policy

The damages that an insured may recover for breach of a liability insurance policy include:

(1) In the case of a policy that provides defense coverage, all reasonable costs of the defense of a potentially covered legal action that have not already been paid by the insurer, subject to any applicable limit, deductible, or self-insured retention of the policy;

(2) All amounts required to indemnify the insured for a covered legal action that have not already been paid by the insurer, subject to any applicable limit, deductible, or self-insured retention of the policy;

~~(3) In the case of a breach of the duty to defend or to pay defense costs on an ongoing basis, the reasonable attorneys' fees and other costs incurred in the legal action establishing the insurer's breach, which sums are not subject to any limit, deductible, or self-insured retention of the policy;~~

(4)In the case of the breach of the duty to make reasonable settlement decisions, the damages stated in §27; and

(5) Any other loss, including incidental or consequential loss, caused by the breach, provided that the loss was foreseeable by the insurer at the time of contracting as a probably result of a breach, which sums are not subject to any limit of the policy.

Council Draft No. 4 §48 (Dec. 4, 2017).