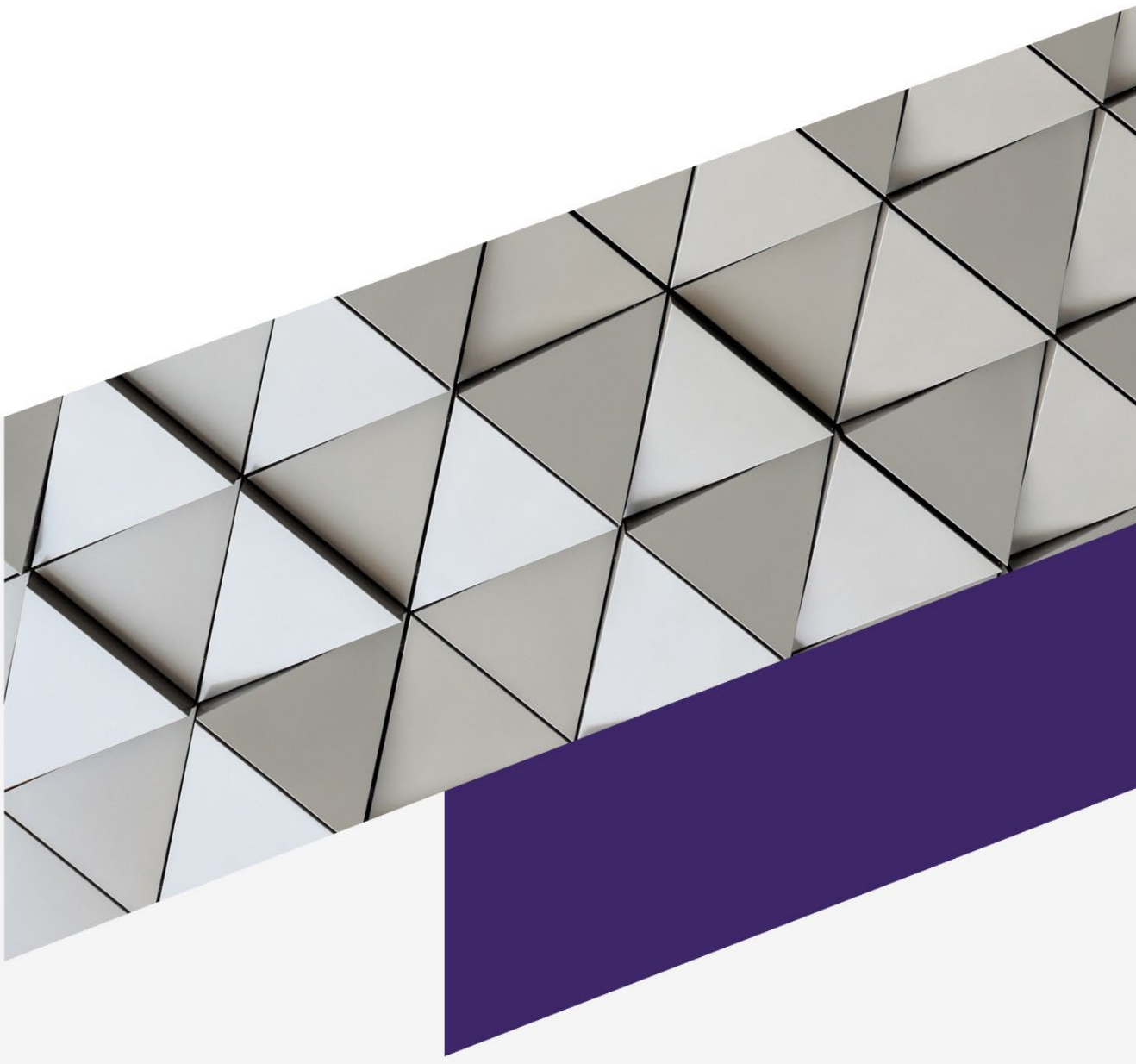
Insurance Recovery Litigation: Key Topics and Considerations



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This edition, *Insurance Recovery Litigation: Key Topis and Considerations*, was authored by Craig C. Martin, Chairman Americas; Skyler Silvertrust, Partner; and Matthew Thomas, Partner.

Acknowledgements

We gratefully acknowledge the many attorneys and associates whose dedicated research, drafting, and editorial contributions made this handbook series possible. In particular, we thank Luke Angelillo, Eve Hastings, Chloe Holt, and Tara Sohns for their contributions and assistance. The quality and rigor of each volume in this series reflects the collaborative spirit and tireless commitment of every contributor across our practice groups.

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Part One
Pre-Litigation Issues and Considerations

I. Notice of Claim

A. Overview

Insured parties who have either suffered a loss or face claims of liability that they believe are covered by their insurance policy must give notice of their potential claim or loss to their insurer in order to recover under the policy. The purpose of such notice is to "afford the insurer a [r]easonable opportunity to protect its interest."[1]

B. Complying with Applicable Notice Requirements in the Policy

Modern insurance policies generally include notice provisions specifying the form, time, contents, and delivery method for notice. Absent an express contractual provision, these requirements are often defined by state law.[2]

Historically, failure to comply with notice requirements, including timing, content, form, and delivery, resulted in forfeiture of recovery under the policy.[3] While some courts continue to strictly enforce notice provisions,[4] other courts have moved to a balancing test where a breach of a notice provision results in forfeiture only if such breach caused harm to or prejudiced the insurer.[5] Most jurisdictions require that insurers identify any alleged defects with notice in their disclaimer letter, otherwise such a defense may be deemed waived.[6]

See:

- *Johnson & Bryan, Inc. v. Utica Mut. Ins. Co.* Interpreting a policy under Georgia law, the court held that it was not required to consider whether the insurer was prejudiced by the insured's failure to give timely notice. Because timely notice was expressly made a condition precedent to coverage under the relevant insurance policy, the insured's 72-day delay in providing notice precluded coverage.[7]

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[1] *Siravo v. Great Am. Ins. Co.*, 410 A.2d 116, 118 (R.I. 1980); *see also Woznicki v. GEICO Gen. Ins. Co.*, 90 A.3d 498, 509–10 (Md. 2014) ("An insured's duty to provide required notice is generally an obligation to give the insurer notice of a claim of occurrence in order to ensure that the insurer has the 'opportunity to acquire full information about the circumstances of the case, assess its right and liabilities, and take early control of the proceedings.'").
[2] *See, e.g., George K. Baum & Co. v. Twin City Fire Ins. Co.*, 760 F.3d 795, 803 (8th Cir. 2014) ("New York law imposes an implied duty on insured parties to notify their insurer 'within a *reasonable* time.'").
[3] *See Klersy Bldg. Corp. v. Harleysville Worcester Ins. Co.*, 36 A.D.3d 1117, 1118 (N.Y. 2007); *Hartford Cas. Ins. Co. v. ContextMedia, Inc.*, 65 F. Supp. 3d 570, 578–79 (N.D. Ill. 2014).
[4] *E.g., Sentinel Ins. Co., Ltd. V. Cogan*, 202 F. Supp. 3d 831, 841 (N.D. Ill. 2016).
[5] *See Ramirez v. Scottsdale Ins. Co.*, No. 20-CV-22324, 2021 WL 5050184, at *5 (S.D. Fla. Oct. 29, 2021); *Contractors Bonding & Ins. Co. v. Sandrock*, 321 F. Supp. 3d 1205, 1211 (D. Mont. 2018); *Jones v. St. Paul Travelers*, 496 F. Supp. 2d 1079, 1085 (N.D. Cal. 2007).
[6] *E.g., Globe & Rutgers Ins. Co. City of New York v. Prairie Oil & Gas Co.*, 248 F. 452, 455 (2d Cir. 1917).
[7] *Johnson & Bryan, Inc. v. Utica Mut. Ins. Co.*, 741 F. App'x 722, 725–26 (11th Cir. 2018).

- *Hunter v. Mass. Mut. Life Ins. Co.* Insurer invoked insured's delayed notice in letter adjudicating insured's initial request for benefits, and thus did not waive defense on the basis of improper notice.[8]

- *Nat'l Union Fire Ins. Co. Pittsburgh, P.A. v. Gen. Star Indem. Co.* The court explained that, under California law, insurers are required to prove "actual and substantial prejudice" in order to deny coverage based on delayed notice. The insured did not provide notice for nearly three years after a verdict giving rise to a claim under the policy and gave notice only four weeks before the judgment was final. The court concluded that the delay "substantially prejudiced" the insurer because the insurer was "denied any right to participate in the appeals or to attempt to broker a settlement for less than the full amount of the judgment."[9]

II. Insurer's Duties

A. Overview

This section discusses the post-loss duties that the insurer owes to the insured, including the duty to investigate, the duty to defend, the duty to cooperate, and the duty to settle or compromise claims, and the consequences of the insurer's failure to fulfill these duties.

B. Duty to Investigate

Many insurance policies specifically provide that an insurer has a duty to investigate claims.[10] However, even when an insurance contract is silent as to the duty to investigate, a statutory or good faith duty to investigate may still be enforced in many jurisdictions. For example, in some jurisdictions, courts will impose a duty to investigate based on the implied covenant of good faith and fair dealing.[11] In other jurisdictions, the duty to investigate can be mandated by statute.[12]

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[8] *Hunter v. Mass. Mut. Life Ins. Co.*, 53 F. Supp. 3d 86, 90–92 (D.D.C. 2014).
[9] *Nat'l Union Fire Ins. Co. Pittsburgh, PA v. Gen. Star Indem. Co.*, 216 F. App'x 273, 280–81 (3d Cir. 2007).
[10] *See, e.g., GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church*, 197 S.W.3d 305, 307 (Tex. 2006) (quoting insurance contract stating insurer "shall have the right and duty to investigate any claim").
[11] *See, e.g., Harbison v. Am. Motorists Ins. Co.*, 636 F. Supp. 2d 1030, 1041 (E.D. Cal. 2009) ("The covenant of good faith and fair dealing implied in all insurance agreements entails a duty to investigate property submitted claims").
[12] For example, in Massachusetts, state statute provides that an insurer's "[f]ailing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies" and "[r]efusing to pay claims without conducting a reasonable investigation based upon all available information" are "unfair claim settlement practices" that constitute "unfair methods of competition and unfair or deceptive acts or practices in the business of insurance." MASS. GEN. LAWS ANN. ch. 176D § 3(9)(c)–(d).
See, e.g., Wade v. EMCASCO Ins. Co., 483 F.3d 657, 672 (10th Cir. 2007) ("Kansas law requires insurers to promptly conduct reasonable, good-faith investigations of claims arising under their policies"); *RLI Ins. Co. v. Conseco, Inco.*, 477 F. Supp. 2d 741, 749 (E.D. Va. 2007) ("An insurer is obliged by Indiana law to 'promptly and thorough investigate all claims.'"); *Lennar Corp. v. Auto-Owners Ins. Co.*, 151 P.3d 538, 547 (Ariz. Ct. App. 2007) ("[A]ccording to Airzona law, once an insured makes some factual showing that the suit is actually one for damages resulting from events that fall under policy terms, an insurer has a duty to investigate those facts and provide a defense when indicated").

The duty to investigate generally is triggered when the insured notifies the insurer of a claim, occurrence, or loss.[13]

The duty to investigate generally requires insurers to investigate a claim before denying coverage or settling the claim, and before making a determination as to its duty to defend.[14] However, some courts hold that there is no obligation to investigate a claim that is invalid on its face.[15]

The insurer's investigation must be reasonable in terms of scope and timeliness.[16] The "reasonableness" standard is often imposed by statute,[17] but may also flow from the implied covenant of good faith and fair dealing.[18] An insurer's duty to conduct a reasonable investigation is not limited to the facts or theories of coverage relied on by its insured—the insurer must investigate whether coverage is available under *any* facts or theories.[19]

See:

- *Capitol Specialty Ins. Corp. v. Higgins.* Applying Massachusetts law, the court concluded nightclub's insurer failed to conduct reasonable investigation. Insurer was aware that injured party was highly intoxicated at the time of the accident, but closed its investigation after receiving self-serving statements from nightclub's owner, manager, and bartender that they had not served alcohol to the underage injured party. Insurer also failed to obtain statements from police officer or other employees present.[20]

- *Grossi v. Travelers Pers. Ins. Co.* Under Pennsylvania law, the court faulted the insurer for conducting its investigation "in bad faith, not merely because of [a] delay, but because there were, inter alia, inexcusable periods of inactivity, unreasonable assumptions, and inadequate communication" by the insurer. Among other things, the court found that the insurer did not conduct initial independent analysis, delayed investigation, rejected insured's future earnings loss claim without basis, committed to arbitration prior to beginning its investigation, and failed to adequately communicate with the insured.[21]

- *Safeco Ins. Co. of Am. v. Parks.* The court held that, under California law, "[w]here an insurer denies coverage but a reasonable investigation would have disclosed facts showing the claim was covered, the insurer's failure to investigate breaches its implied covenant."

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[13] *See Erie Ins. Exch. V. Lobenthal*, 114 A.3d 832, 839 (Pa. Super. Ct. 2015); *Safeco Ins. Co. of Am. v. Parks*, 170 Cal. App. 4th 992, 1003 (Cal. Ct. App. 2009).
[14] *See, e.g., Fed. Ins. Co. v. HPSC, Inc.*, 480 F.3d 26, 36 (1st Cir. 2007); *Wade v. EMCASCO Ins. Co.*, 483 F.3d 657, 672 (10th Cir. 2007); *Ivanov v. Farmers Ins. Co. of Or.*, 185 P.3d 417, 421 (Or. 2008); *Lennar Corp.*, 151 P.3d at 547–48.
[15] *E.g., Liberty Nat. Life Ins. Co. v. Bailey ex rel. Bailey*, 944 So. 2d 1028, 1030 (Fla. Dist. Ct. App. 2006).
[16] *See Safeco*, 170 Cal. App. 4th at 1006 ("Whether the insurer's investigation of a particular claim was reasonable must be determined on a case by case basis and will depend on the contractual purposes and reasonably justified expectations of the parties").
[17] *See, e.g.*, *Fed. Ins. Co.*, 480 F.3d at 36 (recognizing statutory duty to conduct reasonable investigation in Massachusetts); *Lakehurst Condo. Owners Ass'n v. State Farm Fire & Cas. Co.*, 486 F. Supp. 2d 1205, 1217 (W.D. Wash. 2007) (recognizing statutory duty to conduct reasonable investigation in Washington).
[18] *See, e.g.*, *Harbison v. Am. Motorists Ins. Co.*, 636 F. Supp. 2d 1030, 1039 (E.D. Cal. 2009).
[19] *See Safeco*, 170 Cal. App. 4th at 1007–09.
[20] *Capitol Specialty Ins. Corp. v. Higgins*, 953 F.3d 95, 109–10 (1st Cir. 2020).
[21] *Grossi v. Travelers Pers. Ins. Co.*, 79 A.3d 1141, 1154 (Pa. Super. Ct. 2013).

The court concluded that the insurer breached the implied covenant by denying the claim without investigating whether it had issued any other policy that might have covered claim, other than the one referenced by the insured in the claim.[22]

C. Duty to Defend

The insurer's duty to defend is its duty to defend the insured against all actions brought against him or her on allegations of facts and circumstances covered by the policy. The duty to defend is typically intertwined with the insurer's right to exclusive control over litigation against the insured.[23] The duty to defend is separate from—and broader than—the duty to indemnify.[24]

The duty to defend is conferred by contract—courts generally hold that "[t]here is no common law duty to defend."[25] Some jurisdictions, such as California, will presume that there is a duty to defend unless an insurance policy explicitly states otherwise.[26] However, courts in most other jurisdictions will not presume a duty to defend, but instead require that an insurance policy expressly impose such a duty before they will recognize it.[27] For example, many courts have found that where a policy expressly "creates a ***right*** to defend, it is clear and unambiguous that it does not create a ***duty*** on the part of the insurer."[28]

State statutes should also be consulted regarding the existence or scope of and other details pertaining to an insurer's duty to defend.[29] For example, a Florida statute provides that "[n]o insurer shall have any duty to defend uncovered claims irrespective of their joinder with covered claims."[30] A California statute provides that, where a duty to defend exists, "the insurer shall provide independent counsel to represent the insured."[31]

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[22] *Safeco Ins. Co. of Am. v. Parks*, 170 Cal. App. 4th 992, 1008 (Cal. Ct. App. 2009).
[23] *See Nat'l Cas. Co. v. Forge Indus. Staffing Inc.*, 567 F.3d 871, 874 (7th Cir. 2009) ("In Illinois . . . [a]long with an insurer's obligation to defend its insured comes its right to control and direct the defense"); *see also Graper v. Mid-Continent Cas. Co.*, 756 F.3d 388, 392 (5th Cir. 2014) (holding the same under Texas law); *Travelers Indem. Co. of Conn. v. Newlin*, 498 F. Supp. 3d 1262, 1272 (S.D. Cal. 2020) (holding the same under California law).
[24] *See, e.g.*, *Westfield Ins. Co. v. Nat'l Decorating Serv., Inc.*, 863 F.3d 690, 695 (7th Cir. 2017); *Travelers Prop. Cas. Co. of Am. v. H.E. Sutton Forwarding Co., LLC*, No. 21-CV-00719, 2022 WL 3155402, at *3 (M.D. Fla. Aug. 8, 2022); *Allstate Ins. Co. v. Vitality Physicians Grp. Prac. P.C.*, 537 F. Supp. 3d 533, 547 (S.D.N.Y. 2021); *J&J Holdings, Inc. v. Great Am. E&S Ins. Co.*, 420 F. Supp. 3d 998, 1007 (C.D. Cal. 2019).
[25] *Hurley v. Columbia Cas. Co.*, 976 F. Supp. 268, 275 (D. Del. 1997).
[26] *See Travelers Cas. & Sur. Co. v. Am. Int'l Surplus Lines Ins. Co.*, 465 F. Supp. 2d 1005, 1012 (S.D. Cal. 2006) ("Liability policies are presumed to include a defense obligation unless the duty is excluded by clear and unambiguous language").
[27] *See MBIA Inc. v. Certain Underwriters at Lloyd's, London*, 33 F. Supp. 3d 344, 355 (S.D.N.Y. 2014) ("In the absence of a policy provision expressly imposing a duty to defend, New York courts will not find such a duty"); *see also AstenJohnson, Inc. v. Columbia Cas. Co.*, 562 F.3d 213, 230 (3d Cir. 2009).
[28] *E. Fla. Hauling, Inc. v. Lexington Ins. Co.*, 913 So. 2d 673, 678 (Fla. Dist. Ct. App. 2005); *see also Centennial Ins. Co. v. Transitall Servs. Inc.*, No. 00-CV-01383, 2001 WL 289879, at *3 (N.D. Ill. Mar. 15, 2001) ("The plain language of the policy states that Centennial has the right, which is clearly distinguishable from the duty, to settle and provide a defense").
[29] *See, e.g.*, *Minn. Life Ins. Co. v. Columbia Cas. Co.*, 164 So. 3d 954, 970 (Miss. 2014) (recognizing statutes may impose a "higher obligation" regarding an insured's duty to defend than the insurance policy).
[30] FLA. STAT. ANN. § 324.022(1).
[31] ANN. CAL. CIV. CODE § 2860(a).

Whether a duty to defend exists in a particular case depends on whether the claim as alleged in the complaint, falls within the terms of the insuring agreement.[32] In general, "the bar to finding a duty to defend is low."[33]

Generally, an insurer may not refuse to defend unless "it is clear from the face of the complaint that the allegations fail to state facts that bring the case within, or potentially within, the policy's coverage."[34] An insurer who refuses to defend or defends under a reservation of rights "gives up its exclusive control of the defense of its insured and does so at its own risk."[35] A wrongful refusal to defend the insured may result in the insurer being estopped from disputing coverage, losing rights under the policy, and liability for damages for breach of contract and breach of the implied covenant of good faith and fair dealing.[36] Even a good faith refusal to defend, if wrong, "does not relieve [the insurer] of the consequences of breaching that duty."[37] Importantly, the duty to defend is broader than the duty to provide coverage for covered claims. The insurer "must defend a[ny] suit which *potentially* seeks damages within the coverage of the policy,"[38] and any doubts as to whether the allegations fall within the policy must be "resolved in favor of the insured."[39] Where a suit contains multiple claims against the insured, the insurer must defend against the entire suit, even if only one of the claims would be within the scope of coverage.[40] The duty to defend attaches for the claim's lifetime, or until it is determined with certainty that the claim is not covered under the policy, whichever comes earlier.[41]

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[32] *See, e.g.*, *All Green Elec., Inc. v. Sec. Nat'l Ins. Co.*, 22 Cal. App. 5th 407, 412 (2018) ("The determination whether the insurer owes a duty to defend usually is made in the first instance by comparing the allegations of the complaint with the terms of the policy"); *City of New York v. Wausau Underwriters Ins. Co.*, 145 A.D.3d 614, 617 (N.Y. App. Div. 2016) ("A duty to defend exists whenever the allegations in the complaint in the underlying action, construed liberally, suggest a reasonable possibility of coverage, or where the insurer has actual knowledge of facts establishing such a reasonable possibility").

[33] *Sterigenics, U.S., LLC v. Nat'l Union Fire Ins. Co. of Pittsburgh, P.A.*, 619 F. Supp. 3d. 852, 862 (N.D. Ill. Aug. 3, 2022).

[34] *Ill. Cas. Co. v. W. Dundee China Palace Rest., Inc.*, 49 N.E.3d 420, 424 (Ill. App. Ct. 2015).

[35] *Geurden v. Quantum Transp. LP*, 298 F. Supp. 3d 1222, 1229 (D. Ariz. 2018).

[36] *See Eclipse Mfg. Co. v. U.S. Compliance Co.*, 886 N.E.2d 349, 357 (Ill. App. Ct. 2007); *BellSouth Telecomms., Inc. v. Church & Tower of Fla., Inc.*, 930 So. 2d 668, 671 (Fla. Dist. Ct. App. 2006); *Truck Ins. Exch. v. Superior Ct.*, 51 Cal. App. 4th 985, 990 (Cal. Ct. App. 1996).

[37] *Ripepi v. Am. Ins. Cos.*, 349 F.2d 300, 302 (3d Cir. 1965).

[38] *Travelers Cas. & Sur. Co. v. Am. Int'l Surplus Lines Ins. Co.*, 465 F. Supp. 2d 1005, 1013 (S.D. Cal. 2006); *see also Pekin Ins. Co. v. KCJ Consulting, Inc.*, 2020 IL App (4th) 190831-U, ¶ 20 (Ill. App. Ct. 2020).

[39] *see, e.g.*, *Noble Energy, Inc. v. Bituminous Cas. Co.*, 529 F.3d 642, 646 (5th Cir. 2008) (discussing Texas law); *St. Paul Fire & Marine Ins. Co. v. Cypress Fairway Condo. Ass'n, Inc.*, 114 F. Supp. 3d 1231, 1236 (M.D. Fla. 2015); *VierraMoore, Inc. v. Continental Cas. Co.*, 940 F. Supp. 2d 1270, 1278 (E.D. Cal. 2013).

[40] *See, e.g.*, *Arch Specialty Ins. Co. v. Colony Ins. Co.*, 590 F. Supp. 3d 395, 415 (D. Mass. 2022); *Align Tech., Inc. v. Fed. Ins. Co.*, 673 F. Supp. 2d 957, 967 (N.D. Cal. 2009); *Farmers Auto. Ins. Ass'n v. Neuman*, 28 N.E.3d 830, 834 (Ill. App. Ct. 2015).

[41] *See Crosby Est. at Rancho Santa Fe Master Ass'n v. Ironshore Specialty Ins. Co.*, 578 F. Supp. 3d 1123, 1130 (S.D. Cal. 2022) ("The duty to defend arises on tender and is discharged when the action is concluded. It may be extinguished earlier, if it is shown that no claim can in fact be covered"); *see also Dish Network Corp. v. Ace Am. Ins. Co.*, 21 F.4th 207, 212 (2d Cir. 2021) ("[T]he insurer is bound to defend its insured until such time as any ambiguity as to coverage is resolved in the insurer's favor").

See:

- *Panfil v. Nautilus Ins. Co*. Under Illinois law, because there was potential for coverage based on the allegations in the underlying complaint, the insurer had an obligation to defend. Insurer thus breached contract by refusing to defend and, as a consequence, was estopped from asserting policy defenses to coverage.[42]

- *Pac. Hide & Fur Depot v. Great Am. Ins. Co.* Under Montana law, "where the insurer refuses to defend, and does so unjustifiably, that insurer becomes liable for defense costs and judgment." Insurer refused to defend underlying action, and thus was liable for breach of contract. For damages, the court awarded the insured the amount it paid for the consent judgment in the underlying action, attorneys' fees, and post-judgment interest.[43]

- *Schmitz v. Great Am. Assur. Co*. Under Missouri law, the insurer breached the policy by refusing to defend on more than one occasion, thus rendering it liable for breach of contract, and enabling the insured to "without the insurer's consent, enter an agreement with the plaintiff to limit its liability to its insurance policies." The insurer's "claim that its refusals were an honest mistake [was] of no consequence."[44]

D. Duty to Cooperate

"Cooperation is essential to the insurance relationship because that relationship involves a continuous exchange of information between insurer and insured interspersed with activities that affect the rights of both."[45] Most insurance policies include a "cooperation clause,"[46] but if a policy does not include such a clause, one is typically implied in law.[47]

The duty to cooperate is reciprocal.[48] The insurer must use reasonable diligence in obtaining the insured's cooperation.[49]

See:

- *Founders Ins. v. Shaikh.* The insurer properly requested cooperation where it "used reasonable efforts and diligently pursued contact with [insured] in order to secure his cooperation." After the insurer discovered the insured's phone service had been disconnected, the insurer hired an investigator to locate the insured, who visited all last

[42] *Panfil v. Nautilus Ins. Co.*, 799 F.3d 716, 719–22 (7th Cir. 2015).
[43] *Pac. Hide & Fur Depot v. Great Am. Ins. Co.*, 23 F. Supp. 3d 1208, 1225–26 (D. Mont. 2014).
[44] *Schmitz v. Great Am. Assur. Co.*, 337 S.W.3d 700, 710 (Mo. 2011) (en banc).
[45] *Staples v. Allstate Ins. Co.*, 295 P.3d 201, 205 (Wash. 2013) (en banc).
[46] For an example of a cooperation clause, *see, e.g.*, *Sec. Ins. Co. of Hartford v. Schipporeit, Inc.*, 69 F.3d 1377, 1382 (7th Cir. 1995).
[47] *See Sec. Mut. Life Ins. Co. of N.Y. v. DiPasquale*, 756 N.Y.S.2d 5, 5 (N.Y. App. Div. 2003) ("Even in the absence of an explicit cooperation clause, the insured owed the insurer a duty of good faith").
[48] *See E. Air Lines, Inc. v. U.S. Aviation Underwriters, Inc.*, 716 So. 2d 340, 343 (Fla. Dist. Ct. App. 1998).
[49] *See Sec. Ins. Co. of Hartford v. Schipporeit, Inc.*, 69 F.3d 1377, 1383 (7th Cir. 1995) ("The duty to cooperate is only triggered when the insurer demands cooperation"); *Allstate Ins. Co. v. Loester*, 675 N.Y.S.2d 832, 834 (N.Y. Sup. Ct. 1998) ("The methods employed by the insurer must be reasonably calculated to find the insured and secure his cooperation. There must be substantial effort exerted with a reasonable degree of skill").

known addresses of the insured, contacted the insured's family members, and attempted to send mail to the insured. The insurer maintained an "active search," but "[t]he results of [the insurer's] persistent efforts suggest[ed] [the insured] did not want to be found."[50]

- *Rucaj v. Progressive Ins. Co.* Under New York law, the actions taken by an insurer to secure the insured's cooperation "were, as a matter of law, insufficient to be termed either diligent or reasonably calculated to obtain his cooperation." The insurer merely spoke with the insured by phone once, and failed to reach the insured by phone on further occasions. No written correspondence or investigators were sent to the insured's residence, place of employment, family, or neighbors.[51]

- *Wallace v. Woolfolk.* Holding that, under Illinois law, "[m]erely sending letters to its insured was not enough to satisfy [the insurer's] duty to seek its insured's cooperation."[52]

E. Duty to Settle or Compromise Claims

An insurer may also take on a duty to settle or compromise claims under state law,[53] or have the right to negotiate and accept or reject settlement offers under the relevant insurance policy.[54]

"The duty to settle arises because of the inherent conflict of interest created by the different risks faced by the insurer and the insured."[55] As such, the insurer must exercise this duty in good faith, in a manner that does not put the insurer's interests ahead of the insured's.[56] On the other hand, the insurer is not obligated to settle at all costs so long as it considers any potential settlement offer in good faith.[57]

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[50] *Founders Ins. Co. v. Shaikh*, 937 N.E.2d 1186, 1195–96 (Ill. App. Ct. 2010).
[51] *Rucaj v. Progressive Ins. Co.*, 19 A.D.3d 270, 271–72 (N.Y. App. Div. 2005).
[52] *Wallace v. Woolfolk*, 728 N.E.2d 816, 820 (Ill. App. Ct. 2000).
[53] *See Silva v. Steadfast Ins. Co.*, 35 N.E.3d 401, 407 (Mass. App. Ct. 2015) (requiring insurers "to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear").
[54] *see, e.g.*, *Piedmont Off. Realty Tr., Inc. v. XL Specialty Ins. Co.*, 11 F. Supp. 3d 1184, 1189 (N.D. Ga. 2014) (insurance policy stated actions could not be settled without the insurer's written consent); *W. Polymer Tech., Inc. v. Reliance Ins. Co.*, 32 Cal. App. 4th 14, 18 (1995) (insurance policy granted insurer the right to "make such investigation and settlement of any claim or suit as it deems expedient").
[55] *Hedayati v. Interinsurance Exch. of the Auto. Club*, 67 Cal. App. 5th 833, 844 (Cal. Ct. App. 2021).
[56] *See Surgery Ctr. at 900 N. Mich. Ave., LLC v. Am. Physicians Assurance Corp., Inc.*, 922 F.3d 778, 785 (7th Cir. 2019) (under Illinois law, insurer acts in bad faith if it fails to give equal consideration to interests of insured when responding to settlement offer); *In re Sept. 11 Prop. Damage Litig.*, 650 F.3d 145, 151 (2d Cir. 2011) ("[U]nder New York State law, an insurer has discretion to settle whenever and with whomever it chooses, provided it does not act in bad faith"); *W. Polymer*, 32 Cal. App. 4th at 26 (under California law, "the implied covenant of good faith and fair dealing protects the insured's enjoyment of the policy's benefits and purposes and avoids impairing the insured's interests under the policy")*; but see Tibbetts Lumber Co., LLC v. Amerisure Ins. Co.*, 451 F. Supp. 3d 1295, 1303 (M.D. Fla. 2020) (explaining that, under Florida law, "where the policy contains a 'deems expedient' clause with respect to settlement, an insurer may settle a claim within the policy limits even where the claim is frivolous and without consideration of the insured's best interest").
[57] *See Huang v. Brenson*, 7 N.E.3d 729, 740 (Ill. App. Ct. 2014) ("The insurer need not submit to extortion [when considering a settlement offer]; it may reject a bad deal").

In some jurisdictions, there is no duty to settle unless the insurer "assumes exclusive control over the insured's defense."[58] In other jurisdictions, there is no duty to settle until a settlement offer is made within the policy limits.[59]

See:

> *Capitol Specialty Ins. Corp. v. GEICO Gen. Ins. Co.* Court rejected claim against insurer for refusing to accept settlement offer from motorcyclist following accident between motorcyclist and the insured. Under California law, court found insurer did not reject settlement offer in bad faith; but rather, did not have sufficient information to corroborate the medical costs and expenses purportedly underlying the motorcyclist's offer, and was "not required to accept the settlement demand simply because it was within the policy limits." Absent any indication the insurer breached its duty to conduct a reasonable investigation, "no reasonable juror could conclude that [the insurer] acted in bad faith" by refusing to accept the settlement offer.[60]
>
> *Travelers Indem. Co. of Ill. v. Royal Oak Enters., Inc.* Court rejected claim against insurer for refusing to accept settlement offer. Under Florida law, an insurer cannot act "negligently or in bad faith by refusing to settle a claim against which the insured has a valid defense." Because the action against the insured was clearly barred by worker's compensation immunity, the insurer's rejection of the settlement offer was not in bad faith.[61]

III. Insured's Duties

A. Overview

This section discusses the post-loss duties that the insured owes to the insurer, and the consequences for the insured's failure to fulfill its duties.

B. Duty to Cooperate

As explained above,[62] the duty to cooperate is reciprocal.[63] In general terms, the duty to cooperate requires the insured "to make a fair, frank and truthful disclosure to the insurer for the purpose of enabling it to determine whether or not there is a defense, and the obligation, in good faith, both to aid in making every legitimate defense to the claimed liability and to render assistance at trial."[64]

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[58] *Essex Ins. Co. v. Blue Moon Lofts Condo. Ass'n*, 927 F.3d 1007, 1015 (7th Cir. 2019) (discussing Illinois law); *see also Scottsdale Ins. Co. v. McGrath*, 549 F. Supp. 3d 334, 344 (S.D.N.Y. 2021) (discussing New York law).
[59] *Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 77 S.W.3d 253, 262 (Tex. 2002). Other jurisdictions hold that there is no duty to settle absent a reasonable probability of liability. *Surgery Ctr.*, 922 F.3d at 787 (discussing Illinois law); *Calandro v. Sedgwick Claims Mgmt. Servs., Inc.*, 919 F.3d 26, 34 (1st Cir. 2019) (under Massachusetts law, "the duty to settle arises only when liability and damages for the underlying claim have become reasonably clear").
[60] *Capitol Specialty Ins. Corp. v. GEICO Gen. Ins. Co.,* 562 F. Supp. 3d 563, 571–73 (C.D. Cal. 2021).
[61] *Travelers Indem. Co. of Ill. v. Royal Oak Enters., Inc.*, 429 F. Supp. 2d 1265, 1271 (M.D. Fla. 2004).
[62] Section II, *supra.*
[63] *See E. Air Lines, Inc. v. U.S. Aviation Underwriters, Inc.*, 716 So. 2d 340, 343 (Fla. Dist. Ct. App. 1998).
[64] *Woznicki v. GEICO Gen. Ins. Co.*, 90 A.3d 498, 509 (Md. App. 2014); *see also Motorola Sols., Inc. v. Zurich Ins. Co.*, 83 N.E.3d 1063, 1076 (Ill. App. Ct. 2017) (holding that a policy's "cooperation clause does obligate the insured

While policies vary in their exact requirements, a cooperation clause may require specific things, such as that the insurer attend hearings/trials, assist in settlement efforts, or help in securing the attendance of witnesses.

See:

- *Direct Auto Ins. Co. v. Reed.* Insurance policy's cooperation clause required insured to "provide recorded statement(s); an examination under oath; attend hearings and trials; assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses and in the conduct of any legal proceedings in connection with the subject matter of this insurance."[65]

- *Chi. Title Ins. Co. v. Bristol Heights Assocs., LLC.* Insurance policy's cooperation clause entitled insurer "to require the [insured] to submit to examination under oath and produce various records and documentation which reasonably pertain to the loss or damage at issue in a claim that is being investigated."[66]

- *Am. Country Ins. Co. v. Kraemer Bros.* Insurance policy's cooperation clause required insured to tender defense of an underlying suit to any other insurer with applicable coverage.[67]

C. Failure to Comply with the Duty to Cooperate

Jurisdictions differ as to whether the failure to comply with the duty to cooperate relieves the insurer of providing coverage.[68]

Many jurisdictions, including Connecticut, Michigan, New York, Pennsylvania, and Washington, will find an insured has satisfied its duty to cooperate if it "substantially complied" with the clause at issue.[69] However, some courts have insisted on strict compliance with the cooperation clause.[70]

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to disclose all of the facts within his knowledge and otherwise to aid the insurer in its determination of coverage under the policy").

[65] *Direct Auto Ins. Co. v. Reed*, 76 N.E.3d 85, 88 (Ill. App. Ct. 2017).

[66] *Chi. Title Ins. Co. v. Bristol Heights Assocs., LLC*, 70 A.3d 74, 84–85 (Conn. App. Ct. 2013).

[67] *Am. Country Ins. Co. v. Kraemer Bros.*, 699 N.E.2d 1056, 1058 (Ill. App. Ct. 1998).

[68] *Compare Roc Nation LLC v. HCC Int'l Ins. Co., PLC*, 523 F. Supp. 3d 539 (S.D.N.Y. 2021) (requiring insurer's compliance with duty to cooperate) *with Hernandez v. Perez*, 1995 Mass. App. Div. 131, at *2 (Mass. Dist. Ct. 1995) (under Massachusetts law "[a]n insurer who issues a [] automobile policy is obligated to pay third parties who recover damages an amount equal to the compulsory limits of the policy even when . . . the defendant-insured refuses to cooperate"); *and Harris v. Prudential Prop. & Cas. Ins. Co.*, 632 A.2d 1380, 1382 (Del. 1993) (finding noncooperation was a valid defense only after liability extended beyond state statute's minimum insurance requirement of $15,000 in coverage).

[69] *See, e.g.*, *Roc Nation LLC*, 523 F. Supp. 3d at 554; *Vertex Int'l Mgmt. Servs., L.L.C. v. State Farm Fire & Cas. Co.*, 120 F. Supp. 3d 658, 665 (E.D. Mich. 2011); *Staples*, 295 P.3d at 207 ("Breach of a cooperation clause is measured by the yardstick of substantial compliance"); *Double G.G. Leasing, LLC v. Underwriters at Lloyd's, London*, 978 A.2d 83, 92 (Conn. App. Ct. 2009); *Forest City Grant Liberty Assocs. v. Genro II, Inc.*, 652 A.2d 948, 951 (Pa. Super. Ct. 1995).

[70] *See, e.g.*, *In re U.S.A. Elecs., Inc.*, 120 B.R. 637, 644 (Bankr. E.D.N.Y. 1990); *Fisk v. Atl. Nat. Ins. Co.*, 236 A.2d 688, 690 (N.H. 1967) (applying Massachusetts law).

For an insured's noncooperation to override a coverage obligation, most jurisdictions require some additional showing beyond the mere fact of the insured's noncooperation. For example, many jurisdictions require that the insured's breach of the cooperation clause be "material."[71] Many jurisdictions further require that the insurer demonstrate that it was prejudiced by the insured's breach of the clause.[72] Going a step further, some jurisdictions, such as New York and Indiana, require the insurer to show willfulness.[73]

See:

- *McClune v. Farmers Ins. Co., Inc*. Under Missouri law, "[an] insured's failure to assist in the investigation [can] preclude[] any coverage." The court found that the insured materially breached the cooperation clause by refusing to submit to an examination under oath. This refusal prejudiced the insurer by preventing it from continuing its investigation of the insured's claim. Thus, the insurer had the right to deny coverage under the policy.[74]

- *DeLuca v. RLI Ins. Co*. Under New York law, an insurer failed to establish a claim for insured's breach of cooperation clause. Insurer asserted that insured refused to cooperate but did not identify any information that insured failed to disclose, documents that insured failed to provide, or court proceedings that insured failed to attend. The court held that, under these circumstances, the insurer's assertion that the insured "refused to respond to certain telephone calls and letters was insufficient to show 'an attitude of willful and avowed obstruction.'"[75]

- *Goddard v. State Farm Mut. Auto. Ins. Co*. Under Pennsylvania law, "[a] prejudicial breach of the cooperation clause of an insurance policy relieves the insurer of its obligations under the policy." Under the relevant insurance policy, the insured was required to submit to a medical examination in order to recover after suffering injuries following an automobile accident. The court determined that the insured breached the policy's cooperation clause because the insured refused to submit to a medical examination, despite at least six written requests from the insurer. Because the insured's refusal to submit to a medical examination denied the insurer the opportunity to evaluate the state of the insured's health and to

[71] *See, e.g.*, *Verdetto v. State Farm Fire & Cas. Co.*, 837 F. Supp. 2d 480, 484 (M.D. Pa. 2011); *McCartney v. Shelter Mut. Ins. Co.*, 255 So. 3d 1060, 1062 (La. Ct. App. 2018); *Roller v. Am. Mod. Home Ins. Co.*, 484 S.W.3d 110, 116 (Mo. Ct. App. 2015); *Hanover Ins. Co. v. Cape Cod Custom Home Theater, Inc.*, 891 N.E.2d 703, 706 (Mass. App. Ct. 2008); *Latha Rest. Corp. v. Tower Ins. Co.*, 831 N.Y.S.2d 411, 412 (N.Y. App. Div. 2007).
[72] *See, e.g.*, *Biscayne Cove Condo. Ass'n v. QBE Ins. Corp.*, 971 F. Supp. 2d 1121, 1138 (S.D. Fla. 2013); *Ram v. Infinity Select Ins.*, 807 F. Supp. 2d 843, 857 (N.D. Cal. 2011); *Cincinnati Ins. Co. v. Irvin*, 19 F. Supp. 2d 906, 911 (S.D. Ind. 1998); *Travelers Home & Marine Ins. Co. v. Castellanos*, 773 S.E.2d 184, 187 (Ga. 2015); *Soicher v. State Farm Mut. Auto. Ins. Co.*, 351 P.3d 559, 564 (Colo. App. 2015); *Am. Access Cas. Co. v. Alassouli*, 31 N.E.3d 803, 814 (Ill. App. Ct. 2015); *Martinez v. ACCC Ins. Co.*, 343 S.W.3d 924, 930 (Tex. Ct. App. 2011).
[73] *Allstate Ins. Co. v. United Int'l Ins. Co.*, 792 N.Y.S.2d 549, 551 (N.Y. App. Div. 2005) (requiring showing that "the attitude of the insured, after his or her cooperation was sought, was one of willful and avowed obstruction"); *Cincinnati Ins. Co.*, 19 F. Supp. at 911 ("Under Indiana law, [the insurer] clearly bears the burden of proving that [the insured]'s failure to cooperate was willful and intentional").
[74] *McClune v. Farmers Ins. Co., Inc.*, 12 F.4th 845, 849–52 (8th Cir. 2021).
[75] *DeLuca v. RLI Ins. Co.*, 131 N.Y.S.3d 716, 721 (N.Y. App. Div. 2020).

> determine whether the accident caused the insured's injuries, the court found that the insurer was prejudiced by the insured's breach of the cooperation clause.[76]

IV. Insurer's Reservation of Rights

A. Overview

An insurer may elect to provide defense coverage, subject to a reservation of rights, to challenge the availability of coverage under the policy. In such circumstances, the insurer will typically issue a reservation of rights letter to avoid waiving its policy defenses by undertaking the defense of a claim against an insured. A reservation of rights letter can also serve to inform the insured of possible conflicts of interest between itself and the insurer, and help the insured to decide whether to retain its own counsel.[77] An insurer that provides a defense without a reservation of rights may waive its right to later assert defenses to coverage.[78]

Generally, in order to be effective, a reservation of rights must contain sufficient detail with respect to the insurer's coverage position and make clear that the insurer is defending subject to a reservation of rights.[79] In general, an appropriate reservation of rights letter:

> does most, if not all, of the following: (1) identifies the policy at issue; (2) quotes, or at least refers to, the relevant policy provisions and identify any terms, conditions, or exclusions which may bar coverage; (3) refers to specific, relevant allegations in the complaint; (4) identifies which claims may not be covered; (5) explains in detail the basis for the insurer's coverage position; (6) sets forth the proposed arrangement for providing a defense and, depending on the law of the jurisdiction, advises the insured of its right to independent defense counsel; (7) advises the insured of any actual or potential conflicts of interest between the insurer and the insured; (8) reserves the right to withdraw from the defense; (9) contains a general reservation of rights, including the right to assert other defenses the insurer may subsequently learn to exist during further investigation; and (10) uses the words 'reservation of rights.'[80]

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[76] *Goddard v. State Farm Mut. Auto. Ins. Co.*, 992 F. Supp. 2d 473, 478–79 (E.D. Pa. 2014).
[77] *Hous. Auth. of City of Dallas, Tex. v. Northland Ins. Co.*, 333 F. Supp. 2d 595, 600 (N.D. Tex. 2004); *Am. Fam. Mut. Ins. Co. v. Westfield Ins. Co.*, 962 N.E.2d 993 (Ill. App. Ct. 2011).
[78] *See, e.g.*, *Northfield Ins. Co. v. Sandy's Place, LLC*, 530 F. Supp. 3d 952, 969 (E.D. Cal. 2021); *Essex Ins. Co.*, 927 F.3d at 1012; *Am. Nat'l Fire Ins. Co. v. Nat'l Union Fire Ins. Co.*, 796 N.E.2d 1133, 1140 (Ill. App. Ct. 2003).
[79] *See W. Heritage Ins. Co. v. Love*, 24 F. Supp. 3d 866, 878–79 (W.D. Mo. 2014) (holding that reservation of rights letter was improper because, although the letter identified a relevant insurance policy and restated the allegations against the insured, it did "not provide any other information from which [the insured] could infer that [the insurer] was defending subject to a reservation of rights"); *World Harvest Church, Inc. v. GuideOne Mut. Ins. Co.*, 695 S.E.2d 6, 10 (Ga. 2010) ("[an insurer's] reservation of rights must fairly inform the insured that, notwithstanding the insurer's defense of the action, it disclaims liability and does not waive the defenses available to it against the insured").
[80] *W. Heritage*, 24 F. Supp. at 878 (internal citations omitted); *see also Equity General Ins. Co., Inc. v. C & A Realty Co., Inc.*, 715 P.2d 768 (Ariz. Ct. App. Div. 1985) (the reservation of rights letter was adequate where it informed the insured that the insurer would provide a defense under reservation of rights, pointed out specific policy provisions that could result in non coverage, and informed the insured that, because there might be liability in excess of policy limits, they had right to secure independent counsel).

The most important effect of the insurer's reservation of rights is that it suspends the operation of estoppel and allows the insurer to later deploy policy defenses to ultimately deny coverage.[81] However, failure to include all possible policy defenses within the reservation of rights can constitute waiver of those defenses.[82]

There is a split in authority with respect to whether, upon a subsequent determination that the insured is not entitled to coverage, an insurer may recoup defense costs expended under a reservation of rights.[83] Some courts have allowed causes of action by insurers for reimbursement for the cost of litigating claims against which there was no duty to defend, or for a judgment declaring the insurer's right to such reimbursement.[84] In contrast, other courts have refused to recognize claims by insurers for reimbursement of defense costs expended under a unilateral reservation of rights, absent a provision for such reimbursement in the insurance policy.[85]

V. Insurer's Denial of Indemnity or Defense Coverage

An insurer who denies liability under a policy will ordinarily issue a letter denying or disclaiming coverage.

A. Common Reasons for Denial or Disclaimer of Coverage

Insurers seeking to deny or disclaim coverage may rely on various potential defenses, including, for example:

- Misrepresentation and Breach of Warranties. Insureds usually make representations in their application for insurance; if any of these representations are false then the insurer can use the misrepresentation to deny coverage.[86]

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[81] *See Vaughan v. ACCC Ins. Co*., 725 S.E.2d 855 (Ga. Ct. App. 2012); *Apex Mut. Ins. Co. v. Christner*, 240 N.E.2d 742 (Ill. App. Ct. 1968).

[82] *See, e.g.*, *Ill. Ins. Guar. Fund v. Nwidor*, 105 N.E.3d 1035 (Ill. App. Ct. 2018), *appeal denied*, 108 N.E.3d 856 (Ill. 2018) (holding that the reservation of rights notice must make specific reference to the policy defense that ultimately may be asserted); *Armstrong v. Hanover Ins. Co.*, 289 A.2d 669, 673 (Vt. 1972) (holding that an insurer was estopped from asserting additional defenses to coverage when those defenses were not included in its original notice of disclaimer).

[83] *Compare Buss v. Superior Ct.*, 939 P.2d 766, 776–78 (Cal. 1997) (approving of the right), *with Gen. Agents Ins. Co. of Am. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1101 (Ill. 2005) (disapproving of the right), *and Shoshone First Bank v. Pac. Emp. Ins. Co.*, 2 P.3d 510, 511 (Wyo. 2000) (same); *see also Perdue Farms, Inc. v. Travelers Cas. and Surety Co. of Am.*, 448 F.3d 252, 258 (4th Cir. 2006) (acknowledging that "jurisdictions differ on the soundness of an insurer's right to reimbursement of defense costs").

[84] *See, e.g., Buss*, 939 P.2d at 776–77 (allowing an insurer's action for a declaratory judgment stating that it was entitled to reimbursement for costs defending claims not even potentially covered by the policy, reasoning that the insurer had a "right of reimbursement that is implied in law as quasi-contractual, . . . run[ning] against the person who benefits from 'unjust enrichment' and in favor of the person who suffers loss thereby").

[85] *See, e.g.*, *Terra Nova Ins. Co. Ltd. v. 900 Bar, Inc.*, 887 F.2d 1213, 1219 (3d Cir. 1989) ("[W]e believe, the Pennsylvania Supreme Court would preclude an insurer who provides a defense under reservation of rights from recovering the cost of that defense from its insured if it is later determined that there is no coverage"); *Liberty Mut. Ins. Co. v. FAG Bearings Corp.*, 153 F.3d 919, 924 (8th Cir. 1998) (holding that an insurer was not entitled to reimbursement of defense costs expended prior to the court's determination that there was no duty to defend).

[86] *E.g.*, CAL. INS. CODE § 359 ("If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false"); *Bennett v. Nw.*

- Concealment. The insured failed to disclose facts that should have been shared with the insurer.[87]

- The loss was expected or intended by the insured.

- The loss was known at the time the insured sought coverage.

- The insured breached its duties.

- The claim was untimely.

- The claim was outside the policy period.

- Prior acts or claims.

- Injury or damage occurred outside of the policy period.

- The claim is precluded by the exceptions or exclusions to coverage under the policy.

- Punitive damages. Even if an insurance policy does not expressly exclude punitive damages (and even when coverage expressly does include punitive damages), state law sometimes prohibits such coverage. Some policies will expressly provide coverage only for punitive damages where such coverage is legal—called a "most favorable jurisdiction" clause.[88]

- Restitution. Many policies expressly exclude coverage for restitution or disgorgement.

- Public Policy violations. Even without express terms for exclusion, insurers can sometimes successfully deny coverage for public policy reasons.

B. Denial of Defense Coverage – Special Considerations

If the insurer has a contractual duty to defend against claims brought against the insured, the insurer takes on certain risks if it refuses to fulfill its duty to defend. If the insurer provides a defense to a claim brought against the insured in litigation, the insured cannot settle without the consent of the insurer; however, if the insurer refuses to provide a defense, its consent is no longer required, and

Nat'l Ins. Co., 257 P. 586, 589 (Cal. Ct. App. 1927) ("a misrepresentation is material which would affect the rate of the premium or influence the insurer in accepting or rejecting the risk").

[87] *E.g.*, CAL. INS. CODE § 331 ("Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance").

[88] *See, e.g.*, *Travelers Indem. Co. v. Despain*, No. 05-CV-00489, 2006 WL 3747318, at *3 (M.D. Fla. Dec. 18, 2006) (Florida public policy generally prohibits insurance coverage for punitive damages for the direct wrongful conduct of the insured, even where the insurance policy specifically provides for such insurance).

if it is later found that the insurer breached its duty to defend, then the insurer can be liable for the total value of the settlement even if it exceeds policy limits.[89]

An insured may enter into an agreement not to execute with the plaintiff, under which the claim is assigned to the insurer and the plaintiff agrees not to pursue damages against the insurer above the policy limit. However, any judgment reached under such an arrangement must be free of fraud or collusion between the plaintiff and the insured.[90]

C. Effect of Insurer's Refusal to Defend

Under the law of some states, an insurer's wrongful failure to defend may estop the insurer from later raising policy exclusions or defenses to coverage.[91] In these jurisdictions, the safest course of action for an insurer is to defend subject to a reservation of rights and/or seek a declaratory judgment confirming that coverage is not available under the policy.

In some jurisdictions, an insurer's breach of its duty to defend may further subject it to liability for consequential damages incurred as a result of the breach, even if the damages exceed policy limits.[92]

[89] *E.g.*, *Hamilton v. Md. Cas. Co.*, 41 P.3d 128 (Cal. 2002); *Bird v. Best Plumbing Grp., LLC*, 260 P.3d 209, 220 (Wash. Ct. App. 2011), *aff'd*, 259 P.3d 551 (2012) (holding that the trial court did not abuse its discretion in determining that a settlement above the policy limit was reasonable).
[90] *See Pruyn v. Agric. Ins. Co.*, 42 Cal. Rptr. 2d 295, 302–03 (Cal. Ct. App. 1995) (an insured who is abandoned by its liability insurer is free to make the best possible settlement, including a stipulated judgment with a covenant not to execute).
[91] *E.g.*, *Carney v. Vill. of Darien*, 60 F.3d 1273, 1277 (7th Cir. 1995) (Wisconsin law); *Shell Oil Co. v. AC&S, Inc.*, 649 N.E.2d 946 (Ill. App. Ct. 1995).
[92] *E.g.*, *Century Sur. Co. v. Andrew*, 432 P.3d 180, 182–83 (Nev. 2018).

Part Two
Litigation Between Insurer and Insured

I. Choice of Law

The law governing any dispute between an insurer and its insured is determined according to applicable choice of law principles. Many insurance contracts will include choice of law clauses that set out the designated agreed-upon governing law.

A. Choice of Law Clauses

A choice of law clause will set forth the law that will apply to future disputes that arise under the policy. Parties may decide to include a choice of law clause for several reasons, such as a preference for certain state law or a likelihood of lower litigation costs.[93]

Even where parties to an insurance policy have included a choice of law clause, a subsequent dispute may give rise to judicial review of the clause. In adjudicating disputes involving insurance policies containing choice of law clauses, most jurisdictions follow the Restatement (Second) of Conflict of Laws § 187.[94]

Under Restatement § 187(1), the parties' choice of law is valid as to a certain issue to be decided "if the particular issue is one which the parties could have resolved by an explicit provision in their agreement directed to that issue." Alternatively, under Restatement § 187(2), the parties' choice of law is valid "unless either . . . (a) the chosen state has no substantial relationship to the parties or the transaction and there is no reasonable basis for the parties' choice, or (b) application of the chosen state would be contrary to a fundamental policy of a state that has a 'materially greater interest' than the chosen state."

Some courts will also consider Second Restatement of Conflict of Laws § 193 comment e, which states that "effect will frequently not be given to a choice-of-law provision in a contract of fire, surety or casualty insurance which designates a state whose local law gives the insured less

[93] *See, e.g.*, *Fin Assoc. LP v. Hudson Specialty Ins. Co.*, 741 F. Appx. 85, 86 (3d Cir. 2018) (property insurance contract's choice of law clause stating that "[t]his policy shall be interpreted solely according to the law of the State of New York"); *Puna Geothermal Venture v. Allianz Glob. Risks US Ins. Co.*, No. 19-CV-00451, 2019 WL 6619851, at *1 (D. Haw. Dec. 5, 2019) (property insurance contract's choice of law clause stating that "[t]his policy shall be governed by the laws of the State of Nevada"); *GEICO Indem. Co. v. Crawford*, 36 F. Supp. 3d 735, 737 (E.D. Ky. 2014) (automobile insurance contract's choice of law clause stating that "[t]he policy and any amendment(s) and endorsement(s) are to be interpreted pursuant to the laws of the state of Ohio").

[94] *E.g.*, *Catlin Specialty Ins. Co. v. J.J. White, Inc.*, 309 F. Supp. 3d 345, 354 (E.D. Pa. 2018) (Pennsylvania courts "consistently" apply Restatement § 187 "in determining the validity of a choice of law clause in an insurance policy"); *Progressive Gulf Ins. Co. v. Faehnrich*, 327 P.3d 1061, 1063 (Nev. 2014) ("Nevada tends to follow the Restatement (Second) of Conflict of Laws (1971) in determining choice-of-law questions involving contracts, generally, and insurance contracts, in particular.).

protection than he would receive under the otherwise applicable law for the same reasons that effect is not given to such a provision in a life insurance contract."[95]

A summary of the key considerations outlined in the Restatement and some illustrative examples follow:

- *Whether there is a "substantial relationship" between the chosen state and the parties or transaction.*[96]
    - In *CapLOC LLC v. Liberty Mutual Ins. Europe Ltd.*, a Texas insured and a European insurer had agreed to a policy containing a choice of law clause that stated that "any dispute concerning the interpretation of this Certificate shall be governed by the laws of New York." Upon review, however, the court found that there was no substantial relationship between New York and the parties. The court noted that neither party "maintain[ed] a headquarters, mailing address, nor conducted the transaction in or from New York." Further, the court rejected New York's status as an "international commercial center" as a basis for a substantial relationship.[97]
- *Whether there was a "reasonable basis" for the parties' choice of law.*
    - "Reasonable basis" is generally construed broadly in cases between insureds and insurers.[98]
- *Whether the law of the chosen state violates a "fundamental public policy."*[99] [100]

[95] *E.g.*, *Param Petroleum Corp. v. Com. and Indus. Ins. Co.*, 686 A.2d 377, 381 (N.J. 1997) ("[W]e will refuse to enforce the choice-of-law aspect of this insurance contract … [and] consider, in that regard, comment e to Section 193 of the Restatement (Second) Conflicts of Law").
[96] *Wissot v. Great-West Life & Annuity Ins. Co.*, 619 F. Appx. 603, 604 (9th Cir. 2015) (observing that "the parties do not contest that they have a substantial relationship to Illinois," which is where the various versions of a group insurance plan all took effect, and finding that Illinois had an "interest in seeing its substantive law applied to a contract entered into in Illinois by an entity domiciled in Illinois").
[97] *CapLOC LLC v. Liberty Mutual Ins. Europe Ltd.*, No. 20-CV-3372, 2022 WL 19685, at *3–5 (N.D. Tex. Jan. 3, 2022).
[98] *See, e.g.*, *Catlin Specialty*, 309 F. Supp. 3d at 354 (holding that, in a case between a plaintiff headquartered in Pennsylvania and a defendant insurer incorporated in Delaware, the New York choice of law clause was valid on the basis that 1% of plaintiff's business was in New York, and defendant maintained "significant underwriting and claims-handling operations in New York").
[99] *Pitzer Coll. v. Indian Harbor Ins. Co.*, 447 P.3d 669, 680 (Cal. 2019) (holding that, for the purpose of analyzing choice of law clauses in insurance policies, the notice-prejudice rule is a fundamental public policy of California).
[100] *Meshi v. U.S. Life Ins. Co.*, No. 18-CV-00172, 2018 WL 7473961, at *3 (C.D. Cal. Dec. 10, 2018) (considering whether an Illinois choice of law clause was contrary to California public policy, the court recognized that, unlike California law, Illinois law bars insureds from recovering in tort for insurance bad faith. Nevertheless, the court found that "differences in the particular remedies available does not make the Illinois law contrary to a fundamental policy in California").

- *Whether the forum state has a "materially greater interest than the chosen state" in the determination of the particular issue.*[101]

B. International Insurance Contracts

Insurance contracts are frequently agreed to between parties in the United States and parties abroad. Where the underlying insurance contract is international in character, the contract's choice of law clause is presumed valid and enforceable.[102]

C. Legislative Interventions

Despite the prevalence of choice of law clauses in insurance policies, some states have enacted laws that void those clauses in certain circumstances. Those statutes include, for example:

- MASS. ANN. LAWS ch. 175 § 22 ("No company and no officer or agent thereof shall make, issue or deliver any policy of insurance . . . providing that any such policy or contract made in the commonwealth on lives, property or interests therein shall be governed by the laws of any state or country other than this commonwealth. Any such condition, stipulation or agreement shall be void").

- N.Y. INS. LAW § 3103(b)(3) (Only life, accident, health, and property insurance contracts will not "be governed by the laws of any jurisdiction other than this state …").

- WIS. STAT. ANN. § 632.09 ("Every insurance against loss or destruction of or damage to property in this state or in the use of or income from property in this state is governed by the law of this state").

- N.C. GEN. STAT. ANN. § 58-3-1 ("All contracts of insurance on property, lives, or interests in this State shall be deemed to be made therein, and all contracts of insurance the applications for which are taken within the State shall be deemed to have been made within this State and are subject to the laws thereof").

- OR. REV. STAT. ANN. § 742.018 ("No policy of insurance shall contain any condition, stipulation or agreement requiring such policy to be construed according to the laws of any other state or country. Any such condition, stipulation or agreement shall be invalid").

[101] *ABF Cap. Corp. v. Grove Prop. Co.*, 126 Cal. App. 4th 204, 220 (Cal. Ct. App. 2005) (finding that, despite insurance contract's New York choice of law clause, California had a materially greater interest in enforcing the equitable rules governing access to its courts).
[102] *E.g.*, *Weiss v. La Suisse*, 154 F. Supp. 2d 734, 740–41 (S.D.N.Y. 2001) (evaluating choice of law applicable to insurance policy issued by a Swiss insurance company and holding that New York's public policy exception did not apply to invalidate choice of law clause providing that Swiss law would apply to disputes under the policy).

D. Absence of Choice of Law Clauses

Where the parties to an insurance contract have not included a choice of law clause, courts must determine the law to apply to a coverage dispute. In doing so, courts will generally utilize one of the following tests:

The Restatement or Most Significant Contacts Test. This test, which incorporates three sections of the Second Restatement of Conflict of Laws, is used by the majority of jurisdictions. Where the insurance policy is one for fire, surety, or casualty risk, the starting point for the analysis is § 193, which states: "The validity of a contract of fire, surety or casualty insurance and the rights created thereby are determined by the local law of the state which the parties understood was to be the principal location of the insured risk during the term of the policy, unless with respect to the particular issue, some other state has a more significant relationship under the principles stated in § 6 to the transaction and the parties, in which event the local law of the other state will be applied." For other types of insurance contracts, § 188 lists several factors for courts to "evaluate[] according to their relative importance with respect to the particular issue," namely (i) the place of contracting; (ii) the place of negotiating the contract; (iii) the place of performance; (iv) the location of the subject matter of the contract; and (v) the domicile, residence, nationality, place of incorporation, and place of business of the parties. Under this test, "[i]f the place of negotiating the contract and the place of performance are in the same state, the local law of this state will usually be applied." Some examples under the Restatement test include:

- *OneBeacon Am. Ins. Co. v. Narragansett Elec. Co.* Holding that, even though the insured risk was in Rhode Island, the contract between a Rhode Island public utility and a Massachusetts insurer was governed by Massachusetts law because a Massachusetts trust held the insured's stock and negotiated the contract in Massachusetts.[103]

- *Nat'l Union Fire Ins. Co. v. Std. Fusee Corp.* Holding that Maryland law applied in an insurer-insured case because there were an equal number of insured manufacturing sites in Indiana and Maryland, but Maryland was the insured company's headquarters and the location where communication with insurance brokers took place.[104]

- Other Cases: *Jupiter Aluminum Corp. v. Home Ins. Co.*;[105] *Liggett Grp., Inc. v. Affiliated FM Ins. Co.*[106]

***Lex Loci Contractus* Approach**. In jurisdictions that follow this test, such as Alabama, Georgia, Florida, Kansas, New Mexico, North Carolina, Oklahoma, Rhode Island, South Dakota, Tennessee, and Maryland, the law of the state where the contract was executed governs.[107]

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[103] *OneBeacon Am. Ins. Co. v. Narragansett Elec. Co.*, 57 N.E.3d 18, 25 (Mass. App. Ct. 2016).
[104] *Nat'l Union Fire Ins. Co. v. Std. Fusee Corp.*, 940 N.E.2d 810, 817 (Ind. 2010).
[105] *Jupiter Aluminum Corp. v. Home Ins. Co.*, 225 F.3d 868 (3d Cir. 2000).
[106] *Liggett Grp., Inc. v. Affiliated FM Ins. Co.*, 788 A.2d 134 (Del. Super. Ct. 2003).
[107] *See, e.g., Shaps v. Provident Life & Acc. Ins. Co.*, 826 So. 2d 250, 255 n.3 (Fla. 2002) ("This Court has held that under *lex loci contractus*, the law of the jurisdiction where the contract was executed governs substantive issues regarding the contract"); *Ward v. Nationwide Mut. Auto. Ins. Co.*, 614 A.2d 85, 88 (Md. 1992) ("[I]n deciding

Governmental Interest Approach. This analysis, used by courts in California and the District of Columbia, applies the law of the state most interested in seeing its law govern the dispute.[108]

Statutory Provisions. Some states have passed statutes that specifically prescribe how choice of law questions related to insurance contracts will be resolved. Montana and South Carolina are two such states.[109]

II. Claims by Insured Against Insurer

A. Overview

Claims by an insured against an insurer generally fall into two categories: (i) breach of the insurance policy or (ii) bad faith. While a variety of breach of contract and bad-faith theories have been recognized, in the third-party insurance context, claims by insureds against insurers predominantly take the form of bad-faith failure to settle, other bad-faith conduct, and a breach of the insurer's duty to defend or indemnify.

B. Bad Faith Failure to Settle

In general, an insurer must give consideration to the insured's interest when deciding whether to accept or reject a third party's offer to settle a claim against an insured, and the insurer's failure to do so may give rise to a "bad faith" claim against the insurer. The elements of a bad-faith failure to settle claim vary from state to state. In some jurisdictions, the test for an insurer's liability for such a claim is simply whether the insurer acted in "bad faith" when rejecting a settlement offer against an insured within the insurer's policy limits.[110] In other jurisdictions, the test is whether the insurer failed to exercise "due care" when it rejected the settlement offer.[111] Other states require proof that the insurer acted with "gross disregard" for the insured's interests.[112]

Some states have applied a "negligence" standard, holding that an insurer may be liable for a bad-faith failure to settle a third-party claim when an "ordinarily prudent insurer" would consider trying

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questions of interpretation and enforceability of contract provisions, a Maryland court ordinarily should apply the law of the jurisdiction where the contract was made").

[108] *See, e.g., Blair v. Prudential Ins. Co. of Am.*, 472 F.2d 1356, 1359 (D.C. Cir. 1972) ("Where the laws of two jurisdictions are involved, in this Circuit the rule is that the forum applies the law of the state which has the more substantial interest in the resolution of the issue") (internal citations omitted); *Stonewall Surplus Lines Ins. Co. v. Johnson Controls, Inc.*, 17 Cal. Rptr. 2d 713, 718 (Cal. App. Ct. 1993) (explaining that "[w]ith the governmental interest approach, 'relevant contacts' stressed by the Restatement Second of Conflict of Laws [§ 188] are not disregarded, but are examined in connection with the analysis of the interest of the involved state in the issues, the character of the contract and the relevant purposes of the contract law under consideration").

[109] *See, e.g.,* MONT. CODE ANN. § 28-3-102 ("A contract is to be interpreted according to the law and usage of the place where it is to be performed or, if it does not indicate a place of performance, according to the law and usage of the place where it is made"); S.C. CODE ANN. § 38-61-10 ("All contracts of insurance on property, lives, or interests in this State are to be considered made in the State and all contracts of insurance the application for which are taken within the State are considered to have been made within this State and are subject to the laws of this State").

[110] *See* W.E. Shipley, *Duty of Liability Insurer to Settle or Compromise*, 40 AMERICAN LAW REPORTS 168 (1955).

[111] *See id*.

[112] *E.g.*, *Pavia v. State Farm Mut. Auto Ins. Co.*, 626 N.E.2d 24, 27–28 (N.Y. 1993).

the case as creating an unreasonable risk to the insured.[113] Other jurisdictions have rejected such a standard.[114] In other jurisdictions, such as California, an insurer is required to "make reasonable efforts to settle a third party's lawsuit against the insured."[115] To establish a claim under California law, the insured must show that (i) a claimant brought a claim against the insured that was covered by the insurer's policy; (ii) the insurer failed to accept a reasonable settlement demand for an amount within policy limits; (iii) the insurer's failure to accept the settlement demand was unreasonable, which means without proper cause; and (iv) a monetary judgment was entered against the insured for a sum greater than the policy limits.[116]

Typically, claims for bad-faith failure to settle arise when a claimant makes a settlement demand against an insured that is within the insurer's policy limits.[117] However, some jurisdictions have also recognized that, in certain circumstances, an insurer may have an affirmative duty to initiate settlement negotiations, the violation of which duty could also serve as the basis for a bad-faith claim. For example, in Florida, where liability against an insured is clear and damages are likely to exceed policy limits, an insurer has an affirmative duty to initiate settlement negotiations.[118] An insurer's affirmative duty to settle has also been recognized by courts in Washington and New Jersey.[119]

If the insurer refuses to settle a claim against the insured and the third party obtains a judgment against the insured in excess of the insurer's policy limit, the insured may recover the entire amount paid to satisfy the third party's judgment from its insurer (even if in excess of the policy's limits), if the insured successfully establishes that the insurer refused to settle that third party's claim in "bad faith."[120]

1. Statute of Limitations

The applicable statute of limitations for a bad-faith claim is governed by individual state law. State rules regarding the statute of limitations vary from jurisdiction to jurisdiction. In Illinois, for example, the statute of limitations for written contract disputes, including actions brought by insureds against insurers, is ten years absent explicit provisions stating otherwise.[121] However, "tort" actions such as an insurer's bad-faith failure to settle, are subject to Illinois's five-year statute of limitations bar.[122] Other jurisdictions, such as New York, "hold that a cause of action against an insurance carrier based on its bad-faith refusal to settle is governed by the Statute of Limitations

[113] *Cotton States Mut. Ins. Co. v. Brightman*, 580 S.E.2d 519, 521 (Ga. 2003).
[114] *Hartford Ins. Co. v. Methodist Hosp.*, 785 F. Supp. 38, 40 (E.D.N.Y. 1992) (holding that an insurer is not liable for bad-faith failure to settle "if its decision not to settle was the result of an error of judgment or mere negligence").
[115] *PPG Indus., Inc. v. Transamerica Ins. Co.*, 975 P.2d 652, 654 (Cal. 1999).
[116] *Madrigal v. Allstate Ins. Co.*, 215 F. Supp. 3d 870, 888 (C.D. Cal. 2016).
[117] *E.g.*, *Reid v. Mercury Ins. Co.*, 162 Cal. App. 4th 894, 906 (Cal. Ct. App. 2013), *as modified on denial of reh'g* (Nov. 6, 2013).
[118] *Goheagan v. Am. Vehicle Ins. Co.*, 107 So. 3d 433, 438 (Fla. Dist. Ct. App. 2012).
[119] *See, e.g.*, *Smith v. Safeco Ins. Co.*, 50 P.3d 277, 281 (Wash. Ct. App. 2002), *rev'd on other grounds*, 78 P.3d 1274 (Wash. 2003); *Rova Farms Resort, Inc. v. Inv. Ins. Co. of Am.*, 323 A.2d 495, 496 (N.J. 1974).
[120] *Cotton States Mut. Ins. Co.*, 568 S.E.2d at 502; *Swamy v. Caduceus Self Ins. Fund, Inc.*, 648 So. 2d 758, 759 (Fla. Ct. App. 1994); *Reifenstein v. Allstate Ins. Co.*, 92 A.D.2d 715, 716 (N.Y. App. Div. 1983).
[121] *Country Preferred Ins. Co. v. Whitehead*, 979 N.E.2d 35, 43 (Ill. 2012).
[122] *Chandler v. Am. Fire and Cas. Co.*, 879 N.E.2d 396, 398 (Ill. App. Ct. 2007).

applicable to actions based on contract, rather than on tort[.]"[123] New York's statute of limitations for contract actions is six years.[124]

2. Burden of Proof

The burden of proof to establish a bad-faith failure to settle a claim against an insurer is on the party bringing the claim.[125] If an insured satisfies its burden, "[i]t is then up to the insurer to demonstrate that settlement could not have been achieved within the policy limit or for the policy limit plus any amount the insured would have been willing to contribute."[126]

C. Breach of Duty to Defend

In the vast majority of jurisdictions, when an insurance policy contains a "duty to defend," the insurer must defend any actions against the insured for claims that potentially fall within the policy's coverage, even if the claims are meritless. If the insurer refuses to defend and the claim is later deemed to have been "potentially" within the policy's coverage, then the insurer may be liable for failure to defend its insured. Occurrence-based policies require an insurer to defend the insured regardless of when the claim against the insured is made, so long as the occurrence occurs during the policy period. Under a claims-made policy, the duty to defend applies to any claim brought against the insured during the relevant policy period, regardless of whether the alleged "wrong" that gave rise to that claim occurred during the policy period.

Generally, to establish a breach of the insurer's duty to defend, an insured must establish that the claims against it are "potentially covered" by the policy.[127] Put differently, "the insured must prove the existence of a *potential for coverage*, while the insurer must establish *the absence of any such potential*. The insured need only show that the underlying claim *may* fall within policy coverage; the insurer must prove it *cannot*."[128]

The specific requirements of the insurer's duty to defend varies from state to state. The majority rule is that an insurer's duty to defend requires the insurer to provide a "complete defense" to all claims against an insured if only one of those claims is potentially covered by the policy. California and New York, for example, follow the majority rule, recognizing that an insurer's duty to defend requires it to defend all claims against the insured if one of the claims is potentially covered.[129] On the other hand, under Illinois law, a title insurance policy, as distinct from a general liability

[123] *Roldan v. Allstate Ins. Co.*, 149 A.D.2d 20, 31 (N.Y. App. Div. 1989); *see also New England Ins. Co. v. Healthcare Underwriters Mut. Ins. Co.*, 352 F.3d 599, 606 (2d Cir. 2003) ("New York appears to classify suits against insurance carriers for bad-faith refusals to settle . . . as contractual in nature").
[124] N.Y. C.P.L.R. § 213(8).
[125] *E.g.*, *Hollaway v. Direct Gen. Ins. Co. of Miss., Inc.*, 497 S.W.3d 733, 737 (Ky. 2016); *Browning v. Heritage Ins. Co.*, 338 N.E.2d 912, 915 (Ill. App. Ct. 1975).
[126] *Courvoisier v. Harley Davidson of Trenton, Inc.*, 742 A.2d 542, 548 (N.J. 1999) (internal quotation omitted).
[127] *Pope ex rel. Pope v. Econ. Fire & Cas. Co.*, 779 N.E.2d 461, 465 (Ill. App. Ct. 2002); *Aetna Cas. & Sur. Co. v. Cochran*, 651 A.2d 859, 861 (Md. 1995).
[128] *Montrose Chem. Corp. v. Sup. Ct.*, 861 P.2d 1153, 1161 (Cal. 1993) (emphasis in original).
[129] *Buss v. Sup. Ct.*, 939 P.2d 766, 774 (Cal. 1997); *CGS Indus., Inc. v. Charter Oak Fire Ins. Co.*, 720 F.3d 71, 83 (2d Cir. 2013).

insurance policy, does not require an insurer to provide a defense to uncovered claims brought against an insured.[130]

Where multiple insurers have a duty to defend an insured, the insured may select which insurer must provide the defense. Importantly, "[w]hen an insured has knowingly chosen to forgo one insurer's assistance by instructing that insurer not to involve itself in the litigation, the targeted insurer then has the sole responsibility to defend and indemnify the insured up to the limits of its liability and is thereby foreclosed from seeking equitable contribution from the other insurer that was not designated by the insured."[131]

1. Statute of Limitations

State law governs the statute of limitations applicable to a breach of the duty to defend. In Illinois, for example, the statute of limitations for a breach of duty to defend is generally governed by the ten-year statute of limitations applicable to breach of contract actions.[132] An insured can file suit against its insurer for breach of the duty to defend immediately after the insurer refuses to defend the insured; there is no need to wait for a final judgment to be issued in the underlying suit.[133] In New York, a six-year statute of limitations for breach applies to breaches of the duty to defend. The cause of action for breach of the duty to defend begins to accrue once a final decision has been issued in the underlying litigation.[134]

2. Burden of Proof

An insured bears the burden of proving that policy coverage potentially covered the claims against it, whereas an insurer bears the burden of proving that it does not have a duty to defend, and any doubts are resolved in favor of the insured.[135]

D. Bad-Faith Denial of Coverage

1. Legal Standards

An insured may also bring suit against an insurer for breach of duty to indemnify or breach of the general covenant of good faith and fair dealing, both of which are sometimes categorized as "bad-faith" claims. As a general matter, the insured must establish that, essentially, the refusal to indemnify or deal fairly with the insured was done with reckless indifference or knowledge of the insured's resulting harm. It is not enough that coverage was delayed or that a good-faith investigation was inadequate. This type of claim is often judged on a standard of reasonableness—if the insurer's approach to determining whether coverage applied and/or its decision that coverage did/did not apply was reasonable, then there is no viable bad-faith claim.

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[130] *Philadelphia Indem. Ins. Co. v. Chicago Title Ins. Co.*, 771 F.3d 391, 394 (7th Cir. 2014) (Illinois law).
[131] *Chi. Hosp. Risk Pooling Program v. Ill. State Med. Inter-Ins. Exch.*, 925 N.E.2d 1216, 1233 (Ill. App. Ct. 2010).
[132] *Country Preferred Ins. Co. v. Whitehead*, 979 N.E.2d 35, 43 (Ill. 2012).
[133] *See Del Bianco v. American Motorists Ins. Co.*, 392 N.E.2d 120, 125 (Ill. App. Ct. 1979).
[134] *Roldan*, 149 A.D.2d at 29–31.
[135] *See Phila. Indem. Ins. Co. v. Chi. Title Ins. Co.*, 771 F.3d 391, 394 (7th Cir. 2014) (Illinois law).

Jurisdictions analyzing more general "bad-faith" claims fall into two camps. The minority include a few jurisdictions that have followed the example of the California Supreme Court in *Gruenberg v. Aetna Insurance Co.* in defining the phrase broadly: "withhold[ing] unreasonabl[e] payments due under a policy," failing to "act fairly and in good faith in discharging its contractual responsibilities," and "refusing, without proper cause, to compensate its insured for a loss covered by the policy."[136] However, a majority of jurisdictions have followed the example the Wisconsin Supreme Court set in *Anderson v. Continental Insurance Co.* by defining the phrase more narrowly and precisely: "[t]o show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one…"[137]

In California, "bad faith" does not require a showing of malice but is instead defined as "objectively unreasonable conduct" on the part of the insurer in denying the insured the benefits of the policy. The insured must prove that the insurer unreasonably denied them the benefits of the policy but there is no need to establish subjective "bad faith" or motive. Where there is a genuine dispute as to whether the insured's claim is covered by the policy, the insurer's denial or delay of payment of policy benefits will not be considered "bad faith."[138]

In Illinois, "bad faith" may involve three general types of claims—refusal to settle (addressed above), misconduct based on an independent tort, or violation of the Illinois Insurance Code. Section 155 of the Illinois Insurance Code provides an extra-contractual remedy for an insured when the insurer's refusal to pay a policy benefit is "vexatious and unreasonable."[139] Thus, the insurer's "bad-faith" conduct can give rise to standard breach of contract claims as well as independent tort claims.[140] A plaintiff must allege more than "mere allegations of bad faith or unreasonable and vexatious conduct.[141] In New York, there is no recognized independent tort of "bad faith." Instead, the insured must allege some other "claim of egregious tortious conduct directed at [themselves]" to succeed.[142]

2. Statute of Limitations

The applicable statute of limitations is governed by state law. For example:

- In Illinois, the statute of limitations for a bad-faith claim against an insurance agent is two years as promulgated by the Illinois Code of Civil Procedure.[143]

[136] *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032, 1037 (Cal. 1973).
[137] *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978).
[138] *Bosetti v. U.S. Life Ins. Co. in N.Y.*, 96 Cal. Rptr. 3d 744, 768–69 (Cal. Ct. App. 2009).
[139] *Cramer v. Ins. Exch. Agency*, 675 N.E.2d 897, 900 (Ill. 1996).
[140] *Id.* at 904.
[141] *Id.*
[142] *Rocanova v. Equitable Life Assur. Soc'y*, 634 N.E.2d 940, 945 (N.Y. 1994).
[143] 735 ILL. COMP. STAT. § 5/13-214.4; *see also Scottsdale Ins. Co. v. Lakeside Cmty. Comm.*, 76 N.E.3d 1, 6 (Ill. App. Ct. 2016).

- In California, bad-faith claims against an insurer are subject to a two-year statute of limitations period.[144]

E. Service of Process in Insurance Coverage Actions

With limited exception, an insurer or insured must initiate a coverage action just like any other civil action in state or federal court. This includes, namely, service of process upon the defendant.

In the context of federal court, Federal Rule of Civil Procedure 4 outlines the requirements for proper service of process. The plaintiff is responsible for having the summons and complaint served upon the defendant within the time allowed by FRCP 4(m), which is generally 90 days.[145] FRCP 4(h) describes the different ways that service can be properly effectuated on a corporation like an insurer. FRCP 4(h)(1)(a) allows for service in any manner appropriate for an individual.[146] This includes:

- "[F]ollowing state law for serving a summons" in either the state where the district court is located or where service is made.[147] Numerous states have statutes enabling plaintiffs in insurance coverage actions to serve process upon a state official.[148]

- "[D]elivering a copy of the summons and of the complaint to an officer, a managing or general agent, or any other agent authorized by appointment or by law to receive service of process and—if the agent is one authorized by statute and the statute so requires—by also mailing a copy of each to the defendant."[149] Parties should take care when serving process upon a corporate officer or agent in an insurance coverage action, as the sufficiency of such service has been contested:

    - *Republic Bank of Chi. v. Gehrisch Ins. & Fin. Serv. Inc.* Service upon owner of insurer's temporary office space was improper because the owner was not designated as an agent of the insurer for service purposes.[150]

    - *Stewart v. Hartford Fin. Serv. Grp., Inc.* Holding that serving process to an insurer's usual place of business was not authorized by FRCP 4(h), but using the court's

[144] *Richardson v. Allstate Ins. Co.*, 172 Cal. Rptr. 423, 426 (Cal. Ct. App. 1981).
[145] FED. R. CIV. P. 4(m).
[146] FED. R. CIV. P. 4(h)(1)(a).
[147] FED. R. CIV. P. 4(e)(1).
[148] *E.g.*, N.Y. INS. § 1213 (allowing substitute service on state superintendent when insurer is foreign or unauthorized); CONN. GEN. STAT. § 38a-25 (2013) (allowing substitute service on Connecticut Insurance Commissioner when insurer is, inter alia, foreign or alien); N.C. GEN. STAT. ANN. § 58-16-30 (allowing substitute service on Commissioner or their agents so long as the insurer is authorized to do business in North Carolina); *Old Country Store, Inc. v. Auto-Owner Ins. Co.*, No. 21-CV-01128, 2022 WL 110015, at *2 (W.D. Tenn. Jan. 11, 2022) (holding that "[p]laintiff's . . . mailing to the [Insurance] Commissioner arguably satisfies the requirements for service under Tennessee law").
[149] FED. R. CIV. P. 4(h)(1)(B).
[150] *Republic Bank of Chi. v. Gehrisch Ins. & Fin. Serv. Inc.*, No. 21-CV-00415, 2021 WL 4169419, at *1 (M.D. Fla. Sept. 14, 2021).

discretionary authority under FRCP 4(m) to extend the pro se plaintiff's service deadline by 30 days.[151]

- *Emiabata v. Farmers Ins. Corp.* Finding that mailing the summons and complaint "directly to defendants' known address in Texas and to their California HQ" did not meet the requirements of FRCP 4(h).[152]

F. Discovery in the Insurer-Insured Context

Initial Disclosures. Where an insurance coverage action is taking place in federal court, the parties' initial disclosures ordinarily will be the first exchange of discovery. Rule 26(a) of the Federal Rules of Civil Procedure outlines the documents which must be made available by each party as part of their initial disclosures. These include, *inter alia*, the name and contact information of each individual likely to have discoverable information, a copy of all documents and electronically stored information that may be used to support a party's claims or defenses, and any insurance agreement under which a company may be liable to satisfy all or part of a possible judgment or reimburse for payments made to satisfy the judgment.

Some state civil procedural rules have provisions analogous to Rule 26(a).[153] Note, however, that several states—including Illinois, Florida, and Massachusetts—do not require initial disclosures and that discovery in those states is only available upon request.[154]

In the context of insurance coverage actions, the parties may dispute the scope of discovery required by initial disclosures.[155]

Discovery After Initial Disclosures. Parties to an insurance coverage action typically will issue document requests, interrogatories, and other discovery requests to each other. In federal court actions, Rule 26(b)(1) outlines the broad scope of this discovery: "any nonprivileged matter that is relevant to any party's claim or defense and proportional to the needs of the case . . . ."[156]

The broad language in Rule 26(b)(1) may render a wide variety of insurance policy materials discoverable.[157]

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[151] *Stewart v. Hartford Fin. Serv. Grp., Inc.*, No. 19-CV-00304, 2020 WL 264417, at *5 (S.D Ohio. Jan. 17, 2020).
[152] *Emiabata v. Farmers Ins. Corp.*, No. 18-CV-01817, at *5 (D. Conn. Aug. 7, 2019).
[153] *See, e.g.*, CAL. CIV. PROC. CODE § 2016.090 (West) (California); U.R.C.P. 26(a)(1) (Utah); TEX. R. CIV. P. 194.2 (Texas).
[154] ILL. SUP. CT. R. 201; FLA. R. CIV. P. 1.280; MASS. R. CIV. P. 26.
[155] *E.g., Hammer v. PHI Inc.*, No. 16-CV-01048, 2019 WL 3890683 at *1 (W.D. La. Aug. 16, 2019) (finding that defendant Allianz "was required to provide a copy of its policy in its initial disclosures, regardless of Plaintiff's subpoena or discovery requests"); *Idahoan Foods, LLC v. Allied World Assurance Co., (U.S.) Inc.*, No. 4:18-cv-00273, 2020 WL 1948823 at *6 (D. Idaho Apr. 22, 2020) (explaining that in insurance coverage cases, any inquiry regarding the sufficiency of initial disclosures is "discretionary and case specific"); *Hernandez v. Lloyds*, No. 12-CV-00477, 2013 WL 12157587 at *2 (S.D. Tex. Oct. 11, 2013) (finding that, at the *initial disclosure stage*, plaintiff policyholder had failed to show that defendant may use the claim file as part of their defense and that consequently disclosure was inappropriate).
[156] FED. R. CIV. P. 26(b)(1).
[157] *See, e.g.*, *Cinemark Holdings, Inc. v. Factory Mut. Ins. Co.*, No. 21-CV-00011, 2021 WL 2662178, at *2–3 (E.D. Tex., June 29, 2021) (upholding requests for "(1) [t]he drafting of the disputed policy wording and underwriting of

On the other hand, courts do not hesitate to limit overbroad discovery requests in insurance cases.[158]

G. Specific Discovery Issues: Underwriting File & Claim File

Underwriting File. An insurance company's underwriting file normally contains notes on the insured risk and notes about what the insurer construes the policy as covering. Because such a document can illuminate the insurer's understanding of the policy and its reach, insured's commonly seek it during discovery.

Discovery of an insurer's underwriting file is frequently allowed.[159]

Attorney-client privilege and attorney work product protection will generally be inapplicable to the underwriting file.[160]

Note, however, that challenges to the discoverability of the underwriting file based on relevancy sometimes succeed.[161]

See:

> In *Milinazzo v. State Farm Ins. Co.*, the plaintiff requested the underwriting file even though he had not alleged any ambiguity in the policy language. The court ruled that the

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the Policy; (2) [insurer's] investigation and handling of the claim; (3) [g]overning procedure manuals (claims and underwriting); (4) [r]epresentations to state regulators that inform the meaning of the policy wording; (5) [insurer's] knowledge of … [the alleged] loss; and (6) [i]nformation about other similar … claims," as such claims were "relevant because they relate to the central insurance coverage dispute").

[158] *See, e.g.*, *Arena v. RiverSource Life Ins. Co.*, No. 16-CV-05063, 2017 WL 6513056, at *6–7 (D.N.J. Dec. 19, 2017) (finding that plaintiff's document request seeking "[a]ll documents concerning your procedures, policies, practices, rules, regulations, guidelines, standards or agreements relating to the underwriting of life insurance policies" was not proportional to the needs of the case; further finding that plaintiff's interrogatory seeking the names of "all employees, former employees, and third-party advisors who worked on any template versions of the life insurance policies" was not proportional to the needs of the case).

[159] *E.g.*, *Clean Earth of Md., Inc. v. Total Safety, Inc.*, No. 10–cv–00119, 2011 WL 4832381, at *8 (N.D. W.Va. Oct. 12, 2011) ("[m]any courts have already addressed the issue of the discoverability of underwriting files, and the general consensus is that they are discoverable"); *Dish Network Corp. v. Arch Specialty Ins. Co.*, No. 09-CV-00447, 2009 WL 3837887, at *4 (D. Colo. Nov. 12, 2009) ("each named Defendant is ordered to produce . . . the underwriting file . . ."); *Wrangen v. Pennsylvania Lumbermans Mut. Ins. Co.*, No. 07-CV-61879, 2008 WL 5545259, at * 5 (S.D. Fla. Dec. 22, 2008) ("Defendant is to provide . . . a copy of the underwriting file").

[160] *See Renfrow v. Redwood Fire & Cas. Ins. Co.*, 288 F.R.D. 514, 521 (D. Nev. 2013) (underwriting file in bad-faith claim was relevant and not protected by attorney-client privilege); *Westheimer Regency I, L.P. v. Great Lakes Reinsurance (UK) SE*, No. 18-CV-00014, 2018 WL 7198642, at *2–3 (W.D. Tex. Aug. 15, 2018) (finding that request for underwriting files was not overly broad and ordering production because the files were relevant); *PCS Phosphate Co., Inc. v. Am. Home Assurance Co.*, No. 14-CV-00099, 2015 WL 8490976, at *4 (E.D.N.C. Dec. 10, 2015) (underwriting file not protected by work product exception or attorney-client privilege).

[161] *See, e.g.*, *S. Owners Ins. Co. v. Sanborn Builders, Inc.*, No. 18-cv-00145, 2020 WL 13178284, at *1 (N.D. Fla. Sept. 4, 2020) (explaining that "the Court simply fails to see how the information requested in [the underwriting file regarding policy drafting] would tend to clarify any ambiguity in the policy"); *Safeco Ins. Co. of Am. v. Weissman*, No. 17-CV-62032, 2018 WL 7046634, at *7 (S.D. Fla. Sept. 5, 2018) (explaining that the underwriting file is irrelevant to plaintiff's claim because "[a]n insurer's decision to issue insurance is distinct from an insurer's decision to deny a claim").

underwriting file would not be discoverable until plaintiff made "a prima facie showing that material provisions of the policy are ambiguous."[162]

Claim File. The "claim file" or "claims file" refers to the insurer's records related to processing a specific claim by an insured for coverage under a policy. The file may contain records of communications with the insured, communications with counsel, investigative notes, and analysis by claims handlers.[163]

Insureds often seek discovery of the insurer's claim file in bad-faith actions and, in such actions, courts will typically hold that "the need for the information in the file is not only substantial but overwhelming."[164] As succinctly explained by one court, "[h]ow else [other than by seeing the file] could [the jury] have properly determined whether [an insurer] acted fairly and in good faith in its handling of the claim?"[165]

Most courts will consider whether materials in a claim file are discoverable on a case-by-case basis, subject to a "rebuttable presumption that neither attorney work product nor attorney-client privilege protects an insurer's investigatory file on an insured's claim from discovery before a final decision is made[.]"[166]

To prevent production of their claim files, insurers may seek to argue that they are protected by the work product doctrine or the attorney-client privilege. As one court has noted: "[t]here is no all-encompassing privilege which protects claims files; however, courts have found the attorney-client privilege or work product doctrine protects certain documents within an insurer's claims file."[167]

Federal Rule of Civil Procedure 26(b)(3) addresses work product protection. Under that rule, discovery of documents "prepared in anticipation of litigation" is permitted only upon a showing that the party seeking discovery "has substantial need of the materials . . . and cannot, without undue hardship, obtain their substantial equivalent by other means."[168] Most courts evaluate whether the work product doctrine applies to claim files on an individual basis, with the insurer bearing the burden of demonstrating that work product protection attaches.[169]

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[162] *Milinazzo v. State Farm Ins. Co.*, 247 F.R.D. 691, 702–03 (S.D. Fla. 2007).
[163] *See Brown v. Super. Court*, 137 Ariz. 327, 336 (1983) ("The claims file is a unique, contemporaneously prepared history of the company's handling of the claim").
[164] *2,022 Ranch, L.L.C. v. Super. Ct.*, 113 Cal. App. 4th 1377, 1396 (2003) (quoting *Reavis v. Metro. Prop. & Liab. Ins. Co*., 117 F.R.D. 160, 164 (S.D. Cal. 1987)).
[165] *Richardson v. Emps. Liab. Assur. Corp.*, 25 Cal. App. 3d 232, 242 (1972) (overruled on other grounds in *Gruenberg v. Aetna Ins. Co*., 9 Cal. 3d 566, 580 n.10 (1973)).
[166] *Lindley v. Life Invs. Ins. Co. of Am*., 267 F.R.D. 382, 399 (N.D. Okla. 2010).
[167] *St. Joe Co. v. Liberty Mut. Ins. Co.*, No. 5-CV-01266, 2006 WL 3391208, at *3 (M.D. Fla. Nov. 22, 2006).
[168] FED. R. CIV. P. 26(b)(3).
[169] *See, e.g.*, *Evanston Ins. Co. v. OEA, Inc.*, No. 2-CV-01505, 2006 WL 1192737, at *4 (S.D.N.Y. May 4, 2006) (explaining that "the determination to pay (or, more often, not to pay) on an insurance claim has often been held to be a routine business function, even if performed by outside counsel" and "[w]hen an investigation conducted by counsel crosses the line from business-centered (and unprotected) to litigation-centered is a question of fact that must be determined on a case-by-case basis"); *Solano-Sanchez v. State Farm Mut. Auto. Ins. Co.*, No. 19-CV-04016, 2021 WL 229400, at * (E.D. Pa. Jan. 22, 2021) ("An insurance company 'cannot reasonably argue that the entirety of its claims files are accumulated in anticipation of litigation when it has a duty to investigate, evaluate[,] and make

Some courts, on the other hand, do classify claim files as work product.[170] This has since become a very marginalized view, however, and no court has explicitly endorsed this interpretation in the past ten years.

FRCP 26(b)(1) protects against the discovery of any privileged communications between an attorney and their client. Courts generally require that the following conditions are met for it to attach: "(1) Where legal advice of any kind is sought (2) from a professional legal adviser in his capacity as such, (3) the communications relating to that purpose, (4) made in confidence (5) by the client, (6) are at his instance permanently protected (7) from disclosure by himself or by the legal adviser, (8) except the protection be waived."[171] Because the privilege only applies when legal advice is communicated, courts often find that a claims file is not protected by the attorney-client privilege: "to the extent that an attorney acts as a claims adjuster, claims process supervisor, or claims investigation monitor, and not as a legal advisor, the attorney-client privilege does not apply."[172]

However, although pre-denial claim file information may not be protected by the attorney-client privilege, post-denial communications may be protected by the attorney-client privilege.[173]

III. Claims by Insurer Against Insured

A. Overview

Claims by an insurer against an insured regarding insurance coverage typically take the form of a declaratory judgment action, whereby an insurer seeks a judicial determination regarding the scope of coverage and various related obligations under an insurance policy. Insurers may also initiate actions against insureds seeking rescission of the insurance policy, most commonly when an insured has provided the insurer a material misstatement in an insurance application. A less common claim exists when an insurer is faced with competing claims for coverage under an

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a decision with respect to claims made on it by its insureds'") (quoting *Shaffer v. State Farm Mut. Auto. Ins. Co*., No. 13–CV–01837, 2014 WL 931101, at *2 (M.D. Pa. Mar. 10, 2014)); *Thanh Mai v. CSAA Fire & Cas. Ins. Co.*, No. 20-CV-01130, 2020 WL 6708650, at *5 (D. Kan. Nov. 16, 2020) ("This District has held—citing Kansas law—that the initial investigation an insurance company makes is made in the ordinary course of business").

[170] *See, e.g.*, *S.D. Warren Co. v. E. Elec. Co*., 201 F.R.D. 280, 283 (D. Me. 2001) (observing that in a minority of jurisdictions "all materials located in an insurance claims adjuster's files must be deemed to have been collected or created in anticipation of litigation because it is in the nature of the insurance business to always be preparing for litigation"); *Fontaine v. Sunflower Beef Carrier,* 87 F.R.D. 89, 92 (E.D. Mo. 1980) ("… in the context of an insurance investigation of an accident, the analysis hereby adopted will almost always result in a finding that the documents were prepared in anticipation of litigation").

[171] *See, e.g.*, *Cavallaro v. U.S.*, 284 F.3d 236, 245 (1st Cir. 2002).

[172] *Barnard Pipeline, Inc. v. Travelers Prop. Cas. Co. of Am.*, No. 13-CV-00007, 2014 WL 1576543, at *9 (D. Mont. Apr. 17, 2014) (quoting *HSS Enter., LLC v. Amco Ins. Co.*, No. 6-CV-01485, 2008 WL 163669, at *3 (W.D. Wash. Jan. 14, 2008)).

[173] *See, e.g.*, *Garibaldi v. Everest Nat'l Ins. Co.*, No. 19-CV-02558, 2020 WL 6161715, at *2 (D. Ariz. Oct. 21, 2020) (finding that the privilege applies to communications between insurer and counsel before *and after* denial of insured's claim); *Luxottica of Am. Inc. v. Allianz Glob. Risks U.S. Ins. Co.*, No. 20-CV-00698, 2022 WL 1204870, at *3 (S.D. Ohio, May 18, 2022) (explaining that the Supreme Court of Ohio has found that in an action alleging bad faith, the insured is entitled to discover claims file materials that were created *prior* to denial of coverage); *but see Spiniello Co. v. Hartford Fire Ins. Co.*, No. 7-CV-02689, 2008 WL 2775643, at *6 (D.N.J. July 14, 2008) (collecting cases from different jurisdictions and finding that many reject a bright-line rule like Ohio's).

insurance policy. In such a scenario (typically in the bankruptcy context), an insurer may initiate an interpleader action to determine the claimants' rights to payment under an insurance policy.

B. Declaratory Judgment

The most common type of suit filed by an insurer is an action seeking a declaratory judgment. An insurer will usually file a lawsuit seeking a declaratory judgment in three scenarios: (i) to determine whether the insurer must pay a judgment against the insured; (ii) to determine whether there is a duty to defend; or (iii) to determine how much money it must contribute to a settlement on the insured's behalf. Essentially, if the parties to the insurance contract disagree as to the meaning of a policy term, they can seek a declaratory judgment to provide an adjudication of their rights and obligations under the policy.

1. Statute of Limitations

The relevant statute of limitations for declaratory judgment actions will depend on what jurisdiction's law applies. For example:

- *Fitzgerald Morris Baker Firth P.C. v. Mayor of Hoosick Falls*. In New York, there is a six-year statute of limitation period applicable to claims for declaratory judgment.[174]

- *Leahey v. Dept. of Water and Power of City of L.A.* In California, the statute of limitations on a declaratory judgment claim is determined by the statute of limitations on the underlying action, which, in most insurance cases, is three years.[175]

- *State Auto. Mut. Ins. Co. v. Kingsport Dev., LLC*. Illinois employs a "reasonable time" test in insurance cases. That is, the declaratory action can be filed so long as it is within a reasonable time of being notified of the underlying suit.[176]

2. Burden of Proof

In a declaratory judgment case, the insured bears the burden of proving that there is a covered loss or that the duty to defend is triggered, while the insurer bears the burden of proving that the policy is not applicable or that an exclusion applies.

C. Rescission

Rescission is an additional claim available to an insurer, oftentimes brought when an insurer seeks to rescind an insurance policy based on a misstatement in an insurance application. This type of "claim" is arguably more of a remedy, seeking to return the parties to where they were situated pre-contract. Courts generally consider rescission to be a drastic remedy and award it only where

[174] *Fitzgerald Morris Baker Firth P.C. v. Mayor of Hoosick Falls*, 179 A.D.3d 1361, 1364 (N.Y. App. Div. 2020).
[175] *see Leahey v. Dept. of Water and Power of City of L.A.*, 76 Cal. App. 2d 281, 287–88 (1946).
[176] *State Auto. Mut. Ins. Co. v. Kingsport Dev., LLC*, 364 Ill. App. 3d 946, 961 (2006) (holding that waiting seven months from the time insurer received a letter about the suit to bring a declaratory judgment action was not unreasonable).

money damages are insufficient to restore the parties to their pre-contractual positions. Rescission is generally disfavored, as it is viewed as a "drastic remedy [that] courts are reluctant to grant."[177]

While the relevant test to rescind an insurance policy varies by jurisdiction and type of insurance policy, generally, for an insured's misrepresentation to be sufficient to void an insurance policy, the misrepresentation must have been material to the risk assumed by the insurer and relied upon by the insurer when issuing the policy. The test for materiality is whether the insurer would have written the policy, or changed the terms or premium of the policy, had it known the true facts. States have statutorily modified this test in some cases. Some states also require a showing of fraud or intent to deceive the insurer.

1. Statute of Limitations

The relevant statute of limitations for declaratory judgment actions will depend on which jurisdiction's law applies. For example:

- In Illinois, the statute of limitations for rescission is based on 735 ILL. COMP. STAT. § 5/13-205, which proscribes a five-year limitations period to claims involving fraud and material misrepresentations.[178]
- In New York, the statute of limitations is six years.[179]
- In California, the statute of limitations applicable to rescission claims is four years.[180]

2. Burden of Proof

The insurer bears the burden of proving that a misrepresentation was made and that the misrepresentation was material.[181]

D. Interpleader

Interpleader is a less common claim brought by an insurer. Interpleader can be used by an insurance company when facing rival claims for the same insurance policy benefits, in an effort to avoid double liability. In those circumstances, an interpleader action will force the rival claimants to litigate the validity of their claims and determine which claimant the insurer is liable to pay. Before filing an interpleader, the insurer must satisfy the requirement that it be a "disinterested stakeholder" that is "presented with two or more adverse claims [and] have a good-faith fear of double or multiple vexation as a result of these adverse liabilities."[182] In federal court, 28 U.S.C. § 1335 and Federal Rule of Civil Procedure 22 govern interpleader actions; however, several states have their own interpleader mechanisms available to insurers.

[177] *Union Ins. Exch., Inc. v. Gaul*, 393 F.2d 151, 154 (7th Cir. 1968).
[178] *Green v. Mass. Cas. Ins. Co.*, 269 B.R. 782, 793 (N.D. Ill. 2001), *aff'd*, 42 F. App'x 815 (7th Cir. 2002).
[179] N.Y. C.P.L.R. 213(1).
[180] CAL. CIV. PROC. CODE § 337(c).
[181] *See, e.g.*, *Bankers Tr. v. McFarland*, 743 N.Y.S.2d 804, 807 (Sup. Ct. 2002).
[182] 2 LAW AND PRAC. OF INS. COVERAGE LITIG. § 13:2.

1. Statute of Limitations

There are no limitations periods generally applicable to interpleader actions, but certain states have codified when an insurer may file such a claim. In California, for example, under CAL. CIV. PROC. CODE § 386, a defendant may file for interpleader "at any time before [an] answer."

2. Burden of Proof

In an interpleader action, the insurer must show that it is a neutral party with no financial interest in the matter. Any stakeholders must prove an entitlement to the proceeds of a policy.[183]

IV. Insurance Recovery from Third Parties

A. Overview

Over the past several years, some insurers have sought to recover payments to third parties as part of allegedly fraudulent schemes, primarily in the healthcare space. For example, insurers have taken action against medical clinics, laboratories, and other healthcare organizations for fraudulent insurance claims, seeking to recover the cost of payments issued by the insurer. These claims tend to be concentrated in no-fault insurance states, namely, New York, New Jersey, Michigan, and Florida. The majority of these cases are settled. This section explores the most common claims brought by insurers in these types of actions, how fraud is detected, where claims are being brought, and what the common types of defendants in these cases are.

B. Detecting Fraud

Insurance fraud is deliberate deception perpetrated against an insurance company for financial gain. Fraud may be committed at different points by applicants, policyholders, third-party claimants, or professionals who provide services to claimants.[184] Insurance agents and company employees may also commit insurance fraud.[185] Common frauds include "padding" or inflating claims, misrepresenting facts on an insurance application, submitting claims for injuries or damage that never occurred, and staging accidents.[186] A 2022 study by The Coalition Against Insurance Fraud showed that insurance fraud can cost U.S. consumers $308.6 billion yearly. That amount includes estimates of annual fraud costs across several liability areas, including Life Insurance ($74.7 billion), Property and Casualty ($45 billion), Workers Compensation ($34 billion), and

[183] *See Fid. & Deposit Co. of Md. v. Barroga-Hayes*, 13 N.Y.S.3d 106, 106 (2015); *U-Haul Co. v. Baker*, 2022 Cal. Super. LEXIS 3633 at *5-6 (Jan. 31, 2022) (A "stakeholder taking bringing an interpleader action [] need only allege that he or she is holding money or property to which others are making conflicting demands, that he or she is unable to determine the validity of the respective claims, that he or she fears exposure to multiple liability if he or she delivers the money or property to any of the claimant, and that he or she therefore requests a court order determining to whom the money or property belongs"); *Kovitz Shifrin Nesbit, P.C. v. Rossiello*, 392 Ill.App.3d 1059, 1065-66 (2009) (party moving for interpleader must establish that they are a neutral stakeholder who would be exposed to multiple claims for liability should the court deny interpleader).
[184] INS. INFO. INST. INC., *Background on: Insurance fraud*, (Aug. 1, 2022) https://www.iii.org/article/background-on-insurance-fraud (hereinafter "*Background on: Insurance fraud*").
[185] *Id.*
[186] *Id.*

Auto Theft ($7.4 billion).[187] Insurance fraud recovery litigation is a term for the types of lawsuits initiated by insurers to recover money paid out to third parties as a result of fraud.

Insurers often investigate fraud using specialized in-house departments called Special Investigation Units ("SIUs"). These teams work to investigate fraudulent claims internally through a variety of investigative techniques and data analytics.[188]

If a claim is of a repeat nature such as a house fire, a low-impact soft tissue claim, or a stolen and burned vehicle, a checklist is typically developed by an SIU to make sure that the insurer receives complete and consistent documentation for each and every claim.[189] In addition to SIU departments within insurers, there are also consulting firms that assist insurers in investigating claims and testifying in court cases.

Fraudulent claims are often identified through pattern recognition. Fraud investigators often pay close attention to medical providers that exclusively treat auto accident survivors, issue identical treatment plans to a high volume of patients, or refer patients to an inconsistent set of specialists.[190]

C. Causes of Action

An insurance company seeking redress for fraud has a variety of civil remedies available. Insurers often rely on section 1962 of the federal Racketeer Influenced and Corrupt Organizations Act ("RICO"), which enables insurers to file civil lawsuits to recover damages for money paid out by the insurer. RICO also allows a plaintiff to sue for treble damages or "threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee."[191] Since the late 1990s, some of the largest insurers in the country, including health and auto insurers, have been filing and winning lawsuits concerning insurance fraud against individuals and organized rings.[192]

Most insurers will also assert claims for unjust enrichment under relevant state law. Other common causes of action include common law fraud, civil conspiracy, aiding and abetting fraud, payment under mistake of fact, and negligent misrepresentation. State-specific antifraud statutes also provide causes of action for insurers seeking to recover payments, including, for example, the Florida Deceptive and Unfair Trade Practices Act and New Jersey Insurance Fraud Prevention Act. The insurance industry and other stakeholders have encouraged all states to enact antifraud laws to some degree, particularly because it can be easier to prosecute insurance fraud cases in states with penal codes that: (i) specify fraud as a crime; (ii) define fraud; (iii) specify the penalties.[193] By 2016, every state and the District of Columbia had enacted laws that classify fraud as a crime, at least for some lines of insurance, had instituted immunity for reporting insurance fraud, and most states and the District Columbia have set up fraud bureaus or units.[194] Almost two

[187] *Id.*
[188] Michael E. Jacobs, *Insurance Fraud Investigation Strategies for Attorneys and Clients*, 2011 WL 6749927, at *6.
[189] *Id.*
[190] *See* Jim Hulett, *How to Find Fraud in Insurance Claims*, VERISK (Jan. 16, 2020 updated Oct. 24, 2023), https://www.verisk.com/insurance/visualize/how-to-find-fraud-in-insurance-claims/.
[191] 18 U.S.C. § 1964.
[192] *Background on: Insurance fraud*.
[193] *Id*.
[194] *Id.*; *see, e.g.,* ARIZ. REV. STAT. ANN. § 20-463(A)(1)(c); CAL GOV'T CODE § 12650 *et seq*.; IOWA CODE ANN. §§ 685.1–685.7; 740 ILL. COMP. STAT. 92/1.

dozen states and the District of Columbia require insurers to create and implement programs to reduce insurance fraud.[195]

See:

- *Pittsfield Dev., LLC v. Travelers Indem. Co.* Two pipes burst on the tenth floor of Chicago's historic Pittsfield Building leading to a dispute between the owners of the floors of the building and their insurer.[196] The owners filed suit alleging that the insurer had refused to pay the full extent of the covered loss, but the insurer counterclaimed for breach of contract and unjust enrichment alleging that one of the line items in the damages estimate, $1 million for asbestos remediation, was not a result of a bid from a remediation firm as the owners purported, and, rather, that the bid did not exist at all.[197] The insurer sought to void the policy based on the misrepresentation about the asbestos removal as well as to recover the money they had already paid to the owners under the policy.[198] The Court held that the insurer had presented adequate evidence to advance their breach of contract claim based on submitting a false claim for coverage, but dismissed the unjust enrichment claim as the claims are mutually exclusive.[199] The Court held that alleging unjust enrichment implies the existence of a contract, which the insurer was also arguing did not exist because it was voided by the false claim for coverage.[200]
- *State Farm Mut. Auto. Ins. Co. & State Farm Fire & Cas. Co. v. B&A Diagnostic, Inc*. An automobile insurer brought an unjust enrichment action against a health care clinic and its employees, seeking to recover medical benefits it had paid to the clinic for X-ray services that were allegedly unlawfully rendered to insureds pursuant to their no-fault personal injury protection (PIP) policy coverage and declaratory judgment confirming that it was not obligated to pay any remaining unpaid bills.[201] The Court granted summary judgment for insurer finding that the services rendered by defendants during the relevant time period were unlawful and non-compensable.[202]

- *State Farm Mut. Auto. Ins. Co. v. Pointe Physical Therapy, LLC*. An automobile insurer brought action against treatment facilities, clinics, physicians, a diagnostic testing facility, and the entity that allegedly owned or controlled the other defendants, alleging that defendants engaged in a scheme to submit hundreds of bills and false documentation to obtain payment of benefits under Michigan's No-Fault Act for treatments and services that were either never performed or not medically necessary and asserting claims for violation of RICO 18 U.S.C. §§ 1962(c) and (d), common law fraud, and unjust enrichment.[203] The Complaint alleged that a "Management Group" secretly owned and/or controlled each of

[195] *Background on: Insurance fraud.*
[196] *Pittsfield Dev., LLC v. Travelers Indem. Co.*, 542 F. Supp. 3d 791, 795 (N.D. Ill. 2021).
[197] *Id.*
[198] *Id.*
[199] *Id.* at 803.
[200] *Id.* at 803–04.
[201] *State Farm Mut. Auto. Ins. Co. & State Farm Fire & Cas. Co. v. B&A Diagnostic, Inc.*, 145 F. Supp. 3d 1154, 1166 (S.D. Fla. 2015).
[202] *Id.*
[203] *State Farm Mut. Auto. Ins. Co. v. Pointe Physical Therapy, LLC*, 107 F. Supp. 3d 772, 778–80 (E.D. Mich. 2015).

the other Defendants and maintained referral relationships with patients' personal injury attorneys, directed patients' treatments, coordinated patients' transportation to and from treatments through a commonly owned transportation service, referred patients to a commonly owned diagnostic testing facility and profited from all aspects of the scheme.[204] Additionally, the Complaint alleges, the Management Group directed the Prescribing Clinics and Prescribing Physicians to steer patients for medically unnecessary diagnostic tests to facilities owned and/or controlled by Defendants, which were then billed to and paid for by State Farm.[205] The insurer alleged that it justifiably relied on the bills, medical records and supporting documentation submitted by the Defendants, which represented that the Defendants were providing services that were actually and lawfully rendered and reimbursable, when in fact the services were either not performed or performed pursuant to a generic predetermined protocol to enrich Defendants by maximizing their collection of the patients' no-fault benefits.[206] The Court denied Defendant's motion to dismiss, holding that Plaintiffs had alleged facts sufficient to support their RICO claims.[207]

***Practice Note**:* Most states, including Illinois, Michigan, California, New Jersey, and New York, have recognized a longstanding common law doctrine, the "voluntary payment doctrine," which maintains that "'[a]bsent fraud, coercion or mistake of fact, monies paid under a claim of right to payment but under a mistake of law are not recoverable.'"[208] The voluntary payment doctrine "ensures that those who desire to assert a legal right do so at the first possible opportunity; this way, all interested parties are aware of that position and have the opportunity to tailor their own conduct accordingly."[209] The doctrine "applies to any cause of action which seeks to recover a payment on a claim of right, whether that claim is premised on a contractual relationship or a statutory obligation …"[210] While this doctrine may be raised as an affirmative defense by an insured or third party who received payment from an insurer, the doctrine applies only when a payment is made with full knowledge of the facts.[211] Thus, if the insurer can show that they made a payment before they knew of fraud or falsifying of documents, the voluntary payment doctrine will not bar recovery.

D. Repeat Players: Common Claims and Common Defendants

According to the Insurance Information Institute, automobile insurance, healthcare, and workers' compensation are the sectors most affected by insurance fraud, with automobile insurance believed to occupy the top spot.[212] With this in mind, it makes sense then that insurance recovery claims

[204] *Id.* at 778–79.
[205] *Id.* at 779.
[206] *Id.* at 780.
[207] *Id.* at 804.
[208] *Spivey v. Adaptive Mktg. LLC*, 622 F.3d 816, 822 (7th Cir. 2010) (quoting *Randazzo v. Harris Bank Palatine, N.A.*, 262 F.3d 663, 668 (7th Cir. 2001)).
[209] *Randazzo*, 262 F.3d at 668.
[210] *Spivey*, 622 F.3d at 822 (quoting *Harris v. ChartOne*, 841 N.E.2d 1028, 1031 (Ill. App. Ct. 2005)).
[211] *See Lee v. Allstate Life Ins. Co.*, 838 N.E.2d 15, 22 (Ill. App. Ct. 2005).
[212] *Background on: Insurance fraud*; Dimitris Karapiperis *Insurance Fraud*, 13 CIPR NEWSLETTER (Nat'l Assoc. of Ins. Comm'rs & Ctr. for Ins. Pol'y & Rsch.) 17, 17–22 (2014) https://naic.soutronglobal.net/Portal/Public/en-GB/RecordView/Index/24759.

are highly concentrated in no-fault insurance states.[213] No-fault auto insurance is a type of auto insurance that allows the insured to recover financial loss from their insurer regardless of fault in a car accident. While these insurance systems are attractive for consumers who want to use legitimate accidents as a way to make extra money by padding their claims or even fake an accident altogether, the no-fault system is also attractive to those running healthcare fraud schemes, and it is healthcare facilities and medical service providers who represent the majority of defendants in insurance recovery litigation.

"Healthcare facilities and medical service providers" includes chiropractors, physical therapists, acupuncturists, dentists, medical equipment providers, and medical clinics. A unique feature of no-fault insurance is that healthcare providers can bill an insurer directly, instead of a policyholder having to submit claims to the insurer. In some fraud cases healthcare facilities themselves will either perform and bill the insurer for unnecessary medical tests or bill the insurer for procedures and tests that were never performed.[214]

More typically, the doctors see a high volume of auto accident patients and have a system in place to fraudulently refer patients to receive further, medically unnecessary care. The fraudulent referrals are used to obtain care and equipment from secondary service providers. The secondary service then bills the insurer and the prescribing doctor receives a kickback. When the insurer catches on, usually because of repeat billing, it brings a suit against the referral service provider and sometimes the referring doctor. Suits are brought to recover the cost of payments made and to obtain declaratory judgments stating that the insurer is not required to make future payments on pending claims. Examples of referral schemes include:

- pharmacies providing non-FDA-approved drugs with inflated prices;
- diagnostic testing centers providing duplicative, medically unnecessary tests;
- sham radiology clinics operated by providing X-rays and MRIs;
- pain management centers providing chiropractic services and injections without evidence that those services were appropriate;
- durable medical equipment provider issuing unnecessary devices and supports.

Other similar schemes have included medical service providers over-billing insurers so that they can collect high reimbursements.

[213] *See* Michael A. Sirignano, *An Insurance Fraud year in Review*, RIVKIN RADLER (Jan. 5, 2023) https://www.rivkinradler.com/publications/an-insurance-fraud-year-in-review-2/ ("No-fault insurance fraud continues to be a major problem for insurance carriers").
[214] *See State Farm Mut. Auto. Ins. Co. v. Muse*, No. 20-13319, 2022 WL 413417 (11th Cir. Feb. 10, 2022); *Pointe Physical Therapy, LLC*, 107 F. Supp. 3d at 778–79.

V. Damages in Insurance Litigation

A. Overview

The question of damages is often addressed in a separate phase of an insurance recovery case after a court determines that coverage under the relevant insurance policy is available. This section, which focuses on the question of damages, has three parts. The first part of the section covers the most common measure of damages, which is contractual damages, as well as additional and separate amounts that are recoverable in numerous jurisdictions. Such recoveries include (i) consequential damages based on economic losses that flow from the breach of contract or are reasonably contemplated by parties; (ii) tort-based or punitive damages; and (iii) mental or emotional distress damages.

The second part of this section lays out the doctrines of contribution and subrogation, which govern the rights and remedies insurers may have against one another and other relevant parties when seeking recovery for the payment of damages, settlement amounts, or defense costs. More specifically, contribution involves an insurer pursuing a claim against another insurer for recovery of payments, while subrogation involves an insurer pursuing a third party for recovery by stepping into the shoes of the insured.

The third part of this section focuses on how the prevailing party in insurance litigation may also collect amounts in the form of pre-judgment interest, post-judgment interest, or attorneys' fees. As fleshed out below, the extent, scope, and magnitude of collectability vary by jurisdiction.

B. Available Damages and Measure

1. Compensatory Damages

Compensatory damages may be awarded in connection with a breach of contract claim—i.e., where an insurance policy allegedly covers the event in question and a corresponding payout is owed to the insured. The compensatory damages calculation can be based on: (i) the payment due to the insured pursuant to the limits of the insurance policy in question or (ii) the premiums to be refunded as rescission, where the court finds that the policy had not been in effect and the insurer must return to the insured the premiums paid.[215]

2. Consequential Damages

An insurer can be found liable for losses suffered by an insured that are consequential to the insurer's breach of its duties. Such duties include the duty to defend and the duty to settle.

When an insurer has a duty to defend its insured, but breaches that duty, and the result of the breach is an inadequate (or nonexistent) defense, the insurer can be held liable for the insured's losses that

[215] 22 AM. JUR. 2D DAMAGES § 24.

are consequential to the breach. Generally, the insured must show that its losses would have been reduced had the insurer fulfilled its duty to defend.[216]

Separately, under the covenant of good faith and fair dealing, which is present in all insurance contracts, an insurer has a duty to accept a reasonable settlement offer within the policy limits when there exists a risk of judgment against the insured beyond the limits of the policy. When the insurer breaches this duty, it can become liable not only for the judgment in excess of policy limits but also for other losses consequential to the breach.[217]

3. Tort-Based or Punitive Damages

Recovery of tort-based or punitive damages may be possible, but only in certain states like Illinois and California where claims can be brought based upon allegations that the insurer acted in bad faith or violated the state's unfair or deceptive practices statute. In such instances, recovery could be in excess of the limits of the insurance policy in question.

Bad-faith allegations typically relate to an insurer's refusal to defend or settle an underlying matter, and can also stem from other conduct, such as claims-handling practices. By way of example, both Illinois and California view the insurer's breach of the duty to defend as sounding in tort, while California also views the insurer's breach of the duty to settle as typically sounding in tort.[218]

[216] *See, e.g.*, *Siegel v. William E. Bookhultz & Sons*, 419 F.2d 720, 725 (D.C. Cir. 1969) (holding that refusal to defend a claim that could trigger liability coverage is a breach of contract, and thus the insurer becomes liable for losses incurred as a result of the breach, including the ultimate amount of the claim, the insured's expenses in resisting the claim, and any additional loss traceable to the breach); *Gray v. Grain Dealers Mut. Ins. Co.*, 684 F. Supp. 1108, 1113 (D.D.C. 1988), *aff'd*, 871 F.2d 1128 (D.C. Cir. 1989) (applying the ruling in *Siegel* to hold insurer liable for a judgment in excess of the policy limits when the insurer had breached the duty to defend "erroneously, although honestly"); *Reis v. Aetna Cas. & Sur. Co. of Ill.*, 387 N.E.2d 700, 710 (Ill. App. Ct. 1978) (holding that "damages for a breach of the duty to defend are not inexorably imprisoned within the policy limits, but are measured by the consequences proximately caused by the breach"); *but see Conway v. Country Cas. Ins. Co*., 442 N.E.2d 245, 249–50 (Ill. App. Ct. 1982) (holding that, absent a finding of bad faith, mere breach of an insurer's duty to defend does not subject the insurer to liability in excess of the policy limits).

[217] *See, e.g.*, *Nationwide Mut. Ins. Co. v. Farmers' Ins. Grp.*, 76 Cal. App. 3d 1031, 1041 (1978) ("It is well established in this jurisdiction that a liability insurer owes its insured a duty to effect reasonable settlement of a claim against the insured within its policy limits when there is a substantial likelihood of recovery in excess of those limits and that upon breach of that duty by the insurer, the insured has a right of action against the insurer for damages proximately caused thereby"); *Larraburu Bros v. Royal Indem. Co.*, 604 F.2d 1208, 1214 (9th Cir. 1979) (holding that even where an insurer indemnified its insured in excess of policy limits after failing to accept a settlement offer, its failure to accept the settlement offer itself gave rise to consequential damages, including damages to the insured's credit which resulted from the judgment, and the insurer was liable for the resulting losses).

[218] *See, e.g.*, *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 203 (Cal. 1958) (ruling that "a wrongful refusal to settle has generally been treated as a tort," while also noting that "it is the rule that where a case sounds both in contract and tort the plaintiff will ordinarily have freedom of election between an action of tort and one of contract") (internal citations and quotation marks omitted); *Moutsopoulos v. Am. Mut. Ins. Co. of Bos.*, 607 F.2d 1185, 1188 (7th Cir. 1979) (considering a refusal to settle claim in a contract action).

Certain jurisdictions, such as Washington, D.C., do not recognize tort-based awards or punitive awards (in contract actions), but courts may still allow for consequential damages (e.g., lost income or related economic losses).[219]

4. Mental or Emotional Distress Damages

Extracontractual damages can also include an amount for mental or emotional distress if such distress stems in part from the insurer's failure to fulfill its obligations.[220]

C. Proving Damages

1. Contractual Damages

For contractual damages, the insured must prove that the claim for which it seeks recovery falls within the coverage of the insurance policy in question. Once coverage has been proven, the burden of proof then shifts to the insurer to prove that a limitation or exclusion from the policy applies. If the insurer proves a limitation or exclusion, the burden shifts back to the insured to prove that an exception to the exclusion applies.[221]

Often, exceptions to policy exclusions turn on questions of fact. One common example is insurance policies that exclude coverage for certain losses but have an exception when the insured makes "best efforts" or "reasonable efforts" to prevent such a loss.[222]

2. Bad Faith

To make a prima facie showing of bad faith in jurisdictions like California, the insured must show that it was due benefits under an insurance policy and that the insurer's withholding of benefits

[219] *See, e.g.*, *Fireman's Fund Ins. Co. v. CTIA*, 480 F. Supp. 2d 7, 13 (D.D.C. 2007) (finding that punitive damages are not available for breaches of contract but can be recovered only if the breach of contract "merge with and assume the character of a willful tort") (internal citations omitted); *Brand v. Gov't Emps. Ins. Co.*, No. 4-CV-01133, 2005 WL 3201322, at *5 (D.D.C. Nov. 29, 2005) (dismissing claim for punitive damages in contract action as bad-faith refusal to pay insurance claim was not a tort recognized pursuant to D.C. law).

[220] *See, e.g.*, *Crisci v. Sec. Ins. Co. of New Haven, Conn.*, 426 P.2d 173, 179, 433–34 (Cal. 1967) (Recovery of damages for mental suffering is allowed, as "among the considerations in purchasing liability insurance, as insurers are well aware, is the peace of mind and security it will provide in the event of an accidental loss, and recovery of damages for mental suffering has been permitted for breach of contracts which directly concern the comfort, happiness or personal esteem of one of the parties"); *State Farm Mut. Auto. Ins. Co. v. Allstate Ins. Co.*, 9 Cal. App. 3d 508, 527–28 (1970) (finding that an award for pain and distress of an automobile insurer's breach of duty to defend was proper under a breach of contract theory as presented to the court).

[221] *See, e.g.*, *Wells v. State Farm Fire & Cas. Ins. Co.*, 173 N.E.3d 613, 620 (Ill. App. Ct. 2021) ("[Illinois'] supreme court has long held that the burden rests with the insureds to prove that their claim falls within the coverage of its policy. … Once the insured has demonstrated coverage, the burden shifts to the insurer to prove that a limitation or exclusion applies") (internal citations omitted); *Ment Bros. Iron Works Co. v. Interstate Fire & Cas. Co.*, 702 F.3d 118, 121 (2d Cir. 2012) ("Under New York law … an insurer bears the burden of proving that an exclusion applies … Once the insurer establishes that an exclusion applies, however, New York law has evolved to place the burden of proof on the insured to establish the applicability of an *exception to the exclusion*") (italics in original).

[222] *See, e.g.*, *Wells*, 173 N.E.3d at 622–23.

was unreasonable or without proper cause.[223] California treats bad-faith claims as common law tort claims.[224]

Jurisdictions like Illinois, on the other hand, provide only a statutory remedy for bad-faith insurance claims, and such claims must show that the conduct of the insurance company was "vexatious and unreasonable."[225]

3. Punitive Damages

Most jurisdictions strictly require a party seeking punitive damages to meet a high burden and to prove "willful or malicious" conduct; "malice, oppression or fraud"; or "gross or wanton behavior" by the insurer. Certain jurisdictions also impose an elevated burden of proof, requiring a bad faith showing to be made by "clear and convincing evidence."[226]

While plaintiffs will often use the same facts to assert a claim of bad faith and a claim for punitive damages, the conduct required for the latter is more egregious than what is required for the former.[227]

As the U.S. Supreme Court has made clear, the focus when determining whether to issue a punitive damages award is on the reprehensibility of the insurer's conduct. In *State Farm Mut. Ins. Co. v. Campbell*, the U.S. Supreme Court confirmed that, when determining the degree of reprehensibility, courts must consider in part whether "the conduct involved repeated actions or was an isolated incident," and whether "the harm resulted from intentional malice, trickery, or deceit, or mere accident."[228] The Court also clarified that, while evidence of repeated conduct does not need to be identical, the evidence must at least be relevant and tangential to the type of lawsuit at hand.[229]

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[223] *See, e.g.*, *Love v. Fire Ins. Exch.*, 221 Cal. App. 3d 1136, 1151 (1990).
[224] *See Comunale*, 328 P.2d at 203.
[225] 215 ILL. COMP. STAT. 5/155 ("In any action by or against a company wherein there is in issue the liability of a company on a policy or policies of insurance or the amount of the loss payable thereunder, or for an unreasonable delay in settling a claim, and it appears to the court that such action or delay is vexatious and unreasonable, the court may allow as part of the taxable costs in the action reasonable attorney fees, other costs, plus an amount not to exceed any one of the following amounts: (a) 60% of the amount which the court or jury finds such party is entitled to recover against the company, exclusive of all costs; (b) $60,000; (c) the excess of the amount which the court or jury finds such party is entitled to recover, exclusive of costs, over the amount, if any, which the company offered to pay in settlement of the claim prior to the action").
[226] CAL. CIV. CODE § 3294 (creating a "clear and convincing evidence" standard and requiring "oppression, fraud, or malice" to support a punitive damages claim); *O'Neill v. Gallant Ins. Co.*, 769 N.E.2d 100, 109–10 (Ill. App. Ct. 2002) (acknowledging that while the Illinois Supreme Court does not allow punitive damages in first-party insurance recovery claims, as such damages claims are preempted by 215 ILL. COMP. STAT. § 1/155, punitive damages are allowed in third-party cases when a jury is satisfied that "the refusal to settle within policy limits was engaged in with utter indifference and reckless disregard for its policyholder's financial welfare").
[227] *See, e.g.*, *Shade Foods, Inc. v. Innovative Prod. Sales & Mktg., Inc.*, 78 Cal. App. 4th 847, 890 (2000) (quoting *Tomaselli v. Transamerica Ins. Co.*, 25 Cal. App. 4th 1269, 1286 (1994)) (finding that "[t]he same evidence is relevant both to the finding of bad faith and the imposition of punitive damages, but '[t]he conduct required to award punitive damages for the tortious breach of contract . . . is of a different dimension [than that required to find bad faith]'").
[228] *State Farm Mut. Ins. Co. v. Campbell*, 538 U.S. 408, 409 (2003).
[229] *Id.* at 423–24.

D. Contribution

Contribution involves an insurer pursuing a claim against a co-insurer who shares liability and is therefore involved in the payment of damages. Contribution can be sought from another primary insurer or an excess insurer, although with certain restrictions with respect to the latter.

1. Statute of Limitations

In jurisdictions like Illinois, a contribution claim must be brought within two years after the party seeking contribution has made the payment in discharge of its liability to the claimant.[230] In jurisdictions like California, a contribution claim must be brought within two years, but the statute of limitations is "tolled until all of the defense obligations" are "terminated by final judgment in the underlying action."[231]

2. Contribution from Primary Insurers

Where multiple insurers cover an insured, one insurer who has paid the claim (i.e., paid more than its fair share) can recover part of the payment from the other insurers.

Many insurance policies expressly state the formula by which contribution amounts will be calculated. The two most standard methods are contribution by limits (i.e., each insurer's coverage limit divided by the total coverage limit of all insurers represents its proportion of the loss) and contribution by equal shares (i.e., each insurer bears the cost equally).

Where multiple insurance policies cover a loss but at least one of them has a non-contribution (i.e., escape) clause, courts tend to respect that provision. However, where all policies contain such a clause, they generally become inoperative and all of the insurers are involved in the damages payment.[232]

> **Hypothetical Example:** Four bulldozers (X, Y, Z, and A) run into Plaintiff, a construction worker. Plaintiff sues X but not the rest. X settles with Plaintiff by paying $12 million. X, Y, Z, and A each have coverage limits of $20 million (i.e., a total of $80 million). Pursuant to the contribution by limits method, X would sue to get $3 million each from Y, Z, and A ($12 million x ($20 million / $80 million)). Pursuant to the contribution by equal shares method, X would sue to also get $3 million each from Y, Z, and A but arising from a different calculation ($12 million / 4).

[230] *See, e.g.*, 735 ILL. COMP. STAT. § 5/13-204.
[231] *Underwriters of Int. Subscribing to Pol'y No. A15274001 v. ProBuilders Specialty Ins. Co.*, 241 Cal. App. 4th 721, 735–36 (2015).
[232] *See, e.g.*, *Underwriters of Int. Subscribing to Pol'y No. A15274001*, 241 Cal. App. 4th at 731 ("We [California] adhere to the modern trend [of requiring] equitable contributions on a pro rata basis from all primary insurers regardless of the type of 'other insurance' clause in their policies") (internal quotations omitted); *Home Ins. Co. v. Certain Underwriters at Lloyd's*, *London,* 729 F.2d 1132, 1136 (7th Cir. 1984) ("If two applicable policies contain excess clauses, however, such provisions are to be disregarded as being mutually repugnant and each company is liable for a pro rata share of the liability") (internal quotation marks omitted).

3. Contribution from Excess Insurers

Excess insurance covers amounts that exceed the limits of the primary insurance policy. Many excess insurance policies contain a provision indicating that the insurer will only pay claims when all other insurance is exhausted.

In multiple jurisdictions, courts have held in various instances that primary insurers are not entitled to equitable contribution from excess insurers in the form of settlement amounts and defense costs.[233]

Courts have also held that, if the primary insurers wrongfully deny coverage and the excess insurer must pay the whole claim, the excess insurer has an equitable subrogation right against the primary insurers.[234]

Disputes have arisen over what constitutes exhaustion of the relevant insurance policy limits that would compel an excess insurer to effectively drop down from its insurance level and pay out for a claim or contribute to settlement and defense costs. In at least one case, *AXIS Reinsurance Co. v. Northrop Grumman Corp.*, the primary insurer and first-layer excess insurer had agreed to settle a lawsuit brought against the policyholder, and the settlement had exhausted the former's policy and eroded the latter's policy.[235] The policyholder was sued a second time, and in turn, the policyholder asked the second-layer excess insurer to contribute to the settlement. After paying to settle, the second-layer excess insurer sued the policyholder for reimbursement of settlement costs, on grounds that the primary insurer and first-layer excess insurer had improperly exhausted their policy limits and it did not have a duty to cover the second settlement.

The U.S. Court of Appeals for the Ninth Circuit ruled against the second-layer excess insurer and held: "excess insurers generally may not avoid or reduce their own liability by contesting payments made at prior levels of insurance, unless there is an indication that the payments were motivated by fraud or bad faith. Of course, excess insurers may contract around this general rule by including specific language in their policies reserving a right to challenge prior payments (so long as the provision is not prohibited by applicable law). Here, however, there is no indication that [the

[233] *See, e.g.*, *Scottsdale Ins. Co. v. Certain Underwriters at Lloyds, London*, 839 F. App'x 105, 109 (9th Cir. 2020) (ruling against contribution where the excess insurer was not provided notice of the original malpractice action until the primary insurer had denied coverage of the claim); *Am. Indem. Lloyds v. Travelers Prop. & Cas. Ins. Co.*, 335 F.3d 429, 443–44 (5th Cir. 2003) (upholding the well-established rule in Texas that the excess insurer is not obligated to participate in the defense until the primary policy limits are exhausted, even where the lawsuit alleges a damages amount in excess of the primary policy limits, so long as it is settled or results in a judgment for an amount not in excess of the primary limits).

[234] *See, e.g.*, *Home Ins. Co. v. Cincinnati Ins. Co.*, 821 N.E.2d 269, 280 (Ill. 2004) (finding that excess insurer was entitled to equitable subrogation from primary insurer and not contribution); *Galen Health Care, Inc. v. Am. Cas. Co. of Reading*, 913 F. Supp. 1525, 1531 (M.D. Fla. 1996) ("Florida law recognizes a cause of action for equitable subrogation between primary and excess insurers arising from the payment of a claim by the excess insurers"); *Zurich Am. Ins. Co. v. S.-Owners Ins. Co.*, 248 F. Supp. 3d 1268, 1278 (M.D. Fla. 2017) ("More specifically, in a dispute between a primary and excess insurer arising from the payment of a claim by the excess insurer, through equitable subrogation, the excess insurer stands in the shoes of the insured and succeeds to the rights and responsibilities that the insured would normally have against the primary insurer") (internal citations and quotation marks omitted).

[235] *See AXIS Reinsurance Co. v. Northrop Grumman Corp.*, 957 F.3d 840 (9th Cir. 2020).

policyholder] and [the second-layer excess insurer] mutually agreed that the 'covered loss' provision in [the second-layer excess insurer's] policy would have this effect."[236]

4. Pro Rata Rule v. Pro Tanto Rule

Where multiple insurers are responsible for the same claim, such as in the case of contribution, states take different burden-shifting approaches. These approaches include the pro rata rule and the pro tanto rule.

The pro rata rule divides damages equally among parties, even when one party settles before the others. Put another way, if an insurer settles with the insured, that settlement does not impact the damages allocation with respect to the non-settling insurers. Where an insurer settles for less than its share, the insured may not collect additional money from the non-settling insurers. And, where an insurer pays more in settlement than it would have after a judgment, it cannot seek contribution from the non-settling insurers.

The pro tanto rule reduces other insurers' damages allocation by the amount paid by the settling insurer. Since this approach could encourage gamesmanship between the plaintiff and an insurer, some jurisdictions have required hearings on culpability and a showing of good faith before settlements are approved.

Hypothetical Example: The Eleventh Circuit has provided an illustrative example of how both the pro rata and pro tanto rules apply:

> Assume, for example, that the negligence of A and B combine to injure C, who then files a lawsuit against A and B. On the morning of trial A settles with C for $50,000. The jury subsequently finds that A was 75% responsible and B was 25% responsible for the accident and that C's damages totaled $100,000. If neither party had settled, judgment would be entered against A for $75,000 and B for $25,000. But given A's settlement for $50,000, how much should B pay?
>
> Under the pro rata approach, B would receive a credit for 75% of C's damages ($75,000) because A, the settling joint tortfeasor, was 75% responsible for the accident. Thus, B would owe $25,000 ($100,000 - $75,000) to C.
>
> Under the pro tanto approach, B would only receive a credit for the dollar value of A's settlement ($50,000). Therefore, B would owe $50,000 ($100,000 - $50,000) to C.[237]

States like Illinois follow the pro tanto rule, while states like California and New York use a hybrid approach. Specifically:

[236] *Id.* at 844.
[237] *See Great Lakes Dredge & Dock Co. v. Miller*, 957 F.2d 1575, 1579 (11th Cir. 1992).

- In Illinois, the Joint Tortfeasor Contribution Act clearly states a pro tanto rule.[238]

- In California, economic damages are shared jointly and not severally, whereas non-economic damages are shared severally and not jointly.[239] When a settlement is reached with one of multiple co-obligors, the plaintiff's claim against the remaining defendants is reduced by the amount of the settlement.[240]

- *Pollicina v. Misericordia Hosp. Med. Ctr*. In New York, settlement by one co-obligor causes that co-obligor to be relieved of liability for contribution to other co-obligors, and also waives that co-obligor's right to contribution from other co-obligors.[241] The liability of remaining defendants is reduced by the total amount of settlements reached by settling defendants or by the total damages owed by the settling defendants under the judgment, whichever is greater.[242]

See:

Olin Corp. v. Lamorak Ins. Co. Insured industrial chemicals manufacturer sued insurer, claiming breach of contract and seeking coverage under excess liability policies for past damages and, through claims for declaratory judgment, seeking future damages for all costs incurred or allocated for remediation of environmental contamination resulting from insured's waste-disposal practices at multiple sites. Insurer filed third-party claims for contribution and indemnity against insured's other excess insurers that entered settlement agreements with insured. The District Court held that excess liability insurer's claims for contribution from other excess insurers were barred by the insured's settlement with those other insurers, and thus, insurer was only entitled to pro tanto set-off of its liability for remediation costs by amounts actually paid in settlement by insured's other excess

[238] 740 ILL. COMP. STAT. § 100/2(b) ("The right of contribution exists only in favor of a tortfeasor who has paid more than his pro rata share of the common liability, and his total recovery is limited to the amount paid by him in excess of his pro rata share. No tortfeasor is liable to make contribution beyond his own pro rata share of the common liability").
[239] CAL. CIV. PROC. CODE § 1431 ("An obligation imposed upon several persons, or a right created in favor of several persons, is presumed to be joint, and not several, except as provided in Section 1431.2, and except in the special cases mentioned in the title on the interpretation of contracts. This presumption, in the case of a right, can be overcome only by express words to the contrary"); *id.* at § 1431.2(a) ("In any action for personal injury, property damage, or wrongful death, based upon principles of comparative fault, the liability of each defendant for non-economic damages shall be several only and shall not be joint. Each defendant shall be liable only for the amount of non-economic damages allocated to that defendant in direct proportion to that defendant's percentage of fault, and a separate judgment shall be rendered against that defendant for that amount").
[240] CAL. CIV. PROC. CODE § 877(a) ("Where a release, dismissal with or without prejudice, or a covenant not to sue or not to enforce judgment is given in good faith before verdict or judgment … to one or more other co-obligors mutually subject to contribution rights, it shall have the following effect: … It shall not discharge any other such party from liability unless its terms so provide, but it shall reduce the claims against the others in the amount stipulated by the release, the dismissal or the covenant, or in the amount of the consideration paid for it, whichever is the greater").
[241] N.Y. GEN. OBLIG. L. § 15-108(b)-(c) ("A release given in good faith by the injured person to one tortfeasor … relieves him from liability to any other person for contribution. … A tortfeasor who has obtained his own release from liability shall not be entitled to contribution from any other person").
[242] *See, e.g.*, *Pollicina v. Misericordia Hosp. Med. Ctr.*, 624 N.E.2d 974, 978 (N.Y. 1993) (adopting an "'aggregate' approach[] in which the totaled settlement amounts for all settling defendants are compared with the total of the corresponding apportioned shares and the higher of these totals is deducted from the damage award").

insurers, rather than by settled insurers' pro rata shares of liability, since applying pro tanto set-off and allowing for contribution would discourage settlement and lead to unnecessary ancillary litigation of contribution claims.[243]

E. Subrogation

Subrogation is when an individual or entity assumes the legal rights of the individual or entity for whom a legal obligation has been paid. In the insurance context, an insurer can pursue a third party for damages by stepping into the shoes of the insured. As a result, the insurer will have the same rights as the policyholder when seeking compensation for losses.

Hypothetical Example: Insurer Recovers. Plaintiff has $1 million in damages and Defendant has $0 in insurance, but Plaintiff has $1 million in automobile insurance coverage. The insurer pays Plaintiff $1 million. Defendant has money separate from the insurance policy. The insurer sues Defendant under subrogation for Defendant to pay it what it paid to Plaintiff due to Defendant's negligence.

Hypothetical Example: Defendant is Damage Proof. Plaintiff has $1 million in damages and Defendant has $0 in insurance, but Plaintiff has $1 million in automobile insurance coverage. The insurer pays Plaintiff $1 million. Defendant *does not have* money separate from the insurance policy. Although the insurer has subrogation rights, Defendant's lack of assets will prevent the insurer from recovering.

1. Waiver

Parties to a contract may insert a waiver of subrogation provision into their agreement, thereby preventing their insurers from seeking compensation for losses.[244]

There are several ways for insurers to avoid being put in this disadvantageous situation.[245]

[243] *Olin Corp. v. Lamorak Ins. Co.*, 332 F. Supp. 3d 818 (S.D.N.Y. 2018).
[244] *See, e.g.*, *Indus. Risk Insurers v. Port Auth. of New York & New Jersey*, 387 F. Supp. 2d 299, 311 (S.D.N.Y. 2005) ("Parties to commercial leases often provide for waivers of subrogation rights, and these sorts of arrangements are enforceable in New York"); *Empress Casino Joliet Corp. v. W.E. O'Neil Const. Co.*, 68 N.E.3d 856, 875 (Ill. App. Ct. 2016) ("[N]othing in our State's law or public policy prevents competent parties to a construction contract [from negotiating] a full waiver of subrogation rights (regardless of fault) among themselves …").
[245] *See, e.g.*, *Travelers Indem. Co. v. Crown Corr, Inc.*, No. 11-CV-00965, 2011 WL 6780885, at *9 (D. Ariz. Dec. 27, 2011) ("[I]nsurers are in the best position to protect themselves against waivers of subrogation entered into by their insured before the acquisition of the insurance policy by (1) inserting an exclusion into their policies that permits the insurers to deny coverage if any insured waive[d] the insurer's subrogation rights, (2) raising premiums to offset outlays incurred from the loss of their subrogation rights, (3) investigating whether a potential insured has already waived any subrogation rights, (4) requiring insureds to warrant at the time a policy is issued that their insureds have not, and will not, waive the insurers' subrogation rights, and (5) obtaining reinsurance to cover any waiver of subrogation rights") (internal quotations).

2. Statute of Limitations

The statute of limitations periods for subrogation claims vary by jurisdiction and by claim. Since the insurer steps into the shoes of the insured, however, in most states the limitations period that would have applied to the insured attaches to the insurer's action.[246] Consequently, for personal property claims (not exhaustive):

- Louisiana has a one-year period;
- Seventeen states, including Indiana, Ohio, Pennsylvania, Texas, Washington (when intentional), and Colorado (when non-motor) have two-year periods;
- D.C. and 18 states, including California, Massachusetts, Michigan, New York, Washington (when negligent), Wisconsin (when motor), and Colorado (when motor) have three-year periods;
- Five states, including Florida and Georgia, have four-year periods;
- Four states—Illinois, Iowa, Missouri, and Virginia—have five-year periods;
- Seven states, including Maine, Minnesota, New Jersey, and Wisconsin (when non-motor), have six-year periods for many claims; and
- Rhode Island has a ten-year period.[247]

The limitations period generally begins to start on the date of the alleged injury.[248] But, in some situations, it may begin to run only after payment has been made.[249]

3. Types of Subrogation

There are principally two types of subrogation: (i) conventional or contractual subrogation and (ii) legal or equitable subrogation.

Conventional or contractual subrogation rights arise out of a contract, like an insurance policy. "Conventional subrogation can take effect only by agreement and has been said to be synonymous

[246] *See, e.g.*, *Anne Arundel County v. McCormick*, 594 A.2d 1138, 1140 (Md. App. Ct. 1991) ("As a subrogee, the County had no greater rights than its subrogor, and it was bound by the same statute of limitations which governed its employee's action").
[247] Note that the number of states exceeds 50 because Colorado, Wisconsin, and Washington have different statutes of limitation depending on what kind of personal property claim is being asserted.
[248] *See, e.g.*, *Nationwide Mut. Ins. Co. v. Schwartz*, 660 N.Y.S.2d 623, 624 (N.Y. Sup. Ct. 1997) ("[P]laintiff's subrogation rights are subject to the same three-year tort Statute of Limitations, measured from the date of the accident, as though the cause of action had been brought by its insured").
[249] *See, e.g.*, *Pennwalt Corp. v. Metro. Sanitary Dist. of Greater Chi.*, 368 F. Supp. 972, 980 (N.D. Ill. 1973).

with assignment. It occurs where one having no interest or any relation of the matter pays the debt of another, and by agreement is entitled to the rights and securities of the creditor so paid."[250]

When subrogation rights are written into an insurance policy agreement but the terms are unclear as to when subrogation occurs, courts typically interpret those terms according to the principles of legal or equitable subrogation.[251] When subrogation rights are made clear in the contract, however, the insurer's rights depend solely on the agreement's terms.[252]

Legal or equitable subrogation rights arise as a matter of equity, regardless of whether an agreement has been formed. "The object of [legal or equitable] subrogation is the prevention of injustice. It is designed to promote and to accomplish justice, and is the mode which equity adopts to compel the ultimate payment of a debt by one who, in justice, equity, and good conscience, should pay it."[253]

Many jurisdictions require that an insured be "made whole" before an insurer attains equitable subrogation rights.[254] States, via statute and case law, have adopted several variations of the "made whole" doctrine.[255] Jurisdictions like Illinois, however, do not require that a policyholder be "made whole" before asserting a contractual subrogation right.[256]

F. Pre-Judgment and Post-Judgment Interest

Parties typically negotiate and include provisions in their insurance contracts regarding applicable pre- and post-judgment interest rates. Where express contractual language is absent, parties are governed by state statutes and relevant case law that establish what and how much interest to which a party is entitled.

Pre-judgment and post-judgment interest rates vary by jurisdiction. By way of example, Illinois has recognized and upheld 5% to be the applicable pre-judgment interest rate in contract actions.[257]

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[250] *Amica Mut. Ins. Co. v. Muldowney*, 142 A.3d 439, 443 (Conn. App. Ct. 2016), *aff'd*, 180 A.3d 950 (Conn. 2018) (internal quotation marks omitted).
[251] *See, e.g.*, *DeTienne Assocs. Ltd. P'ship v. Farmers Union Mut. Ins. Co.*, 879 P.2d 704, 708 (Mont. 1994) (holding that when an insurance contract has a subrogation clause but "does not dictate upon what terms that subrogation shall occur … the terms of subrogation … are provided by [inherent] equitable principles").
[252] *See, e.g.*, *Hack v. Multimedia Cablevision, Inc.*, 696 N.E.2d 694, 696 (Ill. App. Ct. 1998) ("The right of an insurer to subrogation is measured by and depends solely on the terms of the subrogation provisions in the contract").
[253] *Amica*, 142 A.3d at 443 (internal quotation marks omitted).
[254] *See, e.g.*, *Swanson v. Hartford Ins. Co. of Midwest*, 46 P.3d 584, 587–88 (Mont. 2002) ("The doctrine require[s] that an insured by 'made whole' before an insurer could assert its subrogation rights, which mean[s] that, not only must the insured recover all of her losses but also all costs of recovery as well, such as attorney fees and costs of litigation").
[255] *Cf.* S.C. ST. § 38-71-190 (health insurers can only recover in a subrogation action "the amount of insurance benefits that the insurer has paid previously in relation to the insured's injury by the liable third party") *with Stancil v. Erie Ins. Co.*, 740 A.2d 46, 49–50 (Md. App. Ct. 1999) (declining to establish a "made whole" doctrine in Maryland).
[256] *See, e.g.*, *Capitol Indem. Corp. v. Strike Zone*, 646 N.E.2d 310, 311–12 (Ill. App. Ct. 1995) (rejecting claim that insured should be made whole before insurer asserts conventional subrogation right where terms of contract were clear).
[257] 815 ILL. COMP. STAT. § 205/2; *see, e.g.*, *E.M. Melahn Const. Co. v. Vill. of Carpentersville*, 427 N.E.2d 181, 186 (Ill. App. Ct. 1981).

Pre-judgment interest has traditionally not been recoverable in tort actions brought in the state, but the Illinois state legislature passed for the first time in 2021 the imposition of 6% as the pre-judgment interest rate in personal injury and wrongful death actions, by adding to the existing provision that established 9% as the post-judgment interest rate.[258] However, this pre-judgment interest provision was rejected in 2022 by the Circuit Court of Cook County, in part for violating Article I § 13 of the Illinois Constitution, which guarantees the right to a jury trial.[259]

To provide additional examples, New York has recognized and upheld 9% as the pre-judgment interest rate for both contract and tort actions as well as post-judgment interest, unless otherwise established by statute or contract.[260] In California, the pre-judgment interest rate in contract actions is the rate established in the contract, and if not, 10% for contracts executed following January 1, 1986.[261] The pre-judgment interest rate in tort actions is 7%.[262] The maximum post-judgment interest rate has been set as 10%.[263]

Courts in various jurisdictions have also focused on differing events as triggers for pre-judgment and post-judgment interest accrual dates. Pre-judgment interest accrues, for instance:

- *Nationwide Life Ins. Co. v. Steiner*. Pursuant to Rhode Island law, when the prevailing party was entitled to its money and did not receive it.[264]

- *Smith v. Huston*. Pursuant to Texas law, the earlier of the 180th day after the date the defendant receives written notice of a claim or the date the complaint was filed.[265]

- *Licudine v. Cedars-Sinai Med. Ctr*. Pursuant to California law, "[a] plaintiff who sues and prevails at trial is statutorily entitled to pre-judgment interest starting from the date she makes a settlement offer."[266]

Post-judgment interest accrues, for instance:

- Pursuant to Illinois law, on the day after the verdict and ordinarily continues to accrue until the judgment is satisfied, unless the judgment is vacated or reserved on appeal.[267]

- *Univ. Med. Ctr., Inc. v. Beglin*. Pursuant to Kentucky law, on the date the judgment was entered (i.e., not on the following day).[268]

[258] 735 ILL. COMP. STAT. § 5/2-1303.
[259] *See Hyland v. Advocate Health and Hosp's Corp.*, No. 2017-L-003541 (Cook County, Ill. May 27, 2022).
[260] N.Y. C.P.L.R. §§ 5004, 5001(a).
[261] CAL. CIV. CODE § 3289.
[262] CAL. CONST. ART. XV, §1.
[263] CAL. CIV. PROC. CODE § 685.010.
[264] *See, e.g.*, *Nationwide Life Ins. Co. v. Steiner*, 757 F. Supp. 2d 114, 117–18 (D.R.I. 2010).
[265] *See, e.g.*, *Smith v. Huston*, 251 S.W.3d 808, 827 (Tex. App. Ct. 2008).
[266] *Licudine v. Cedars-Sinai Med. Ctr.*, 242 Cal. Rptr. 3d 76, 79 (Cal. App. Ct. 2019).
[267] *See* 735 ILL. COMP. STAT. 5/2-1303.
[268] *See, e.g.*, *Univ. Med. Ctr., Inc. v. Beglin,* 432 S.W.3d 175, 180 (Ky. App. Ct. 2014).

- *Upper Occoquan Sewage Auth. v. Blake Const. Co., Inc./Poole & Kent*. Pursuant to Virginia law, on the date that a fixed amount of judgment debt was rendered by the factfinder charged with making the determination.[269]

G. Recovery of Attorneys' Fees

The availability of attorneys' fees is governed by state statute, case law, or insurance contracts where applicable. Within certain contracts, arbitration clauses may provide for the payment of the prevailing party's attorneys' fees and costs.

A request for attorneys' fees must meet a high bar to be granted. For instance, Illinois only allows for recovery of attorneys' fees for conduct that is "vexatious and unreasonable."[270]

Attorneys' fees are typically available as damages where the insurer breaches its duty to defend, as such costs are incurred because of the breach.[271]

VI. Equitable Remedies

A. Overview

Generally, equitable remedies are not available to a plaintiff where she has an adequate legal remedy.[272] However, the existence of a legal remedy is not sufficient to warrant the denial of equitable relief; the legal remedy must be as efficient as the equitable remedy would allow under the same circumstances.[273] By and large, the most common equitable remedies in insurance disputes are rescission of the contract, injunctive relief, and reformation of the insurance policy.

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[269] *See, e.g.*, *Upper Occoquan Sewage Auth. v. Blake Const. Co., Inc./Poole & Kent,* 655 S.E.2d 10, 24–25 (Va. 2008).

[270] 215 ILL. COMP. STAT. 5/155; *see, e.g.*, *Est. of Price v. Universal Cas. Co.*, 779 N.E.2d 384, 390–91 (Ill. App. Ct. 2002) (finding that failure to participate in an arbitration and to pay the award was vexatious and unreasonable); *Mobil Oil Corp. v. Maryland Cas. Co*., 681 N.E.2d 552, 562 (Ill. App. Ct. 1997) (finding that the insurer's delay in reserving rights, which caused conflict of interest in middle of pretrial litigation, was vexatious and unreasonable); *Smith v. Equitable Life Assur. Soc. of U.S.*, 67 F.3d 611, 618 (7th Cir. 1995) (noting that a finding of vexatious or unreasonable delay must be based on the totality of the circumstances).

[271] *See, e.g.*, *Brandt v. Sup. Ct.*, 693 P.2d 796, 798 (Cal. 1985) ("When an insurer's tortious conduct reasonably compels the insured to retain an attorney to obtain the benefits due under a policy, it follows that the insurer should be liable in a tort action for that expense. The attorney's fees are an economic loss—damages—proximately caused by the tort"); *Fleet & Farm of Green Bay, Inc. v. United Fire & Cas. Co.*, No. 13-CV-01013, 2015 WL 5839056, at *2 (E.D. Wis. Oct. 7, 2015) (holding that the attorney fees incurred by insured must be paid by insurer because "[h]aving refused to provide a duty to defend, the insurer also gave up its right to control the defense, as well as the reasonableness of its attendant costs") (internal quotations omitted); *Am. Serv. Ins. Co. v. China Ocean Shipping Co.*, 932 N.E.2d 8, 25 (Ill. App. Ct. 2010) (holding that the trial court's award of attorney fees in a duty to defend breach case was appropriate and the dollar amount of the award reasonable).

[272] *See, e.g.*, *Fed. Deposit Ins. Corp. v. Bank of Am., N.A.*, 308 F. Supp. 3d 197, 202 (D.D.C. 2018); *Coastal Wellness Ctrs., Inc. v. Progressive Am. Ins. Co.*, 309 F. Supp. 3d 1216, 1222 (S.D. Fla. 2018); *Ernst v. N. Am. Co. for Life and Health Ins.*, 245 F. Supp. 3d 680, 687 (M.D. N.C. 2017).

[273] *See Fed. Deposit Ins. Corp.*, 308 F. Supp. 3d at 202.

B. Rescission

"The effect of rescission is to render the contract abrogated and of no force and effect from the beginning."[274] If a fraudulent or material mistake was made during the formation of the policy (such as a misrepresentation), the insurer and/or the court can declare that the policy was never binding and thus rescind the contract.[275]

See:

> *W. Coast Life Ins. Co. v. Hoar.* An insurer sought declaratory judgment to rescind a policy because of the insured's failure to advise the life insurer of his engagement in hazardous activities. The insured participated in heli-skiing on numerous occasions but stated he did not engage in hazardous activities. The insured died after an avalanche occurred while he was heli-skiing. The Tenth Circuit affirmed the trial court's determination that the insurer was entitled to rescission of the insured's policy based on nondisclosure of the hazardous activities.[276]

C. Injunctive Relief

An injunction is an equitable remedy that requires a party to do—or refrain from doing—a particular thing.[277] In the insurance context, an injunction may generally issue to prevent a litigant from bringing a second action to evade the possible outcome of a first action. For example, where the court has obtained jurisdiction of a suit to cancel a life insurance policy for fraud in the application, it may enjoin the prosecution of another action subsequently instituted upon the policy, pending the outcome of the first suit.[278]

See:

> *Jefferson Standard Life Ins. Co. v. Keeton.* Decedent Joseph Keeton took out three policies of life insurance for $5,000 each in early 1921, two with the Jefferson Standard Life Insurance Company and one with the Equitable Life Assurance Society of the United States. Each of them contained a provision that it should be incontestable after one year from the date of its issue. Following Joseph Keeton's death later that same year, the insurance companies learned that the decedent made certain false statements which would avoid the policies provided the appellants sought cancellation within one year of their

[274] *Borck v. Holewinski*, 459 So. 2d 405, 405 (Fla. Dist. Ct. App. 1984).
[275] *See, e.g.*, *Wheelabrator Env't Sys., Inc. v. Galante*, 136 F. Supp. 2d 21, 32 (D. Conn. 2001) ("Rescission of a contract on the ground of mutual mistake may be granted in a proper case where the mistake is common to both parties and by reason of it each has done what neither intended") (internal citation omitted)); *Scottsdale Indem. Co. v. Sun Coast Gen. Ins. Agency, Inc.*, No. 19-CV-00194, 2020 WL 8569410, at *6 (C.D. Cal. 2020) ("When a policyholder conceals or misrepresents a material fact on an insurance application, the insurer is entitled to rescind the policy"); *Amster v. Stratton*, 244 N.W. 201, 202 (Mich. 1932) ("[e]quitable relief . . . is not strictly a matter of right, but rather a remedy, the granting of which rests in the sound discretion of the court").
[276] *W. Coast Life Ins. Co. v. Hoar*, 558 F.3d 1151 (10th Cir. 2009).
[277] *See, e.g.*, *Zitella v. Mike's Transportation, LLC*, 99 N.E.3d 535, 538 (Ill. App. Ct. 2d Dist. 2018); *Bellwether Comm. Credit Union v. Chipotle Mexican Grill, Inc.*, 353 F. Supp. 3d 1070, 1088 (D. Colo. 2018) (holding that injunctive relief is not a freestanding cause of action but, rather, a form of relief to redress a plaintiff's other claims).
[278] *See Jefferson Standard Life Ins. Co. v. Keeton*, 292 F. 53, 56 (Cal. Ct. App. 1923).

respective dates. Decedent's widow and executrix refused to surrender the policies and filed suit. Insurance companies sought an injunction to stay the proceedings brought by decedent's widow. The trial court denied the injunctions, but the appellate court reversed, holding that the trial court should have enjoined the widow's suits pending the resolution of the insurance companies' claims that the decedent's policies should be cancelled.[279]

D. Reformation of the Policy

If a mistake during the creation of the insurance contract is mutual, or in cases of fraud or inequitable conduct, such that the policy as written does not reflect the actual and real agreement of the insurer and the insured, reformation of the policy can be used as an equitable remedy.[280] While the particular requirements for reformation can vary from state to state, a party must generally establish that a variance exists between the parties' original agreement and the subsequent writing memorializing that agreement and that there is an equitable basis for enforcing the parties' original agreement.[281] But, generally courts see reformation as an extraordinary remedy and exercise it with great caution.[282]

See:

May v. Travelers Prop. Cas. Co. of Am. A motor vehicle passenger injured in an accident sued the vehicle's insurer, seeking reformation of the policy for added personal injury protection (APIP) benefits, and asserting claims for breach of contract and bad faith. The trial court entered summary judgment granting reformation of the policy but placed an aggregate cap of $200,000 per person, per accident on the policy. The appellate court affirmed after the passenger appealed.[283]

Richard v. Anadarko Petroleum Corp. A contractor's employee brought an action against an offshore oil rig operator and contractors to recover for personal injuries sustained in a work accident. Defendants filed third-party complaints against the employee's employer and its insurer. The court entered summary judgment in the insurer's favor and granted other defendants' motions for reconsideration and reformed the master services contract between the employer and the oil rig operator. The court of appeals affirmed, holding that reformation of the master services contract to require the contractor to indemnify the oil rig operator was warranted.[284]

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[279] *Jefferson Standard Life Ins. Co. v. Keeton*, 292 F. 53 (Cal. Ct. App. 1923).
[280] *E.g.*, *Am. Sur. Co. v. Heise*, 289 P.2d 103, 107–08 (Cal. Ct. App. 1955); CAL. CIV. PROC. CODE § 3399; *Fruge v. Amerisure Mut. Ins. Co.*, 663 F.3d 743, 748 (5th Cir. 2011) (holding that Louisiana law permitted consideration of extrinsic evidence to determine whether there was mutual mistake that merited reformation of insurance policy); *Mut. of Omaha Ins. Co. v. Russell*, 402 F.2d 339, 345 (10th Cir. 1968) (holding that while Kansas law does allow reformation of insurance contracts, the insurer failing to tell the insured about other available policies and explaining their provisions is not grounds for reformation of the policy).
[281] *See, e.g.*, *Briarcliffe Lakeside Townhouse Owners Ass'n v. City of Wheaton*, 524 N.E.2d 230, 236 (Ill. App. Ct. 1988); *Protective Life Ins. Co. v. Hansen*, 632 F.3d 388, 393 (7th Cir. 2011).
[282] 13 Appleman, INSURANCE LAW AND PRACTICE § 7608 (1943).
[283] *May v. Travelers Prop. Cas. Co. of Am.*, 263 F. App'x 673 (10th Cir. 2008).
[284] *Richard v. Anadarko Petroleum Corp.*, 850 F.3d 701 (5th Cir. 2017).