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Mind the Gap: Redefining Exhaustion and Zeig's Role in the Judicial Construction of Excess Insurance Policies

Patrick Coughlin

I. INTRODUCTION

A. The Basics of Insurance Coverage and the Use of Excess Insurance in the Commercial Context.

The traditional concept of carrying insurance to hedge against the risk of financial loss is, in its most basic form, readily understandable to the casual reader. If John Doe becomes ill or gets into an auto accident, he will most likely expect, providing that he is insured, the insurer to cover at least a portion of his financial loss. If John's insurance provider denies coverage, he is free to argue that the loss falls within the scope of the policy.¹ In many instances this formulaic approach to the resolution of disputes can even carry over to the realm of commercial insurance.² However, things can become far more complicated when examining disputes involving commercial entities facing larger, sometimes astronomically larger, threats of exposure. In these cases, resolving disputes over coverage often involves multiple insurance companies, all with their own individual policies and an interest in limiting their own liability to avoid paying for damages outside the scope of their contracts with the insured.³

¹ See Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 DENV. U. L. REV. 29, 55 (2000).

² See, e.g., *Wm. C. Vick Const. Co. v. Pennsylvania Nat. Mut. Cas. Ins. Co.*, 52 F. Supp. 2d 569 (E.D.N.C. 1999).

³ See Richard Squire, *How Collective Settlements Camouflage the Costs of Shareholder Lawsuits*, 62 DUKE L.J. 1, 3 (2012) ("When a lawsuit's trial outcome is uncertain, the primary insurer is biased toward trial, the insured defendants are biased toward settling before trial, and the excess insurers divide in their biases based on where the expected damages fall within the tower [of coverage].") For a more detailed discussion of the potential problems posed by the individual insurers' motivations see *infra* Part V.B.

Common themes emerge when analyzing insureds' considerations regarding insuring against potential losses, namely "(1) the amount of coverage required to protect themselves against losses; (2) breadth or scope of coverage; and sometimes (3) the cost of insuring against potentially severe losses."⁴ To account for these interwoven and at times competing concerns, many commercial entities have adopted what has been labeled a "tiered" insurance scheme.⁵ Under this approach, insureds will supplement liability insurance with "excess" or "umbrella" policies, often with completely different insurance companies, to insure against the risk of catastrophic loss should the entity be subject to substantial economic exposure or civil liability.⁶ Lee M. Brewer and Barbara Ewing, provided a hypothetical model for the basic structure of a coverage tower:

- (1) A Primary Policy with limits of \$10 million;
- (2) A First-Layer Excess Policy with limits of \$10 million once the limits of (1) were exhausted;
- (3) A Second-Layer Excess Policy with limits of \$10 million once the limits of (1) and (2) are exhausted;
- (4) A Third-Layer Excess Policy with limits of \$10 million once the limits of (1), (2) and (3) are exhausted; and

⁴ 3-29A New Appleman Insurance Law Practice Guide 29A.01.

⁵ See Lee M. Brewer and Barbara Ewing, *Exhaustion—What Does It Mean?*, 16 FIDELITY L.J. 207, 208-09 (Oct. 2010).

⁶ Because in many cases no one insurer will be willing to underwrite the entire potential loss, insureds must take out policies with more than one insurer, each responsible for a portion of the insured's desired coverage. See *id.* See, e.g., *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, 629 F.3d 653, 655 (7th Cir. 2010) (plaintiff had multiple primary policies with additional umbrella policy in case liability exceed or fell outside the scope of the primary policies); *Citigroup, Inc. v. Federal Ins. Co.*, 649 F.3d 367, 369 (5th Cir. 2011) (Plaintiff "purchase[d] integrated risk policies from ten insurers that provided a total of \$200 million in coverage."); *Koppers Co., Inc. v. Aetna Cas. and Sur. Co.*, 98 F.3d 1440, 1444 (3d Cir. 1996) ("The district court *limited the scope of the trial to twelve specific policies*, which provided multiple layers of occurrence based, excess liability coverage for third-party property damage.") (emphasis added); *Sherwin-Williams Co. v. Insurance Co. of Pennsylvania*, 105 F.3d 258, 259-60 (6th Cir. 1997) (in addition to excess insurance, plaintiff maintained multiple primary policies with several different insurers).

- (5) A Fourth-Layer Excess Policy with limits of \$10 million once the limits of (1), (2), (3) and (4) are exhausted.⁷

While the issues raised by this note are undoubtedly complex in nature, their proper resolution can be found in a return to well-established and foundational principles of contract interpretation.

B. The Scope of This Note

The purpose of this note is to analyze the disparate methods of construing excess insurance policies within the federal courts. Specifically, this note will address the debate over whether public policy considerations favoring out-of-court settlement of disputes should render excess insurers liable even when the primary insurers have settled cases for less than the full policy amount. The overarching question is whether a settlement with an underlying insurer for less than the limits of the underlying policy can properly “exhaust” that policy for the purposes of accessing excess coverage.⁸ An examination of the state of the law reveals that the circuits are currently split over the extent to which the goal of encouraging settlements should inform

⁷ Brewer and Ewing, *supra* note 5, at 208-09. *See also, e.g.*, *Comerica Inc. v. Zurich American Ins. Co.*, 498 F. Supp. 2d 1019, 1021-22 (E.D. Mich. 2007); *Maximus, Inc. v. Twin City Fire Ins. Co.*, No. 1:11cv1231 (LMB/TRJ), 2012 WL 848039, at *1 (E.D. Va. March 12, 2012).

⁸ This article deals solely with the ramifications for *vertical* exhaustion, as opposed to *horizontal* exhaustion. Vertical exhaustion concerns the relationship between primary and excess insurers during a given year or specified time period. *See* Richmond, *supra* note 1, at 79. Horizontal exhaustion is more commonly encountered in instances of “continuous loss,” where a court must look to coverage questions spanning multiple years in determining coverage liability. *See id.* (“Horizontal exhaustion means that the primary insurance must be exhausted across all of the triggered policy periods before the next layer of coverage, whether excess or umbrella, must respond to a continuous loss.”) (internal quotations omitted).

Also, in this article I will not attempt to address the question of whether excess insurers can be required to provide “drop-down” coverage in the case of a primary insurer’s insolvency. For a discussion on “drop-down” coverage *see* *Continental Marble & Granite v. Canal Ins. Co.* 785 F.2d 1258 (5th Cir. 1989); *Revco D.S., Inc. v. Government Employees Ins. Co.*, 791 F. Supp. 1254 (N.D. Oh. 1991); *Washington ins. Guar. Assoc. v. Guaranty Nat’l Ins. Co.*, 685 F. Supp. 1160 (W.D. Wa. 1988).

judicial policy construction.⁹ This split has its roots in a Second Circuit decision from 1928. In *Zeig v. Massachusetts Bonding & Ins. Co.*,¹⁰ the Second Circuit held that, because public policy considerations favor out-of-court settlement of disputes, a court could find that an insured had functionally “exhausted” its primary coverage even though it had settled with its primary insurer for less than the policy limits, thus permitting it to tap into excess coverage.¹¹

In Part II of this article I will lay the groundwork for our inquiry by analyzing the Second Circuit’s decision in *Zeig*.¹² Additionally, I will demonstrate how, although post-*Erie*, federal common law has been resoundingly rejected, the policy arguments set forth by the court in *Zeig* have survived as a doctrinal tool, operating in concert with and sometimes independently of state law, for those courts wishing to broadly define “exhaustion” as it applies to excess insurance contracts.¹³

In Part III I will examine *Zeig*’s current viability as public policy doctrine through an examination of two recent decisions from the federal circuits: the Seventh Circuit’s adoption of

⁹ See *supra* Part III.A.

¹⁰ 23 F.2d 665 (2d Cir. 1928).

¹¹ See *id.* at 666. See also Brewer and Ewing, *supra* note 5, at 211 (“Not surprisingly, excess policies virtually all contain “exhaustion” clauses; and policy writers strive to word them so carefully that no one can misunderstand. The language must be unambiguous. But what is blazingly clear to a policy writer may have the opposite effect on a judge.”).

¹² See *infra* Part II.A.

¹³ See *infra* Part II.B. Despite its roots in the federal courts, *Zeig*’s policy conclusions have permeated downward into state forums. In recent years, numerous insureds have relied on *Zeig* in arguing for a broader view of exhaustion. Consequently, state courts have grappled with the issue and are currently split over the extent to which public policy can inform policy interpretation. Compare *Qualcomm, Inc. v. Certain Underwriters at Lloyd’s, London*, 161 Cal. App. 4th 184, 197 (Cal. App. 4th Dist., 2008) (“We are not persuaded that *Zeig* compels excess coverage in this case.”); *Intel Corp. v. Am. Guar. & Liab. Ins. Co.*, 51 A.3d 442, 450 (Del. 2012) (applying California law) (“We find *Zeig* inapplicable here as well: the plain language of the policy controls.”); *with Reliance Ins. Co. v. Transamerica Ins. Co.*, 826 So. 2d 998, 999 (Fla. Dist. Ct. App. 3d Dist. 2001) (“We align ourselves with *Zeig*...the leading case in this area.”); *Rummel v. Lexington Ins. Co.*, 123 N.M. 752, 763 (1995) (“There are strong public policy reasons for permitting the underlying insurer to settle for less than its policy limits.”) (citing *Zeig*, 23 F.2d at 666). These decisions are, for the most part, outside the scope of this article.

Zeig in *Trinity Homes v. Ohio Cas. Ins. Co.*,¹⁴ and the Fifth Circuit's rejection of *Zeig* in *Citigroup Inc. v. Federal Ins. Co.*¹⁵ I will also summarize the competing policy implications under both approaches.¹⁶

In Part IV I will argue for uniformly adopting the Fifth Circuit's approach in *Citigroup*, rejecting *Zeig* and enforcing the four corners approach to the interpretation of excess insurance policies.¹⁷ Finally, in Part V, I will attempt to summarize the rights and responsibilities of insureds and insurers moving forward under the proposed standard of construing excess policies.¹⁸

Prior scholarship has attempted to clarify the rights and responsibilities of excess insurers in litigating coverage disputes.¹⁹ John O'Connor's analysis focuses on the issue of who is responsible for the gap in coverage resulting from a primary insurer's settlement with the insured for less than the policy limits: the excess insurer, or the insured.²⁰ O'Connor argues that requiring the insured to pay the difference is the best solution, as it adequately spreads the risk of settlement "to the policyholder instead of an excess insurer that is a stranger to the underlying settlement agreements."²¹ In this note I will take a different approach by arguing that, in cases where the primary insurer settles with the insured for less than the policy limits, excess insurers should not be liable regardless of who covers the resulting gap in coverage between the

¹⁴ 629 F.3d 653 (7th Cir. 2010). *See infra* Part III.A.

¹⁵ 649 F.3d 367 (5th Cir. 2011). *See infra* Part III.A.

¹⁶ *See infra* Part III.B.

¹⁷ *See infra* Part IV.A.

¹⁸ *See infra* Part V.

¹⁹ *See* John F. O'Connor, *Insurance Coverage Settlements and the Rights of Excess Insurers*, 62 MD. L. REV. 30 (2003).

²⁰ *See id.* at 35.

²¹ *Id.* at 36.

settlement amount and the primary policy's limits.²² For our purposes, therefore, O'Connor's analysis is irrelevant because this note is not concerned with who pays for any existing gap in coverage. Put simply, the existence of any gap whatsoever should relieve excess insurers of liability.

More recently, various practitioners have analyzed the issue directly under scrutiny here: *Zeig's* role in the construction of excess policies and its current viability.²³ The consistent theme seems to be that *Zeig's* influence is waning. To support their conclusions each author points to recent decisions from state and federal forums where the courts have refused to adopt *Zeig* in interpreting the meaning of excess policies. However, in this author's view, each fails to adequately account for the Seventh Circuit's decision in *Trinity Homes* and the multitude of courts within the federal circuits that have similarly adopted *Zeig* essentially as a means of reading additional terms into the insurance policies in question. Furthermore, the question analyzed in this article—the disparate applicability of *Zeig* in the *federal* courts—is unique from the more general trends examined in the works mentioned above. For these reasons, this work breaks new ground and adds a variant perspective to the existing scholarship on the topic.

II. BACKGROUND

A. The Second Circuit's Decision in *Zeig*.

At first glance, the four-paragraph opinion penned by Augustus Hand in *Zeig v. Massachusetts Bonding Ins. Co.*²⁴ seems to be of little significance.²⁵ However, from these four paragraphs emerged a doctrine that has come to shape the construction of excess insurance

²² See *infra* Part IV.A.

²³ See Brewer and Ewing, *supra* note 5, at 207; Michael F. Aylward, *Paying to Play: What Does it Mean to "Exhaust" Underlying Insurance?*, 54 No. 5 DRI FOR DEF 27 (May, 2012).

²⁴ 23 F.2d 665 (2d Cir. 1928)

²⁵ See *generally* *id.*

policies for decades. The conclusions that Judge Hand posited have had momentous ramifications for contractual interpretation and continue to play a prominent role in complex commercial insurance litigation today.²⁶ In trying to understand the present split and the state of the law within the various federal circuits, it is essential to conduct an examination of *Zeig* to grasp the circumstances surrounding and the rationale behind the Second Circuit’s public policy determinations.

The case before the Second Circuit concerned an appeal by the plaintiff Louis Zeig of the district court’s judgment for the defendant, Massachusetts Bonding and Insurance Company (“Mass. Bonding”).²⁷ The initial case came about after a burglary in which Zeig suffered financial loss.²⁸ Mass. Bonding had issued an insurance policy to Zeig for the amount of \$5,000.²⁹ However, this policy did not constitute Zeig’s primary insurance against the risk of such loss as Zeig had underlying policies covering up to \$15,000.³⁰ The tower structure of coverage meant that Mass. Bonding’s policy was intended, at least from the insurer’s perspective, to cover those costs in *excess* of the \$15,000 of underlying coverage purchased by Zeig in the case of a burglary or similar financial loss.³¹ The problem arose, as is so often the case in these disputes, when Zeig settled with his underlying insurers.³² Rather than demanding,

²⁶ See *infra* Part III.

²⁷ *Zeig*, 23 F.2d at 665.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* This meant, at least theoretically, that Zeig had \$15,000 of coverage to go through before Mass. Bonding would be on the hook for any of the damages. However, as demonstrated below, the court’s construction of the excess policy issued by Mass. Bonding effectively read out this protective barrier underlying the Mass. Bonding coverage.

³¹ 23 F.2d at 665. The policy read in relevant part: “As excess and not contributing insurance, and shall apply and cover only after all other insurance herein referred to shall have been *exhausted* in the payment of claims to the full amount of the expressed limits of such other insurance.” *Id.* (emphasis added).

³² *Id.*

and litigating if need be, for the full coverage amount, Zeig settled for a total of \$6,000, thus releasing the underlying insurers from further liability regarding coverage.³³ This created a gap of \$9,000 between the amount actually paid out to Zeig and the amount Mass. Bonding anticipated being paid out prior to becoming liable.³⁴ In dismissing the complaint and entering judgment for the defendant, Mass. Bonding, the district court held, “as a matter of law, that the policies had not been exhausted in the payment of claims to the full amount of the expressed limits of such other insurance.”³⁵ Zeig appealed the trial court’s ruling and the issue was brought before the Second Circuit.

Judge Hand rejected the defendant’s argument and the district court’s holding because to do otherwise, the court opined, would require that the “plaintiff actually [] collect the full amount of the policies for \$15,000, in order to ‘exhaust’ that insurance.”³⁶ Hand took the position that, from a practical point of view, it should make no difference to the excess insurer where the payment of the resulting gap in coverage, in this case \$9,000, comes from.³⁷ If Zeig paid for the loss between the settlement amount and the underlying policy limits of \$15,000, Mass. Bonding would be no worse for the wear, “so long as [the defendant] was only called upon to pay such portion of the loss as was in excess of the limits of those policies.”³⁸ This argument has become one of the most important conclusions used by those courts that have adopted *Zeig* in subsequent disputes.³⁹

³³ *Id.*

³⁴ *Id.*

³⁵ 23 F.2d at 665.

³⁶ *Id.* at 666.

³⁷ *See id.*

³⁸ *Id.*

³⁹ *See infra* Part III.

Additionally, Hand went on to say that “to require an absolute collection of the primary insurance to its full limit would in many, if not most, cases involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable.”⁴⁰ Consequently, the Second Circuit reversed the district court’s judgment for Mass. Bonding. Judge Hand established that, for the purposes of determining excess insurer liability in similar situations, “claims are paid to the full amount of the policies, if they are settled and discharged, and the primary insurance is thereby exhausted.”⁴¹ With this decision, Judge Hand and the Second Circuit established an ambitious new doctrine governing the judicial construction of excess insurance contracts that has served as a justification for subsequent courts to essentially read in terms more favorable to insureds, even if the insureds did not specifically contract for these terms.⁴²

B. Zeig’s Place as Common Law Doctrine Operating Independently of State Contract Law.

Zeig was decided in 1928, before the Supreme Court’s landmark decision in *Erie R.R. v. Tompkins*,⁴³ which established the principle that federal courts sitting in diversity must apply state law.⁴⁴ Before *Erie*, federal courts were able to employ the “federal common law” in resolving disputes rooted in state substantive law.⁴⁵ What this means for understanding *Zeig* is

⁴⁰ 23 F.2d at 666.

⁴¹ *Id.*

⁴² *See infra* Part II.B. *See, e.g.,* Wm. C. Vick Const. Co., 52 F. Supp. 2d 581 (E.D.N.C. 1999). For a more thorough discussion of interpreting policy ambiguity against the insurer *see generally* Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (1970).

⁴³ 304 U.S. 64 (1938).

⁴⁴ *See id.* at 78.

⁴⁵ *Id.* at 71 (“*Swift v. Tyson* [] held that federal courts exercising jurisdiction on the ground of diversity of citizenship need not, in matters of general jurisprudence, apply the unwritten law of the State as declared by its highest court; that they are free to exercise an independent judgment as to what the common law of the State is – or should be.”).

that, although the basis for Zeig's complaint undoubtedly resided in state law, Judge Hand was free to establish an overarching policy argument which shaped and ultimately defined the Second Circuit's construction of excess insurance policies and the concept of exhaustion.⁴⁶ Even more fundamental to understanding the present state of insurance jurisprudence in the circuit courts is the fact that, despite *Erie*'s rejection of federal common law principles, *Zeig*'s conclusions have survived and continue to inform the judicial construction of insurance policies.⁴⁷

Given its foundations in contract law, insurance disputes are governed by state, rather than federal law. Therefore, a federal court sitting in diversity on a dispute between insured and insurer, whether regarding primary or excess coverage, is bound to apply the relevant state law governing the construction of insurance policies and contracts more generally.⁴⁸ The primary issue often determined by the individual state's law is any finding of ambiguity, and how the court should construe the policy upon the finding of such ambiguity.⁴⁹ However, while state law does control in federal diversity disputes, an analysis of the case law demonstrates that, in addition to and independently of state law, the federal courts have repeatedly grappled with the conclusions set forth by Judge Hand in *Zeig*.⁵⁰ The courts and the parties litigating excess coverage disputes have had to confront *Zeig* and its implications in the interpretation of policies. This demonstrates that the principle of public policy considerations overriding the language of insurance contracts established by *Zeig* has continued to be a major factor in the federal courts.⁵¹

⁴⁶ See *Zeig*, 23 F.2d at 666.

⁴⁷ See *infra* notes 52-60 and accompanying text.

⁴⁸ See *infra* notes 52-60 and accompanying text.

⁴⁹ See *supra* note 42 and accompanying text.

⁵⁰ See *infra* notes 52-60 and accompanying text.

⁵¹ See *infra* notes 52-60 and accompanying text.

In *Koppers Co., Inc. v. Aetna Cas. and Sur. Co.*,⁵² the Third Circuit, applying Pennsylvania law, was tasked with deciding whether an insured could pursue a claim against its excess insurer despite the fact that the insured had settled with the primary insurer for less than the full policy amount.⁵³ Because Pennsylvania's highest court had yet to rule on the issue, the court in *Koppers* was provided little substantive guidance as to what the relevant state law actually was.⁵⁴ Noting "the absence of guidance from the state's highest court," ultimately the court held that:

[t]he Pennsylvania Supreme Court would adopt the widely-followed rule that the policyholder may recover on the excess policy for a proven loss to the extent it exceed the primary policy's limits...[and that] settlement with the primary insurer functionally exhausts primary coverage and therefore triggers the excess policy."⁵⁵

In reaching this conclusion, the Third Circuit did not provide any substantive Pennsylvania law that supported the proposition that a settlement for less than the full policy amount could properly exhaust the underlying policy.⁵⁶ The court cited only to the Federal District Court for the District of Delaware's decision in *Stargatt v. Fidelity & Cas. Co.*,⁵⁷ where that court, applying Delaware law, utilized the same analytical framework to predict what Delaware law would say on the issue.⁵⁸

⁵² 98 F.3d 1440 (3d Cir. 1996).

⁵³ *See id.* at 1445.

⁵⁴ *See id.*

⁵⁵ *Id.* at 1445, 1454 (internal quotations omitted).

⁵⁶ *See id.* To date, no Pennsylvania court has directly taken up the issue of *Zeig* and its applicability in excess insurance disputes.

⁵⁷ 67 F.R.D. 689 (D. Del. 1975).

⁵⁸ *See id.* 690. However, the court in *Stargatt* noted that there was no controlling Delaware ruling on the issue, and therefore applied the federal common law in resolving the dispute. *See id.* at 690-91 ("Neither of the parties, nor the Court, has found any Delaware authority, which would be controlling on this question. However, the Second Circuit, ruling as a matter of general common law in the pre-Erie-Tompkins era, answered this argument in a case on all fours with this one ... I believe the reasoning of the *Zeig* case was correct and am confident that the

Both of these cases demonstrate that courts are willing to rely on the doctrinal conclusions proffered by Judge Hand in *Zeig* as a means of redefining “exhaustion” in excess insurance policies, regardless of the fact that the state law in question is often not yet determined. Other federal courts have used this model of analysis as a means of adopting *Zeig* and therefore broadly defining exhaustion of primary policies.⁵⁹ Even in instances where courts have refused to adopt *Zeig* and use public policy concerns to override strict contractual interpretation, many insureds have relied extensively on Judge Hand’s conclusions in arguing for a broad definition of exhaustion.⁶⁰ As the cases demonstrate, whether or not the courts are amenable to *Zeig*’s

Delaware courts would reach the same result in this case.”). To date, Delaware law has not been definitively settled regarding *Zeig*. However, in a recent decision the Delaware Supreme Court, applying California law, refused to apply *Zeig*’s policy arguments as a means of altering an excess insurance policy to allow for exhaustion where the insured had settled with underlying insurers for less than the full policy amount. *See Intel Corp. v. American Guar. & Liab. Ins. Co.*, 51 A.3d 442, 450 (Del. 2012) (“We find *Zeig* inapplicable here as well: the plain language of the policy controls.”).

⁵⁹ *See Trinity Homes LLC v. Ohio Cas. Ins. Co.*, 629 F.3d 653, 659 (7th Cir. 2010) (“While the parties have not put forth any Indiana precedent directly on point, our sister circuits have dealt with similar umbrella policies, and their holdings lend further support [cites *Zeig* and the Third Circuit’s ruling in *Koppers*]. Although Indiana law controls, there is no reason to suspect it would differ from these analogous holdings.”); *Maximus, Inc. v. Twin City Fire Ins. Co.*, 1:11 cv 1231, 2012 U.S. Dist. LEXIS 32970 (E.D. Va. March 12, 2012) (“[I]n light of well-established principles of insurance contract interpretation and the substantial policy considerations articulated by *Zeig* and its progeny, [plaintiff’s] settlements with the underlying insurers for less than the full limits of their respective policies and agreeing to fill the gap so that the policy limits have been reached satisfies the exhaustion requirement.”).

⁶⁰ *See Citigroup Inc. v. Fed. Ins. Co.*, 649 F.3d 367, 371 (5th Cir. 2011) (“Citigroup urges us to apply the rule established in *Zeig*.”); *Federal Ins. Co. v. Srivistava*, 2 F.3d 98, 102 (5th Cir. 1992) (“Appellants rely upon a sixty-five-year [old] Second Circuit decision, holding that actual payment of underlying policies is not required in order to exhaust them and trigger excess coverage.”); *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1029 (E.D. Mich. 2007) (“[Plaintiff] insists that its own payment of \$6 million toward settlement filled the gap between [the underlying insurer’s] payment and the balance of the policy limit... [t]he foundation of its argument is *Zeig*.”); *Wright v. Newman*, 598 F. Supp. 1178, 1197 (W.D. Mo. 1984) (“Beyond all this there is, as plaintiffs pointed out ... an argument that policy provisions such as those involved here may, in effect, be ignored upon the theory that an excess insurer has no rational interest in whether the insured *collected* the full amount of the primary policies, so long

reasoning, the public policy conclusions put forth by Judge Hand continue to be in play in insurance litigation in the federal courts.

Part III. THE CURRENT SPLIT ON *ZEIG* WITHIN THE CIRCUIT COURTS AND THE POLICY CONSIDERATIONS AT STAKE

A. Divergent Application of *Zeig* in Defining “Exhaustion” in the Construction of Excess Insurance Policies.

While different circuits have dealt with the issue of adopting *Zeig*'s policy considerations, an analysis of two recent decisions adequately clarifies the present split. The Seventh Circuit's adoption of *Zeig* in *Trinity Homes LLC v. Ohio Cas. Inc. Co.*⁶¹ and the Fifth Circuit's rejection in *Citigroup, Inc. v. Federal Ins. Co.*⁶² are optimal lenses through which to examine *Zeig*'s current viability. Both of these cases are recently decided and provide insight into the continuing dispute over how best to construe excess insurance policies. Additionally, they clearly and concisely present the two opposing schools of thought when it comes to contractual interpretation within the context of complex insurance disputes.⁶³

In *Trinity Homes*, the Seventh Circuit reviewed a suit brought by general contractors against their primary and excess insurers alleging breach of contract and seeking a declaration that both insurers had a duty to provide coverage.⁶⁴ The plaintiff had settled with most of its primary insurers, but one, Ohio Casualty Insurance Company (“Ohio”), refused to do so.⁶⁵ Cincinnati Insurance Company (“Cincinnati”), which provided excess coverage, piggybacked on

as [the excess insurer] was only called upon to pay such a portion of the loss as was in excess of those policies.”) (citing *Zeig*, 23 F.3d at 666).

⁶¹ 629 F.3d 653 (7th Cir. 2010).

⁶² 649 F.3d 367 (5th Cir. 2011).

⁶³ See *infra*.

⁶⁴ See *Trinity Homes*, 629 F.3d at 655.

⁶⁵ See *id*.

Ohio's refusal to settle and argued that it was not liable because all underlying insurance had yet to be exhausted.⁶⁶ Cincinnati also relied on the fact that not all of Trinity Homes' settlements with the underlying insurers were for the full policy amount.⁶⁷ The Cincinnati policy at issue in the case defined the parameters of excess liability as:

(a) if the limits of underlying insurance have been reduced by payments of claims, this policy will continue in force as excess of the reduced underlying insurance, [or] (b) [i]f the limits of underlying insurance have been exhausted by payment of claims, this policy will continue in force as underlying insurance.⁶⁸

The district court found that all relevant underlying policies had not been exhausted, thereby releasing Cincinnati from liability.⁶⁹ On appeal, the Seventh Circuit reversed. The Cincinnati policy did not clearly require exhaustion by insurer payout alone.⁷⁰ As the court put it, "[t]he umbrella policy is clear only insofar as it requires that the underlying CGL coverage be unavailable—either by exhaustion or denial of coverage before Cincinnati's coverage is triggered."⁷¹ The court seized upon this finding of ambiguity to hold that the underlying policies were functionally exhausted by the settlement agreements between the primary insurers and Trinity Homes.⁷²

⁶⁶ *See id.*

⁶⁷ Each of the settling primary insurers had settled for at least seventy-five percent of the policy limits. *See id.*

⁶⁸ 629 F.3d at 658. The policy defined "underlying insurance" as "the policies of the insurance listed in the Schedule of underlying Policies and the insurance *available to the insured under all other insurance policies applicable to the occurrence* [of the loss]." *Id.* (emphasis added) (internal quotations omitted).

⁶⁹ *See id.*

⁷⁰ *See id.*

⁷¹ *Id.*

⁷² 629 F.3d at 658-9. The court noted that neither party had "put forth any Indiana precedent directly on point." *Id.* at 659. Consequently, the court relied in large part upon Hand's analysis in *Zeig*. *Id.* (citing *Zeig*, 23 F.2d at 666). The court also pointed to the Third Circuit's decision in *Koppers* to underscore its conclusion that public policy considerations in favor of out of court settlement of disputes permitted to functional exhaustion of primary policies, even when the insured had settled for less than the policy limits. *See id.* (citing *Koppers*, 98 F.3d at 1454)

One might argue that, taken individually, the Seventh Circuit's decision in *Trinity Homes* merely constitutes a deviation from the developing trend in the law towards reining in *Zeig*'s influence on excess insurance disputes.⁷³ This argument, however, fails to account for the fact that other circuit and district courts have come to the same conclusion in adopting *Zeig*.⁷⁴ While numerous circuits have used the *Trinity Homes* approach, it is by no means ubiquitous and represents only one of the approaches currently employed by federal courts addressing *Zeig*'s role in defining exhaustion within the context of complex commercial insurance disputes.

In its recent decision in *Citigroup*, the Fifth Circuit Court of Appeals took the diametrically opposite stance in resolving a similar dispute between insured and excess insurer.⁷⁵ In that case, the court reviewed a case brought by Citigroup against a number of excess insurers who had denied coverage based upon Citigroup's failure to properly exhaust its underlying

("[S]ettlement with the primary insurer functionally exhausts primary coverage and therefore triggers the excess policy—though by settling the policyholder loses any right to coverage of the difference between the settlement amount and the primary policy's limits.") (internal quotations omitted). The court concluded by stating that "[a]lthough Indiana law controls, there is no reason to suspect that it would differ from these analogous holdings." *Id.* To date, no Indiana court has explicitly addressed *Zeig* and its application to excess coverage disputes.

⁷³ See *supra* note 23 and accompanying text.

⁷⁴ The Third Circuit has, as previously noted, followed *Zeig* on multiple occasions. See *generally* *Koppers Co., Inc. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440 (3d Cir. 1996); *Stargatt v. Fidelity & Cas. Co.*, 67 F.R.D. 689 (D. Del. 1975), *aff'd* 758 F.2d 1375 (3d Cir. 1978). Likewise, courts within the Fourth Circuit have adopted a pro-*Zeig* stance. See *generally*, *Maximus, Inc. v. Twin City Fire Ins. Co.*, 1:11 cv 1231, 2012 U.S. Dist. LEXIS 32970 (E.D. Va. March 12, 2012). For application of *Zeig* within the Eighth Circuit see *Reliance Ins Co. in Liquidation v. Chitwood*, 433 F.3d 660, 664 (8th Cir. 2006); *Archer Daniels Midland v. Aon Risk Services, Inc. of Minnesota*, No. Civ. 97—2185JRTRLE, 1999 WL 34818933 at *5 (D. Minn. Feb. 25, 1999), *aff'd* 356 F.3d 850 (8th Cir. 2004). For the Tenth Circuit see *Coffeyville Res. Ref. Mktg., LLC v. Liberty Surplus Ins. Corp.*, 714 F. Supp. 2d 1119, 1131 (D. Kan. 2010). Finally, *Zeig* is still considered good law within the Second Circuit. See *Lexington Ins. Co. v. Tokio Marine & Nichido Fire Ins. Co.*, 11 Civ. 391, 2012 U.S. Dist. LEXIS 59635 (S.D.N.Y. March 28, 2012) (*[Zeig]* continues to be the seminal decision interpreting New York insurance law *in this Circuit.*) (emphasis added). However, there is currently a case before the Second Circuit that implicates the *Zeig* doctrine. See *Federal Ins. Co. v. Mehdi Ali, The Estate of Alexander M. Haig*, No. 11-5000, 2012 U.S. 2nd Cir. Briefs LEXIS 44 at *3-4 (2d Cir. 2012).

⁷⁵ See *generally* *Citigroup, Inc. v. Federal Ins. Co.*, 649 F.3d 367 (5th Cir. 2011).

policies when it settled with primary insurers for less than the full policy limits.⁷⁶ Associates First Capital Corp. (“Associates”), a nationwide consumer lender, had purchased integrated risk policies from ten insurers, providing a total of \$200 million in coverage.⁷⁷ Associates’ primary policy was issued by Lloyd’s of London (“Lloyd’s”) and covered the initial \$50 million of loss.⁷⁸ Associates then went on to purchase excess policies from an additional nine insurers.⁷⁹

Following its acquisition of Associates in November of 2000, Citigroup brought a declaratory judgment action in state court concerning coverage for two underlying actions against Associates; a statewide class action filed in California and a Federal Trade Commission suit alleging that Associates had violated federal truth in lending statutes.⁸⁰ While Citigroup did notify its insurers of the pending litigation against it in connection with its acquisition of Associates, Citigroup later settled these actions for \$240 million plus \$23 million in class counsel’s fees and costs, without obtaining the consent of the carriers.⁸¹ After the defendant-

⁷⁶ See *id.* at 370.

⁷⁷ *Id.*

⁷⁸ *Id.* at 369.

⁷⁹ 649 F.3d at 369. The structure of the tower of coverage was as follows:

- National Union Fire Insurance Company of Pittsburgh provided \$25 million of coverage in excess of Lloyd’s policy.
- Starr Excess Liability Insurance International, Ltd.’s additional \$25 million constituted the “Secondary Layer” of excess coverage.
- The third layer, or “Quota Share Layer,” provided an additional \$100 million of coverage and was spread among seven different insurers: Ace Bermuda Insurance, Ltd., \$25 million; Federal Insurance Company, \$17 million; Chubb Atlantic Indemnity, \$17 million; Twin City Insurance Company, \$17 million; St. Paul Mercury Insurance Company, \$10 million; Steadfast Insurance Company, \$9 million; SR International Business Insurance Company, \$5 million. *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* at 370 (emphasis added). See *infra* Part III.B. for a discussion of the policy considerations implicated by Citigroup’s decision to unilaterally settle these underlying suits without consulting its insurers, and then turning around and demanding coverage for the losses incurred.

excess insurers removed the case to federal court, Citigroup settled with its primary insurer, Lloyd's, for \$15 million.⁸²

The excess insurers subsequently denied coverage, arguing that Citigroup's settlement with Lloyd's had failed to properly exhaust the underlying insurance.⁸³ At trial and before the Fifth Circuit, Citigroup relied extensively on *Zeig* to argue that the court should find, despite the substantial gap between the settlement amount and the Lloyd's policy limits, that Citigroup had functionally exhausted its primary coverage and could therefore access the roughly \$150 million in excess coverage under the additional policies.⁸⁴ One can't help but appreciate the way in which the facts of the *Citigroup* case so clearly illuminate the stakes for each of the parties involved in these disputes. By gambling on the fact that the court would approve of its settlement with Lloyd's and allow it to tap into its excess policies, Citigroup was opening itself up to the significant possibility that it would personally have to cover over \$200 million of its settlement with the class in California and the FTC regarding its violation of federal law.⁸⁵ Citigroup relied on this approach despite the fact that neither the Texas Supreme Court nor the

⁸² *Id.* Under the terms of its policy with Lloyd's, Associates had purchased no less than \$50 million in primary coverage. *See id.*

⁸³ 649 F.3d at 369. The relevant policies for the four excess insurers stated that excess coverage attached only:

- Federal Insurance Company—when “(a) all Underlying Insurance carriers have paid in cash the full amount of their respective liabilities, [and] (b) the full amount of the Underlying Insurance policies have been collected by plaintiffs”;
- St. Paul Mercury Insurance Company—when “the total amount of the Underlying Limit of Liability has been paid in legal currency by the insurers of the Underlying Insurance as covered loss thereunder”;
- Starr Excess Liability Insurance International, Ltd.—when “any Insurer subscribing to any Underlying Policy shall have agreed to pay or have been liable to pay the full amount of its respective limits of liability”; and
- Steadfast Insurance Company—“in the event of the exhaustion of all of the limit(s) of such ‘Underlying Insurance’ solely as a result of payment of loss thereunder.” *Id.* at 372-73.

⁸⁴ *Id.* at 371-372.

⁸⁵ *See id.*

Fifth Circuit sitting in diversity applying Texas law had ever adopted *Zeig* in interpreting the meaning of excess insurance policies.⁸⁶ Ultimately, the Fifth Circuit rejected Citigroup's argument and held that "the plain language of the policies dictate that the primary insurer pays the full amount of its limits of liability before excess coverage is triggered."⁸⁷ Other federal courts have followed a similar analysis in rejection plaintiff-insureds' arguments for adopting *Zeig* and broadly construing the definition of exhaustion.⁸⁸

B. The Policy Implications at Issue Under Both Approaches.

As demonstrated in the previous section, the federal circuits are split on the proper role of *Zeig* in informing the judicial construction of excess insurance policies.⁸⁹ This split creates significant problems of symmetry and ultimately requires a definitive resolution of the issue that will provide guidance for both future insureds and insurers and consistency within the legal system.⁹⁰ However, this cannot be the end of the inquiry.⁹¹ The unique problem of interpreting excess insurance policies and the historical role of *Zeig* in courts' attempts to do so present substantial questions of public policy for both camps. The resolution of these competing policy concerns is by no means clear-cut and exposes the high stakes involved in the resolution of complex commercial insurance litigation.

1. The Pro-*Zeig* Argument

⁸⁶ *Id.* See, e.g., *Federal Ins. Co. v. Srivastava*, 2 F.3d 98, 103 (5th Cir. 1993).

⁸⁷ 649 F.3d at 372.

⁸⁸ See *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1029 (E.D. Mich. 2007); *Wright b. Newman*, 598 F. Supp. 1178, 1197 (W.D. Mo. 1984).

⁸⁹ See *supra* Part III.A.

⁹⁰ Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting off the Formal for the Function*, 52 OHIO ST. L.J. 1037, 1038 (1991) (concluding that in insurance disputes, "it is not enough to know the law of insurance ... [o]ne must also know the judge.")

⁹¹ See *infra* Part IV.A.

The argument in favor of utilizing *Zeig* as a means of broadly defining exhaustion and therefore permitting insureds to access excess insurance in the event of a settlement with the primary insurer for less than the policy's limits is centered on the notion that it is generally a good thing for parties to resolve their disputes on their own.⁹² These considerations were, of course, clearly and concisely laid out by Judge Hand in his opinion nearly a century ago.⁹³ In resolving the dispute over *Zeig*'s attempt to access the coverage provided by the excess policy with Mass. Bonding, Judge Hand first noted that "the defendant [insurer] had no rational interest in whether the insured collected the full amount of the primary policies," so long as that defendant-insurer was called upon only to pay for those losses in excess of the primary policy's full limits.⁹⁴ Numerous courts have seized upon Hand's contention that allowing functional exhaustion in such cases does not disadvantage insurers in any practical sense in justifying their decision to adopt *Zeig* and permit the insured to access excess coverage despite having settled for below-policy-limit amounts.⁹⁵

In addition to the "no worse for the wear" argument, Judge Hand went further in arguing a more far-reaching justification for the court's ruling in *Zeig*. "To require an absolute collection of the primary insurance to its full limit," the court held, "would in many, if not most, cases involve delay, promote litigation, and prevent an adjustment of disputes which is both

⁹² See *Zeig*, 23 F.2d at 666.

⁹³ See *id.*

⁹⁴ *Id.*

⁹⁵ See *Trinity Homes*, 629 F.3d at 659 ("Moreover, this construction of the policy neither has a punitive effect on Cincinnati nor does it alter its underwriting considerations. [Insured] is not asking Cincinnati to drop down and pay the remainder of the [primary] limits after its settlement with the [primary] insurers...[the insured] has paid the remainder of the [primary] limits itself."); *Koppers*, 98 F.3d at 1454 ("The excess insurer cannot be made liable for any part of this difference because the excess insurer never agreed to pay for losses below a specified floor.").

convenient and commendable.”⁹⁶ Unsurprisingly, this statement has become the linchpin for courts in adopting *Zeig* and broadly defining exhaustion to the benefit of the insured in many disputes.⁹⁷ Taken together, these two conclusions posited by the Second Circuit in *Zeig* have proven to be persuasive to many judges over the years. These arguments are not without merit, and undoubtedly deserve serious consideration in resolving the asymmetrical state of the law as it presently stands. However, Hand’s opinion only addresses half of the policy implications to be considered.

2. The Anti-*Zeig* Argument

In reality the policy analysis required to fully understand the dilemma presented by *Zeig* is not so one-sided an exercise.⁹⁸ What Judge Hand, and subsequent courts adopting *Zeig*, failed to comprehend is that there are in fact significant repercussions for excess insurers in so broadly defining exhaustion and rendering excess insurers liable in cases where the insured has settled with the primary insurers for below-the-limit amounts. To properly demonstrate the interests of excess insurers in narrowly reading the policy’s meaning through the language of the policy itself, one must first look at the economics of issuing excess insurance policies.

⁹⁶ *Zeig*, 23 F.3d at 666.

⁹⁷ See *Trinity Homes*, 629 F.3d at 659 (“Rather than agree to a lower payout by a [primary] insurer as part of a settlement, an insured with an excess policy would be forced to fully litigate each and every one of its [primary] policy claims before seeking recourse from its umbrella insurer.”); *Koppers*, 98 F.3d at 1454 (“Courts have adopted this rule because it encourages settlement and allows the insured to obtain the benefit of its bargain with the excess insurer, while at the same time preventing the insured from obtaining a double recovery.”)

⁹⁸ See *Zeig*, 23 F.2d at 666 (“We can see no reason for a construction so burdensome to the insured.”)

Generally speaking, the cost to the insured for obtaining excess coverage is considerably less than for primary coverage.⁹⁹ One reason for this is that “insureds need to turn to their policies less often than those of underlying insurers meaning that they will generally only respond in the event of catastrophic losses, or, in limited circumstances.”¹⁰⁰ More importantly, the excess insurer assumes “that the claims that penetrate the excess layer will already have been processed through the underlying layers.”¹⁰¹

As Michael Aylward notes, what this process is theoretically intended to guarantee is that any claim that reaches the excess level has been adequately scrutinized by the primary insurer and therefore merits coverage.¹⁰² If courts permit an insured to access excess coverage without availing itself of the procedural devices negotiated for with the excess insurer, they have functionally permitted “an insured [to] tender a large liability loss to its high-level excess insurers without the claims first being vetted both for liability and damages as well as for insurance coverage.”¹⁰³ This deprives the excess insurers the benefit of *its* bargain with the insured.¹⁰⁴

⁹⁹ See Aylward, *supra* note 23, at 35.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ Aylward, *supra* note 23, at 35. See also Brewer and Ewing, *supra* note 5, at 210 (“[U]pper level insurers price the coverage based on not having to deal with less-than legitimate claims, as these should never make it past the level of the Primary Policy.”).

Numerous courts have noted the disadvantage that excess insurers face if less-than-limit settlements are permitted to trigger excess coverage. See *U.S. Fire Ins. Co. v. Lay*, 577 F.2d 421, 423 (7th Cir. 1978) (“A settlement for less than the primary limit that imposed liability on the excess carrier would remove the incentive of the primary insurer to defend in good faith or to discharge its duty to represent the interests of the excess carrier.”) (citation omitted); *Comerica Inc. v. Zurich American Ins. Co.* 498 F. Supp.2d 1019, 1032 (E.D. Mich. 2007) (“[Insured] had a fundamental disagreement with its primary insurer as to whether [that primary insurer] was liable for *any* amount of the settlement. That dispute did not directly involve [the excess insurer], and

In addition to the inequitable treatment of excess insurers under such a doctrine, there are more practical, far-reaching reasons for rejecting *Zeig* and more narrowly construing excess policies. Should the *Zeig* model prevail, what will inevitably follow will be a drastic recalculation of the risks involved in the issuance of excess insurance contracts. This recalculation will ultimately lead to increased rates for excess coverage across the board.¹⁰⁵ In his article *The Current Insurance Crisis and Modern Tort Law*,¹⁰⁶ George L. Priest examines the possible causes of the insurance crisis of the mid-1980s and goes to great lengths to illuminate the incentives and calculations of insureds and insurers from a systemic perspective. Central to Priest's analysis is the fact that in order to maintain economic viability, insurers must attract customers with a sufficiently "low range of exposure to risk for the insurance to remain financially attractive to each [policy purchaser]."¹⁰⁷ When increased exposure to risk occurs, for whatever reason, the insurer is then forced to adjust the premiums paid by all participants accordingly. In this situation, "low-risk [insureds] pay a premium that, because it is based on an average which includes high-risk [insureds]," is more than they would have to pay if isolated from the higher-risk policyholders.¹⁰⁸ If the financial burden on low-risk insureds becomes too substantial, those policyholders may opt "to drop out of the pool because they find alternative means of protection cheaper than market insurance."¹⁰⁹

[the insured] did not have the right to tie [the excess insurer] to any aspect of its settlement with [the primary] without [the excess'] consent."); *Wright v. Newman*, 598 F. Supp. 1178, 1197 (W.D. Mo. 1984) ("[T]o ignore the policy provisions in question would effectively deprive [insurer] the material benefit for which it implicitly bargained when it undertook the risk of excess coverage.") (citation omitted).

¹⁰⁵ See *Brewer and Ewing*, *supra* note 5, at 215.

¹⁰⁶ George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 *YALE L.J.* 1521 (1987).

¹⁰⁷ *Id.* at 1541.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

Further complicating this already troubling scenario is the fact that “as low-risk [insureds] drop out, a pool will consist more predominantly of high-risk members, requiring the premium to be raised and placing greater pressure on the remaining low-risk members of the pool.”¹¹⁰ What this means in the context of excess insurance coverage is that, should excess insurers’ potential exposure increase through permitting functional exhaustion of primary policies through settlement for less-than-policy-limits amounts, the subsequent rise in premiums could make those interested in purchasing excess coverage opt for other means of protecting themselves financially, if at all. Such a result would harm not only insurers, but also all commercial entities seeking an economically viable means of protecting themselves against the risk of catastrophic loss.¹¹¹

Part IV. RECOMMENDATIONS FOR UNIFORMITY: UNIVERSAL REJECTION OF ZEIG AND A RETURN TO A FOUR-CORNERS APPROACH TO POLICY INTERPRETATION

As Part III of this note demonstrates, the present state of the law as it concerns *Zeig*’s viability in the federal circuits is inconsistent at best, arbitrary at worst. The lack of clarity and predictability across the circuits has potentially detrimental consequences for those engaged in the insurance markets, both purchaser and provider, and those seeking to litigate coverage claims, both insured and insurer.¹¹² In order to resolve this problematic status quo the federal courts must adopt a uniform position regarding the exhaustion of primary policies and *Zeig*’s conclusions regarding public policy and functional exhaustion through settlements for less-than-policy-limits amounts.

¹¹⁰ *Id.*

¹¹¹ *See infra* Part IV.B.

¹¹² *See supra* note 90 and accompanying text.

In doing so, the circuits should adopt the position enunciated by the court in *Citigroup*, where the Fifth Circuit rejected the insured's argument that settling with its primary insurer for \$15 million of a \$50 million policy properly exhausted that policy and therefore exposed the excess insurers to liability.¹¹³ In *Citigroup*, the court unequivocally found *Zeig* inapplicable and refused to employ Judge Hand's public policy analysis as a means of getting around the clear meaning of the policy's language. The federal circuits should adopt *Citigroup* as the standard for analyzing excess policies because the Seventh Circuit's decision in *Trinity Homes* wrongly trivialized the consequences for excess insurers under the *Zeig* approach and failed to apply clear Seventh Circuit precedent in reaching its holding. Additionally, the public policy considerations at stake favor the stricter contractual interpretation of insurance policies undertaken by the Fifth Circuit in *Citigroup* and those jurisdictions that have rejected *Zeig*.

A. In *Trinity Homes* the Seventh Circuit failed to apply clear precedent and mischaracterized the policy considerations at stake.

In *Trinity Homes*, the Seventh Circuit reversed the district court's grant of summary judgment to the excess insurer Cincinnati, holding that the insured's settlement with the primary insurer for roughly seventy-five percent of the primary policy's limits constituted exhaustion and therefore rendered Cincinnati liable for the damages exceeding the primary policy's limits.¹¹⁴ In addition to citing to *Zeig* for support of its holding, the court stated that "this construction of the policy neither has a punitive effect on Cincinnati nor does it alter its underwriting considerations."¹¹⁵ This assertion echoed the position taken by Judge Hand in *Zeig*, where he posited that "the defendant had no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss

¹¹³ *Citigroup*, 649 F.3d at 372.

¹¹⁴ *Trinity Homes*, 629 F.3d at 660.

¹¹⁵ *Id.* at 659.

as was in excess of the limits of those policies.”¹¹⁶ What both Judge Hand and the Seventh Circuit failed to grasp is that, despite their confident assertions to the contrary, excess insurers do have a tangible interest in the disposition of an insured’s claim against its primary insurer, and any settlement between the insured and primary insurer can have substantial consequences for those located higher up the ladder of coverage.

As previously described above, excess insurers operate under the assumption that potential claims over coverage will be tested and analyzed for merit at the primary level, so that any “claims that penetrate the excess layer will already have been processed through the underlying layers.”¹¹⁷ Therefore, from the excess insurer’s perspective, a settlement between the primary and the insured, especially for significantly less than the policy limit, removes the structural protections against unmeritorious claims. This potential for exposure to claims that were not properly scrutinized at the primary level firmly demonstrates that excess insurers do have an interest in the outcome of any settlement discussion between the primary insurer and the insured.¹¹⁸ Furthermore, it frustrates traditional notions of contract interpretation to hold, as *Zeig* and *Trinity Homes* do, that an excess insurer may be bound by an agreement between independent parties that is outside the scope of its policy with the insured.¹¹⁹ What all of these

¹¹⁶ *Zeig*, 23 F.2d at 666.

¹¹⁷ *See Aylward*, *supra* note 23, at 35.

¹¹⁸ *See Wright v. Newman*, 598 F. Supp. 1178, 1197 (W.D. Mo. 1984) (finding that the excess insurer “has, in these circumstances, a compelling interest in enforcing the policy provisions in question”) (internal quotations omitted). In *Wright v. Newman*, the court further stated that “to ignore policy provisions in question would effectively deprive [the excess insurer] of a material benefit for which it implicitly bargained when it undertook coverage.” *Id.* Consequently, the court held that a settlement for less than the primary policy limit failed to exhaust the policy and trigger excess coverage. *Id.*

¹¹⁹ In *Comerica Inc. v. Zurich American Ins. Co.*, 498 F. Supp. 2d 1019 (E.D. Mich. 2007), the court noted that although the insured’s settlement with claimant securities litigation plaintiffs “potentially implicated [the excess insurer] Zurich’s excess policy because the settlement amount exceed the primary insurance coverage,” the settlement between the insured and its primary

considerations highlight is the fact that, regardless of the circumstances, excess insurer's do have a strong interest in the outcome of disputes between insured and primary insurer, especially pertaining to possible settlement agreements.¹²⁰

In addition to its erroneous dismissal of the potential harm to excess insurers under *Zeig*, the Seventh Circuit's decision in *Trinity Homes* is fatally flawed because it failed to either adhere to binding precedent. In *U.S. Fire Ins. Co. v. Lay*,¹²¹ the Seventh Circuit heard another case involving the proper standard for exhaustion of primary policies in order to expose excess insurers to coverage liability.¹²² In that case, the primary insurer had negotiated a settlement with the injured claimant before the claimant brought the anticipated suit for wrongful death.¹²³ When U.S. Fire Insurance Company ("U.S. Fire") brought a declaratory judgment action against the administratrix of the decedent's estate seeking a declaration that it was not liable for any damages, the claimant relied on *Zeig* to argue that U.S. Fire was liable for coverage in excess of

insurer had no such binding effect on Zurich. *See id.* at 1032. As the court put it, the insured "had a fundamental dispute with its primary insurer as to whether [the primary] was liable for any amount of the settlement." *Id.*

"That dispute did not directly involve Zurich, and [the insured] did not have the right to tie Zurich to any aspect of its settlement with [the primary] without Zurich's consent." *Id.* The court was not moved by the insured's arguments, finding that the insured sought "the certainty that its settlement brought and the benefit of coverage from its excess carrier as if it had won its dispute with the primary insurer...[n]o public policy argument says that [the insured] may have its cake and eat it too." *Id.*

¹²⁰ Permitting under the limit settlements, as endorsed by *Zeig*, would radically and irrevocably alter the thought process of excess insurance underwriters. As so aptly put by Lee Brewer and Barbara Ewing, the question, from the insurer's point of view, in issuing new policies would go from, "[h]ow often will a loss realistically valued at more than \$10 million occur?" to something more along the lines of, "[h]ow often will the underlying policy carrier settle the claim, and the insured seek to recover for its additional claims under the excess policy?" Brewer and Ewing, *supra* note 5, at 224.

¹²¹ 577 F.2d 421 (7th Cir. 1978).

¹²² In *Lay* the settlements in question were between a third-party personal injury claimant and the insured and primary carrier for less than the limits of the primary policy. *See id.* at 421.

¹²³ *Id.* at 422.

the limits of the primary policy.¹²⁴ The Seventh Circuit affirmed the district court's holding that U.S. Fire was not liable.¹²⁵ Although the outcome of the case did not hinge on a *Zeig* determination because of the procedural peculiarities, the court nonetheless went on to say that “[w]e can conceive of good reasons for an excess carrier to be unwilling to accept liability unless the amount of the primary policy has actually been paid.”¹²⁶ “A settlement for less than the primary limit that imposed liability on the excess carrier would remove the incentive of the primary insurer to defend in good faith or to discharge its duty to represent the interests of the excess carrier.”¹²⁷

In *Premcor USA, Inc. v. American Home Assur. Co.*¹²⁸ the plaintiff, Premcor USA, Inc. (“Premcor”), relied on *Zeig* in arguing that its excess insurers were obligated to cover its losses emanating from two underlying tort actions, regardless of the fact that Premcor had settled with its primary insurer for less than the policy limits.¹²⁹ The court granted the excess insurer's motion for summary judgment because “*Zeig*'s holding that exhaustion of the primary policies' payments does not require collection of the primary policies as a condition precedent to the right to recover excess insurance is contrary to Seventh Circuit precedent.”¹³⁰ In *Zurich*, the Seventh Circuit affirmed the district court's judgment on the pleadings in favor of the plaintiff, Zurich.¹³¹ Zurich brought a declaratory judgment action against the insured seeking a determination that

¹²⁴ *See id.* at 423.

¹²⁵ *See id.* The court reasoned that because the settlement between the insured and primary and the claimant occurred before any suit for damages was brought, the excess carrier was in fact at no point liable under the terms of the excess policy. *See id.*

¹²⁶ 577 F.2d at 423.

¹²⁷ *Id.*

¹²⁸ No. 03 C 7377, 2004 WL 1152847 (N.D. Ill. May 21, 2004).

¹²⁹ *Id.* at *8.

¹³⁰ *Id.* (internal quotations omitted) (citing *New Process Baking Co. v. Federal Ins. Co.*, 923 F.3d 62, 63 (7th Cir. 1991); *Zurich Ins. Co. v. Heil Co.*, 815 F.2d 1122, 1126 (7th Cir. 1987)).

¹³¹ *Zurich Ins. Co.*, 815 F.2d at 1122.

Zurich was not required to “drop-down” to cover the insured’s loss as a result of the primary insurer’s insolvency.¹³² Rejecting the plaintiff’s claim of functional exhaustion, the Seventh Circuit opined: “Zurich did not contract to bear the risk of the primary carrier’s insolvency, nor do its premiums reflect the cost that the assumption of this risk would entail...an excess liability insurer does not anticipate such a burden.”¹³³

The Seventh Circuit reaffirmed this principle four years later in *New Process*, where the insured brought a declaratory judgment action seeking to determine the scope of its excess policy with Federal Insurance Company (“Federal”).¹³⁴ Affirming the district court’s grant of summary judgment to Federal, the Seventh Circuit held that “[e]xhaustion does not occur until the underlying insurance limits have been met through payment.”¹³⁵ It is true that the specific factual parameters of *New Process* and *Zurich* are not directly on point with *Trinity Homes* and the other cases addressed here. In *New Process* and *Zurich* the analysis centered on whether or not the excess insurer was required to “drop-down” and fill the shoes of an insolvent primary insurer.¹³⁶ However, what each unequivocally illuminates for the purposes of this note is that, as put so aptly by the court in *Premcor*, *Zeig*’s policy conclusions are contrary to existing law within the Seventh Circuit.¹³⁷

In *Trinity Homes*, Cincinnati relied on the Seventh Circuit’s proclamations in *Lay* in arguing that it could not be held liable for coverage. In deciding the case the district court

¹³² Id. See also *infra* note 8.

¹³³ Id. at 1126. The court went further, stating that “secondary coverage is coverage whereby, under the terms of the policy, liability attaches only after a predetermined amount of primary coverage has been exhausted...[t]his reduced risk is reflected in the cost of the policy.” Id. (citing *Continental Marble & Granite v. Canal Ins. Co.*, 785 F.2d 1258, 1259 (5th Cir. 1986).

¹³⁴ See *New Process*, 923 F.2d at 62.

¹³⁵ Id. at 63 (citing *Zurich*, 815 F.2d at 1126).

¹³⁶ See *infra* notes 8, 132 and accompanying text.

¹³⁷ *Premcor*, 2004 WL 1152847, at *8.

addressed *Lay*'s status as authority on the issue.¹³⁸ The court noted that, "although its reasoning applies in part, *Lay* is not entirely [determinative]" because of the involvement in *Lay* of the claimant in the settlement agreement.¹³⁹ Despite the distinguishing fact that the settlement in *Lay* involved a third-party claimant, the district court's purposeful critique of *Zeig*'s conclusions was an accurate reflection of existing law within the circuit. On appeal, the Seventh Circuit wrongly reversed the district court's holding that the policy was not exhausted and endorsed *Zeig*. In doing so, the Seventh Circuit addressed neither Cincinnati's reliance on *Lay* or the district court's discussion of the case.¹⁴⁰ This failure to do so amounted to a strategic side-step around clear precedent which was unfavorable to *Zeig* and the court of appeals' desired ends in *Trinity Homes*. For these reasons, the decision is fatally flawed. Courts should therefore reject *Trinity Homes*' conclusions in adjudicating questions of exhaustion in excess coverage disputes.

B. The Totality of the Public Policy Considerations Favor Endorsing the Fifth Circuit's Rejection of *Zeig*.

In addition to the legally questionable nature of the Seventh Circuit's decision in *Trinity Homes* to maneuver around its prior decision in *Lay*, the totality of the policy considerations at stake favor endorsing the Fifth Circuit's rejection of *Zeig*. Adopting such an approach to policy interpretation would both provide excess insurers with the benefit of their bargain with the insured and help to ensure the continued relatively lower cost of maintaining excess insurance for commercial entities to help protect against the risk of catastrophic loss.

¹³⁸ See *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, No. 1:04-cv-1920-SEB-DML, 2009 WL 3163108, at *11 (S.D. Ind. Sept. 25, 2009).

¹³⁹ *Id.* Despite this, the district court still found for Cincinnati and ruled that the primary policy had not been exhausted. *Id.*

¹⁴⁰ See generally *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, 629 F.3d 653 (7th Cir. 2010).

In *Zeig*, Judge Hand relied on public policy considerations to support for his conclusion that permitting settlements for less than the policy limit to functionally exhaust primary policies and trigger excess coverage was sound.¹⁴¹ As Hand saw it, “[t]o require an absolute collection of the primary insurance to its full limit would in many, if not most, cases involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable.”¹⁴² Hand’s utterances notwithstanding, a nuanced reading of the policy effects of the *Zeig* approach inevitably leads one to the opposite conclusion. If the *Zeig* court’s primary concern was preventing litigation over excess coverage disputes then its reasoning, and the reasoning of subsequent courts that have followed *Zeig*, likely does little to prevent parties from litigating coverage cases in the future. Even if, under *Zeig*, a court would no longer have to grapple with the question of whether below-policy-limits settlements should be found to exhaust those policies, a thornier issue remains: “how far below the limits can the settlement be before it ceases to be the functional equivalent” of exhaustion?¹⁴³

An examination of any of the cases implicating *Zeig* elucidates the shortcomings of Hand’s argument that permitting functional exhaustion maximizes judicial efficiency by encouraging out-of-court settlement of coverage disputes.¹⁴⁴ There is great variance in the proportion of the settlements with underlying insurers to the given policy’s limits. In *Trinity Homes*, the insured’s settlements with its underlying insurers was “for at least seventy-five percent of the policy limit, and each settlement agreement provided that [the insured] would be

¹⁴¹ See generally *Zeig v. Mass. Bonding & Ins. Co.*, 23 F. 2d 665 (2d Cir. 1928). Nowhere in the opinion does Hand provide any semblance of a legal rationale for the court’s holding. The result of this total reliance on public policy, in addition to frustrating proponents of the freedom to contract, renders *Zeig* particularly vulnerable to meritorious criticisms attacking its accuracy and continued usefulness.

¹⁴² *Id.* at 666.

¹⁴³ *Brewer and Ewing*, *supra* note 5, at 224.

¹⁴⁴ See *Zeig*, 23 F.2d at 666.

responsible” for the resulting gap in coverage.¹⁴⁵ As discussed above, the court in *Trinity Homes* found the settlements for seventy-five percent of the policy limits to be sufficient to trigger excess coverage.¹⁴⁶ In *Citigroup* the insured settled with its underlying insurer for \$15 million.¹⁴⁷ This constituted thirty percent of the policy’s \$50 million limit.¹⁴⁸ While thirty percent does pale in comparison with the seventy-five percent settlements in *Trinity Homes*, in no way does it serve as a floor for the ratios of settlement amount to policy limit that have been litigated. In *New Process* the insured argued that its settlement with its primary insurer for \$850,000 should serve to functionally exhaust its primary coverage and therefore trigger excess liability.¹⁴⁹ However, the primary policy covered up to \$20.5 million.¹⁵⁰ That means that the insured believed that its settlement with its primary insurer for a meager 3.4 percent of the primary policy should trigger excess coverage.

No matter how one reads Judge Hand’s opinion in *Zeig*, it fails to provide a limiting principle of any sort to the idea that below-policy-limits settlements should be honored. Furthermore, no subsequent case endorsing the *Zeig* approach has established a clear line in the sand regarding when a settlement between primary carrier and insured will fail to trigger excess liability. Is fifty-percent sufficient? What about twenty-five? Ten? Five? Needless to say, one could go on and on and never arrive at a definitive conclusion. What this means in terms of *Zeig*’s self-proclaimed policy rationale is that, at a minimum, it very likely has not had any consequential impact on the amount of subsequent litigation in coverage disputes.¹⁵¹ Without the

¹⁴⁵ *Trinity Homes*, 629 F.3d at 656.

¹⁴⁶ *See id.* at 655.

¹⁴⁷ *See Citigroup*, 649 F.3d at 370.

¹⁴⁸ *See id.*

¹⁴⁹ *See New Process*, 923 F.2d at 63.

¹⁵⁰ *See id.*

¹⁵¹ *See Zeig*, 23 F.2d at 666.

benefit of the doubt, it is easy to see how the state of the law under *Zeig* could result in *more* litigation over exhaustion disputes than under an alternative regiment which requires full payment of the primary policy in its entirety to trigger excess coverage.

Notwithstanding the vulnerability of *Zeig*'s asserted judicial efficiency justification, there are more far-reaching and practical concerns that dictate rejecting *Zeig* and enforcing a stricter four-corners approach to policy construction. As outlined above in Part III.B-2, continued adherence to *Zeig* presents significant potential consequences for insurers by denying them the benefit of their bargain in issuing excess policies.¹⁵² Even more troubling are the potential detrimental effects on a systemic level that could result from too liberal an interpretation of policy terms. In time, if forced to account for the increasing risk of coverage liability in cases involving below policy limits settlements, excess insurers, in order to maintain economic viability and solvency, will have little choice but to raise the rates and premiums they charge to policyholders.¹⁵³ This in turn will, if history is any metric, make coverage inaccessible to many due to financial concern.¹⁵⁴

Another alternative is that excess insurers may find certain industries or commercial activities too risky to justify, refusing coverage “at any premium, thereby forcing these products and services to be withdrawn from the market.”¹⁵⁵ While the detriment to commercial enterprise would be significant enough on its own to warrant serious concern, the potential economic effects of a constriction in the insurance market do not end there: state and local government

¹⁵² See *supra* notes 101-104 and accompanying text.

¹⁵³ Brewer and Ewing, *supra* note 5, at 223-4.

¹⁵⁴ See *supra* notes 107—109 and accompanying text.

¹⁵⁵ Priest, *supra* note 106, at 1521.

could bear a substantial portion of the resulting hardship.¹⁵⁶ For all of these reasons, the totality of public policy concerns at stake favor embracing a stricter interpretation of excess insurance policies and rejecting *Zeig*'s conclusions.

PART V. WHERE DOES THAT LEAVE US?: THE RIGHTS AND RESPONSIBILITIES OF INSURED AND INSURERS MOVING FORWARD

Having concluded that the federal circuits should, in the interests of both the law and public policy, reject *Zeig*'s approach to the exhaustion of primary insurance policies, one is left with several questions about how insureds and insurers must act moving forward. Historically much analysis has been focused on the requisite efforts of insurers: namely the steps to be taken when drafting policies to limit excess liability.¹⁵⁷ This trend in advising excess insurers to preemptively avoid *Zeig*'s thrust through more carefully constructed exhaustion clauses has continued to be the focus of the relevant scholarly work.¹⁵⁸ Ultimately, however, this emphasis on avoiding ambiguity *ex-ante* is not enough to guarantee against a potential finding of excess liability even when the insured has settled with the primary carrier for less than the policy limits: ambiguity is often in the eye of the beholder. A closer examination of the particular policy language employed by excess insurers in various cases demonstrates the fact that a finding of ambiguity in a disputed policy can sometimes depend less on the explicit language and more on the judge before whom the case is argued.

¹⁵⁶ *Id.* at 1521-22 (Describing the insurance crisis of 1986, Priest noted that “[t]he crisis extended beyond commercial enterprises. Municipalities and other governmental entities faced similarly extreme premium increases or the unavailability of market insurance coverage altogether. Some cities closed jails and suspended police patrols until insurance coverage was obtained. Parks and forest preserves were closed. Fourth of July celebrations were cancelled because of concerns over uninsured liability.”) (citations omitted).

¹⁵⁷ See Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1183-86 (1954).

¹⁵⁸ See Brewer and Ewing, *supra* note 5, at 225-8; Aylward, *supra* note 23, at 27.

In *Trinity Homes* the Seventh Circuit went to great lengths to argue that its finding for the insured in that case hinged upon the ambiguous nature of Cincinnati's excess policy.¹⁵⁹ Cincinnati's "Limits of Insurance" clause stated that coverage would be triggered "[i]f the limits of 'underlying insurance' have been exhausted by payment of claims."¹⁶⁰ The court found that while this language made it clear that excess coverage was conditioned upon the underlying policy limit being "expended," it did not "clearly provide that the full limit must be paid out by the [underlying] insurer alone."¹⁶¹ The court rejected Cincinnati's reliance on *Comerica Inc. v. Zurich Am. Ins. Co.*¹⁶² and held that the case was distinguishable because the policy language in *Comerica* was more specific in its limitations on excess coverage.¹⁶³ Ultimately the *Trinity Homes* court's assertions of ambiguity regarding the required payer of the underlying insurance are unconvincing. By their very nature, "claims" can only be paid by insurance companies. Upon this realization it becomes clear that the both the intended and literal meaning of the Cincinnati policy are on all fours with that in *Comerica*.¹⁶⁴ Therefore the court's conclusion that Cincinnati's reliance on the phrase "payment of claims" permitted the inference that some other party could be responsible for the payment of the underlying claims distorts the clear meaning of the policy language and exceeds the bounds of reasonable contract interpretation.

¹⁵⁹ See *Trinity Homes*, 629 F.3d at 658.

¹⁶⁰ Id. This language is similar to *Zeig*, where Mass. Bonding's policy read in relevant part: "[a]s excess and not contributing insurance, and shall apply and cover only after all other insurance herein referred to shall have been exhausted in the payment of claims to the full amount of the expressed limits of such other insurance." *Zeig*, 23 F.2d at 665.

¹⁶¹ *Trinity Homes*, 629 F.3d at 658.

¹⁶² 498 F. Supp. 2d 1019 (E.D. Mich. 2007).

¹⁶³ See *Trinity Homes*, 629 F.3d at 658-9. The policy in *Comerica* "required payment by the 'applicable insurers' before coverage was triggered." Id. (citing *Comerica*, 498 F. Supp. 2d at 1022).

¹⁶⁴ See *infra* notes 160-163 and accompanying text.

Even putting aside the questionable policy interpretation in *Trinity Homes*, a survey of other cases demonstrates that findings of ambiguity in excess policies can vary greatly between jurisdictions and put litigants at significant risk of inconsistent judgments. In *Citigroup* one of the excess insurers, Steadfast Insurance Company (“Steadfast”), employed language similar to that of the defendant-insurer in *Trinity Homes*.¹⁶⁵ Steadfast’s policy advised that coverage attached “[i]n the event of the exhaustion of all of the limit[s] of liability of such ‘Underlying Insurance’ solely as a result of payment of loss thereunder.”¹⁶⁶ Like Cincinnati’s policy in *Trinity Homes*, the Steadfast policy made no explicit reference to the requisite payer of the “loss.”¹⁶⁷ However, unlike the court in *Trinity Homes*, the Fifth Circuit found no disqualifying ambiguity and held that Steadfast’s inclusion of the phrase “payment of loss” unequivocally established “that the *underlying insurer* must make *actual* payment to the insured in order to exhaust the underlying policy.”¹⁶⁸ Likewise, in *Molina v. U.S. Fire Ins. Co.*,¹⁶⁹ the Fourth Circuit rejected the plaintiff-insured’s argument that the primary insurer’s insolvency functionally exhausted the policy and triggered excess coverage under similar policy language.¹⁷⁰ Before *Trinity Homes*, even the Seventh Circuit had ruled similarly in a coverage dispute. In *Zurich Ins. Co. v. Heil Co.*,¹⁷¹ Zurich’s exhaustion clause stated that:

[i]n the event that the aggregate limits of liability of the underlying policies ... are reduced or exhausted, the company [Zurich] shall, subject to the company’s limit of liability ... *and to the other conditions of this policy*, with respect to occurrences

¹⁶⁵ Compare *Citigroup*, 649 F.3d at 373, with *supra* note 160 and accompanying text.

¹⁶⁶ *Citigroup*, 649 F.3d at 373.

¹⁶⁷ *Id.* See also *supra* note 161 and accompanying text.

¹⁶⁸ *Citigroup*, 649 F.3d at 367 (emphasis added).

¹⁶⁹ 574 F.2d 1176 (4th Cir. 1978).

¹⁷⁰ See *id.* at 1178. The excess policy read in relevant part: “[i]n the event of the reduction or exhaustion of the aggregate limit of liability of the underlying professional liability policy listed in Schedule A *by reason of losses paid thereunder*, the policy ... shall constitute as underlying insurance.” *Id.* (alterations in original) (emphasis added).

¹⁷¹ 815 F.2d 1122 (7th Cir. 1987).

which take place during the period of this policy continue in force as excess of the reduced primary insurance or, in the event of exhaustion, continue in force as underlying insurance.¹⁷²

The court held this language to require that Zurich could not be liable until “after the *underlying insurer* has paid claims up to its retained limit.”¹⁷³

What the variant results of these cases emphasize is that the traditional focus on an insurers’ efforts to preemptively avoid a finding of ambiguity through more diligent drafting of exhaustion clauses is insufficient to solve the problem of potentially inconsistent judgments across the circuits. What is ultimately required is a new understanding of the interactions between insureds and insurers, particularly regarding settlements. In retiring *Zeig*’s outdated and unreasonable policy arguments, the necessary next step is acknowledging that, moving forward, both insureds and insurers owe each other additional duties to ensure that only meritorious claims will trigger excess liability and that settlements can more effectively promote judicial efficiency. Not all of the duties are easily explained or adopted. However, all are essential to maintaining the integrity of the settlement process.

A. The Rights and Responsibilities of the Insured

Operating in a post-*Zeig* world, the impetus will, and should, be on the insured when initiating settlement discussions with an insurer at any level. Perhaps the greatest inequity under the *Zeig* doctrine was the opportunity it created for gamesmanship on the part of the insured. *Zeig*’s holding undercut the procedural protections excess insurers rely upon in issuing policies.¹⁷⁴ Consequently, excess insurers could no longer be confident that claims that pierced

¹⁷² Id. (alterations in original).

¹⁷³ Id. (emphasis added).

¹⁷⁴ See *supra* notes 99-101 and accompanying text.

the excess level were actually meritorious and deserving of coverage.¹⁷⁵ This opened the door for insureds, in some cases, to surreptitiously and unilaterally settle claims without informing all of the interested insurers. In *Citigroup*, this unilateral action manifested in Citigroup's settling of the underlying actions with the FTC and class in California for \$263 million without informing any of its insurers, primary or excess.¹⁷⁶ In *Comerica*, the plaintiff-insured settled its claim against the primary carrier without informing the excess insurer, Zurich.¹⁷⁷ The insured's motivation for doing so can likely be found in the court's observation that Zurich, as excess insurer, "had a fundamental dispute with [the] primary insurer as to whether [the primary] was liable for *any* amount of the settlement."¹⁷⁸ Given the facts in *Comerica*, the reasonable conclusion is that the insured, predicting Zurich's denial of coverage on the merits of the claim, attempted to skirt around the usual protections of the primary level by settling with the primary insurer for less than the policy limit in order to tap into Zurich's excess coverage. Ultimately the court in *Comerica* rejected the insured's exhaustion argument and found that Zurich was not liable.¹⁷⁹

Each of these cases demonstrates the rationale behind rejecting *Zeig* and enforcing a four-corners approach to the judicial construction of excess policies. They also help to clarify the necessary model for insureds' behavior pertaining to settlement discussions moving forward. What is required is clarity and openness regarding any potential settlement. The responsibility of the insured is to bring in all interested parties and get everyone in the same room to discuss the

¹⁷⁵ See *supra* notes 102-103 and accompanying text.

¹⁷⁶ See *Citigroup*, 649 F.3d at 370.

¹⁷⁷ See *Comerica*, 498 F. Supp. 2d at 1032.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* See also, e.g., *Intel Corp. v. Am. Guar. & Liab. Ins. Co.*, 51 A.3d 445 (Del. 2012) (plaintiff-insured, Intel, filed suit against primary insurer alone and only after below-policy-limits settlement with the primary did Intel "turn to its excess insurer" for coverage).

case at issue. When this occurs, in the vast majority of cases, rationality and risk calculation will win the day and each insurer should be able to agree to a set of terms regarding a collective settlement.¹⁸⁰ Only rarely should an insurmountable impasse arise where one insurer favors settlement and another litigation. However, the overarching effect of this new requirement that insureds bring in all interested parties when discussing settlement will serve to remove both the motivation and opportunity for gamesmanship from the equation.

B. The Rights and Responsibilities of Insurers

Now the insured has fulfilled its duty and duly informed each of its insurers, primary or excess, about its interest in settling its suit demanding coverage. All interested parties are sitting around the same table to hear the insured's proposed terms. This scenario alone, while a significant improvement over the alternative under the *Zeig* doctrine, unfortunately does not guarantee that all settlement discussions will be rationally and efficiently resolved. In most instances, the insurers will be able to work collectively to determine each carrier's *pro rata* share of any settlement with the insured. However, the danger exists that one or more of the insurers may come to a different conclusion regarding the merits of the claim and refuse to settle under any terms. Because after the rejection of *Zeig* any insured that settles with underlying carriers will be unable to successfully argue exhaustion in bringing a claim against the non-settling entities, one insurer's refusal to assent to the collective settlement can effectively kill the deal for all parties.¹⁸¹ In order to avoid this potentially inefficient "stag hunt" dilemma, one must

¹⁸⁰ Cf. William P. Skinner, Lawrence A. Hobel, *Subprime Litigation Assessing the Insurance Issues*, 41-SPG BRIEF 26, 34 (2012) ("One way to avoid the problem is to settle with all of the insurers at the same time.")

¹⁸¹ See *supra* notes 112-113 and accompanying text.

conclude that in addition to the new duties owed by insureds, insurers also must account for the interests of other insurers when conducting settlement discussions.

The source of this dilemma can be found in the unique relationship between the multiple insurers of a single insured. It is well settled that an insured can sue its insurer for breach of contract.¹⁸² In addition to the explicit terms of the contract, an insurer owes the insured an implied duty of good faith and fair dealing, a violation of which risks a successful tort claim for “bad faith.”¹⁸³ While the nature of the insurer’s duties owed to the insured are clearly defined, the duties that arise between *insurers* are much more opaque. In *Puritan Ins. Co. v. Canadian Universal Ins. Co.*,¹⁸⁴ the Third Circuit elaborated on the unique relationship between and among primary and excess insurers:

[t]he relationship between the primary and excess carrier is an unusual one; each has a separate contract with the insured, but they have none with each other. Conflicts of interest invariably arise when the underlying tort injury is of such severity that a recovery over the limits of the primary policy is possible. In that circumstance, the excess carrier wishes the primary insurer to dispose of the case within its limits and is not unduly impressed with the primary insurer's desire to save some or all of its policy limits by a favorable verdict at trial. Conversely, the primary carrier is unlikely to have such paternalistic feelings as will induce it to concede its limits when there is some chance of obtaining a favorable verdict. In each instance, one carrier is to some extent gambling with the other's money.¹⁸⁵

Without some other arrangement between insurers, the absence of privity could undermine the ability of parties to effectively settle disputes without resorting to litigation.

There is of course the possibility that the market may react on its own in such a way as to discourage holdouts in settlement discussions.¹⁸⁶ Insurers could attempt to “punish” those insurance companies that routinely decide to unilaterally reject settlements in contravention of

¹⁸² See Richmond, *supra* note 1, at 55.

¹⁸³ *Id.* at 55-6.

¹⁸⁴ 775 F.2d 76 (3d Cir. 1985).

¹⁸⁵ Richmond, *supra* note 1, at 57 (quoting *Puritan Ins. Co.*, 775 F.2d at 78).

¹⁸⁶ See Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1206 (1990).

the wishes of the group.¹⁸⁷ However, courts have come up with more efficient alternative means of promoting collective action and deterring individual insurers from torpedoing meritorious settlement agreements for selfish motivations: the duty to settle doctrine.¹⁸⁸ Motivated by the desire to limit litigation and maintain a reasonable rate structure between primary and excess insurance coverage, many courts have permitted excess insurers to recover against underlying insurers who “failed to settle” a claim that subsequently went to trial and returned a judgment in excess of the underlying insurer’s policy limit.¹⁸⁹ When the question involves the relationship between a primary and an excess insurer, certain rights have “been recognized in favor of the excess insurer against the primary insurer.”¹⁹⁰ The basic rationale is that had the underlying insurer properly settled the claim within its policy limits, the excess insurer would never have been liable. Therefore, the primary carrier’s bad faith in failing to do so can require it to reimburse the excess carrier for any loss sustained at trial.

There are two ways through which courts have found that an excess insurer can recover against a primary insurer for failure to properly settle a claim. The first recognizes a direct duty from the primary to the excess insurer. This theory holds that an excess insurer “is entitled to rely on a primary insurer to not elevate its interests ahead of the excess insurer’s interests.”¹⁹¹ Direct duty jurisdictions hold that the excess insurer is put in the same position as an insured regarding the duties owed to it by the primary carrier.¹⁹² While the direct duty theory has its

¹⁸⁷ See, e.g., *id.* (“Of course, some primary carriers might refuse to accommodate excess insurers, and premiums for excess coverage over primary policies issued by these carriers would be higher.”).

¹⁸⁸ See *id.* at 1204.

¹⁸⁹ *Id.* at 1204-5.

¹⁹⁰ Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1152 (1954).

¹⁹¹ Richmond, *supra* note 1, at 72.

¹⁹² *Id.*

supporters,¹⁹³ most courts reject it in favor of the equitable subrogation theory.¹⁹⁴ Equitable subrogation holds that a primary insurer's duty to the excess carrier is derived from the primary's duty to the insured.¹⁹⁵ However, a successful claim under a theory of equitable subrogation therefore hinges on the excess insurer's ability to prove that the primary carrier violated one of its duties to the insured: since the excess insurer's rights are derivative of the insured, an asserted injury cannot exist without a corresponding harm to the insured.¹⁹⁶ This innate limiting principle has inspired criticism of equitable subrogation doctrine for its narrow scope.

However, for the purposes of operating in a post-*Zeig* world, the distinction between the direct duty and equitable subrogation theories is in fact secondary to a more pressing concern. As the law stands, a right to recover under the duty to settle doctrine, whether through a direct duty or equitable subrogation claim, is limited in its application. The right is not reciprocal: it exists only for the benefit of excess insurers against primary insurers.¹⁹⁷ Therefore no right is recognized for the benefit of excess insurers between and amongst themselves. This is problematic because in the complex realm of tiered commercial insurance coverage, it is not unlikely that the holdout will be one of many excess carriers involved in the dispute.

In order to maintain the legitimacy of settlement discussions in coverage cases involving multiple insurers and to promote judicial efficiency, courts should expand the duties owed to excess insurers by primary carriers to cover all relationships between insurers in a given case and

¹⁹³ See V. Eileen Stuhr, *Excess Carrier Tort Suits: Are Primary Insurers Up the Canal without a Paddle?*, 29 HOUS. L. REV. 661, 715 (1992).

¹⁹⁴ Richmond, *supra* note 1, at 72.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ See *id.* at 71-74; Keeton, *supra* note 190.

to run *reciprocally*. This proposal is not a recent innovation.¹⁹⁸ However, the rejection of *Zeig*'s policy arguments and renewed emphasis on the four-corner approach to policy interpretation make the adoption of a reciprocal set of duties between and among insurers more urgent than ever. Since insurers stand to benefit under the new regime post-*Zeig*, it is only right that their responsibilities expand correspondingly. As Professor Robert Keeton put it, “[r]egardless of the lack of a contractual relationship between the two companies, there is a close factual relationship—one under which they share the control over the litigation which normally would be enjoyed by one company alone.”¹⁹⁹ Because of the this joint control, Keeton argues, “each should be held to a duty to the other.”²⁰⁰

Ultimately, the circuit courts should adopt the conclusions advanced by Keeton more than six decades ago. Only with the universal recognition of a reciprocated duty between and amongst insurers can the courts maximize the equity and efficiency of the resolution of complex commercial insurance disputes.

¹⁹⁸ See Stuhr, *supra* note 193 (proposing a reciprocal right of action); Keeton, *supra* note 190, at 1153.

¹⁹⁹ Keeton, *supra* note 190, at 1153.

²⁰⁰ *Id.*