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# *Vade Mecum: Mediators and Disputes Involving Insurance*

*Robert H. Jerry, II\**

For businesses, insurance is indispensable to a well-functioning economy; for individuals, insurance is essential to both securing the well-being of our dependents and protecting our most cherished and important assets. Yet those who do not work in or study the industry are likely to underappreciate or miss entirely the profound implications of the foregoing statements. Justice Black wrote almost seventy-five years ago: “Perhaps no modern commercial enterprise directly affects so many persons in all walks of life as does the insurance business. Insurance touches the home, the family, and the occupation or the business of almost every person in the United States.”<sup>1</sup> If Justice Black were speaking today, his statement would be no less accurate. In 2016 total insurance premiums in the life/health and property/casualty sectors in the U.S. were \$1.13 trillion, or nearly \$3,500 for every man, woman, and child in the country.<sup>2</sup> These premiums represented approximately 6.1 percent of U.S. gross domestic product.<sup>3</sup> These are astonishing statistics, but their true relevance lies in the security these premiums purchase.

Given the pervasiveness of insurance, the observation that some level of understanding of insurance law is important for most lawyers seems very nearly self-evident. The same is true of mediators tasked with assisting parties to resolve their

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1. *United States v. Se. Underwriters’ Ass’n*, 322 U.S. 533, 540 (1944).

2. INSURANCE INFORMATION INSTITUTE, *THE 2018 INSURANCE FACT BOOK* (2018), <https://www.iii.org/publications/2018-insurance-fact-book> [hereinafter *FACT BOOK*]. The life/health sector does not include insurers whose only product is health insurance. In 2016, total national health expenditures were \$3.3 trillion, and private health insurance spending accounted for one-third of this total, or \$1.12 trillion. See *NHE Fact Sheet*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> (last updated Apr. 17, 2018). A vast proportion of this figure (i.e., the portion not including health insurance sold by the life/health sector) must be added to the \$1.13 trillion figure to get a figure that represents all insurance spending in the U.S.

3. The U.S. gross domestic product was \$18.6 trillion at the end of 2016. *GDP (Current US\$)*, THE WORLD BANK, <https://data.worldbank.org/indicator/NY.GDP.MKTP.CD> (last visited June 6, 2018).

disputes.<sup>4</sup> Thus, this article—in the spirit of a *vade mecum*<sup>5</sup>—seeks to assist mediators in identifying and understanding key aspects of insurance law important to effective resolution of mediated disputes.<sup>6</sup> It also undertakes to articulate some insights that should assist mediators in applying their skills and acumen effectively in situations where insurance is an important variable in the dispute between or among the parties. It will address both kinds of disputes involving insurers—cases where the insurer is a direct party to the dispute and cases where the insurer provides the insured’s defense with the potential of becoming the insured’s indemnitor if the case is lost.<sup>7</sup>

To accomplish these objectives, this article is divided into five parts. Part I surveys the space where insurance and mediation intersect. Part II articulates a “checklist” of insurance concepts and vocabulary, the understanding of which comprises a mediator’s foundational “insurance literacy.” Part III identifies and frames the issues, interests, and positions that mediators are most likely to encounter in disputed cases in which insurance is involved. Part IV examines a variety of procedural considerations relevant to mediations involving disputed insurance claims, and Part V concludes the article with a closing thought.

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4. Despite the importance of insurance, relatively little attention has been given to its intersection with dispute resolution. For an overview of some of these intersections, see Robert H. Jerry, II, *Dispute Resolution, Insurance, and Points of Convergence*, 2015 J. DISP. RESOL. 255 (2015). Likewise, the specific intersection of mediation and insurance has received limited attention, although the Web has a number of essays and blog posts, many of which are cited in this article, that discuss aspects of the intersection. In a review of the considerable University of Missouri Law Library collection on the subject of dispute resolution, only a handful of texts that focus on mediation even mentioned insurance in the index, and none had an extended discussion of mediation of insurance disputes. A noteworthy exception is Paul J. Van Osselaer, *The Art of Mediation of Coverage Disputes*, 47 BRIEF 48 (2018). Although written as a guide for attorneys contemplating taking an insurance case to mediation, the article is a useful resource for mediators as well. The 2018 article expands upon two earlier pieces: Paul J. Van Osselaer & Karl Bayer, *Strategies for Mediating the Underlying Case Along with the Coverage Dispute*, ABA SEC. OF LITIG. (Mar. 7, 2015), [https://www.americanbar.org/content/dam/aba/administrative/litigation/materials/2015/2015\\_inscle\\_materials/written\\_materials/10\\_1\\_strategies\\_for\\_mediating\\_the\\_underlying\\_case\\_along\\_with\\_the\\_coverage\\_dispute.authcheckdam.pdf](https://www.americanbar.org/content/dam/aba/administrative/litigation/materials/2015/2015_inscle_materials/written_materials/10_1_strategies_for_mediating_the_underlying_case_along_with_the_coverage_dispute.authcheckdam.pdf); and Paul J. Van Osselaer, *Coverage Mediations: Are They Really that Different?*, 21 COVERAGE 24 (Jan.-Feb. 2011), [https://www.bestlawyers.com/Content/Downloads/Articles/2230\\_1.pdf](https://www.bestlawyers.com/Content/Downloads/Articles/2230_1.pdf).

5. Literally translated from the Latin, *vade mecum* means “go with me,” and the word has been used since at least 1629 to refer to manuals or guidebooks, often of the sort that are compact enough to be carried in a pocket on the hip. On March 12, 2017, *vade mecum* was the Merriam-Webster “Word of the Day.” See *Vade Mecum*, MERRIAM-WEBSTER.COM, <https://www.merriam-webster.com/dictionary/vade%20mecum> (last visited March 30, 2018). This article’s title incorporates *vade mecum* to signal that the article has characteristics of a manual for mediators seeking guidance on the implications of the presence of insurance in a dispute submitted to mediation.

6. This article limits its discussion to specific aspects of insurance that have implications for how a mediator should consider approaching a case and does not go into detail on the general characteristics of an effective mediator, almost all of which are relevant to insurance mediation as well. For a useful summary of many of these general characteristics, see Paul J. Van Osselaer, *The Art of Mediation of Coverage Disputes*, 47 BRIEF 48, 51-53 (2018).

7. The utility of mediation in managing the enormous number of property damage cases involving policyholders and insurers that result from a mass disaster, such as a hurricane or flood, has received much well-deserved attention in recent years. For more on mediation’s role in mass disasters, see Jerry, *supra* note 5, at 260-71. This article, however, focuses on the more typical mediation setting involving an insurer and insured, both in the situation where the insured’s claim is directly against the insurer and in the situation where the insurer is present in its role of representing the insured against a claim brought by an injured plaintiff pursuant to liability insurance.

## I. THE INSURANCE-MEDIATION INTERSECTION

Although insurance is sometimes portrayed as a policyholder's bet with an insurance company about whether a bad thing will happen,<sup>8</sup> insurance is actually about security, i.e., securing freedom from negative economic consequences that might visit us in an uncertain future. One of the few certainties in our world is that uncertainty rules our existence, which is another way of saying that risk is all around us, we try to manage it, and we adapt to risks we cannot control. Some risks are desirable (i.e., the possibility that good things will happen to us<sup>9</sup>), and we do not worry about those. What concerns us are the risks of bad things happening (including some certain-to-occur events that happen at uncertain times).<sup>10</sup> Indeed, one could narrate the history of humankind as a story of how all generations, present and past, have sought to manage this world of uncertainty.

It is in the realm of negative risk where insurance does its work. Insurance does not prevent bad things from happening; other important risk management tools exist to reduce the probability of loss-producing events occurring. Still other risk management tools seek to reduce the amount of loss suffered once a damage-causing event happens. When loss prevention and damage mitigation tools cease to provide cost-effective benefits, individuals and organizations purchase insurance to manage any remaining risks that cannot be ignored. The transaction is a familiar one: a person or organization desiring to transfer risk pays an insurance company, which is a kind of business organization that specializes in the transfer and distribution of risk, to assume that risk, and this arrangement between insured and insurer is reduced to writing in a contract, i.e., the insurance policy. The insurer, through the predictive powers of the law of large numbers, distributes the risks it assumes over a large pool of similarly situated insureds with whom it has made the same or a similar contract, charging each insured a sum large enough to enable the insurer to cover its costs and make a small profit. By distributing the risks assumed over a large pool of insureds, the insurer achieves certainty, and the insured substitutes a predictable recurring payment for the risk of incurring a large, unmanageable economic loss.

Markets exist to enable the transfer of most kinds of negative risks. Examples include dying too soon or living too long, incurring health care expenses due to illness or accident, losing the ability to work due to illness or accident, losing the ability to conduct business activity without interruption, incurring liability to third parties, losing or suffering damage to tangible, and sometimes intangible, assets,

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8. See, e.g., Yaniv, *Insurance: It's Just Gambling Essentially*, GELL-MANN AMNESIA (Aug. 7, 2013), <http://gellmannamnesia.blogspot.com/2013/08/insurance-its-just-gambling-essentially.html>; Richard Chapo, *Liability Insurance for Your Online Business*, LAW OFFICE OF RICHARD A. CHAPO (Mar. 4, 2017), <http://www.socalinternetlawyer.com/liability-insurance-for-your-online-business/>; ("Liability insurance is a bet").

9. The possibility of winning the lottery is an example of a beneficial risk; generally speaking, acquiring more assets through chance makes us better off, and this is a good thing. The risk of getting a promotion at work or a raise is a good thing. One aspect of risk is probability, and the probability that a good thing will happen is described as a "beneficial risk."

10. The probability of bad things happening are called "negative risks." The possibility that property will be destroyed through some peril is a negative risk. Death is certain to occur eventually, but its timing is uncertain; because death is generally unwelcome, death is an example of a negative risk.

and much more.<sup>11</sup> This means that the range of disputes in which individuals or organizations find themselves opposed to an insurance company is vast. In addition, an entire universe of disputes exists in which a liability insurance company takes a position alongside the insured in defending the insured against the claims of injured or damaged third parties. Indeed, it is almost impossible to imagine a dispute—or for that matter, an event or transaction of any kind—that does not involve insurance in some way. Thus, when events or transactions give rise to disputes, the likelihood that insurance will be at least in the background is extremely high.

Thus, “the business of insurance is, first and foremost, the business of providing financial security against the risk of loss[,] [b]ut when loss occurs, the business of insurance becomes the business of resolving claims.”<sup>12</sup> The sheer number of policies in force and the large number of covered incidents means that tens of millions of claims are filed annually. Most claims are resolved smoothly, but a small percentage mutate into disputes, and this yields an enormous number of claims that are ultimately resolved through a consensual (negotiation or mediation) or adversarial (arbitration or litigation) process.<sup>13</sup>

Unfortunately, definitive data about the number of insurance claims and disputes that move through claims processing and informal dispute resolution mechanisms each year are unavailable. The NAIC reported in 2017 that state insurance departments “received 305,420 official complaints and nearly 1.9 million inquiries” in 2016,<sup>14</sup> but exactly what these numbers mean, including what kinds of resolutions occurred, is difficult, and perhaps impossible, to ascertain. Professor Schwarcz’s 2009 examination of state insurance department complaint resolution processes reported that the data “are overlapping, confusing, and ambiguous,”<sup>15</sup> and that the organization of the results into categories of “confirmed,” “justified,” or “closed” with descriptions of company responses such as “corrective action” or “other outcomes”<sup>16</sup> makes it “impossible to make much sense out of the numbers that are published.”<sup>17</sup> Professor Feinman’s attempt to find data on consumer complaints and suits filed with respect to insurance claims led him to conclude that the “reported figures of consumer complaints, and the even more rare numbers on suits filed [are] limited and unreliable . . . . [S]ome states require insurance companies

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11. The list in the text contains most of the common risk covered by insurance policies, but the industry insures many odd or even bizarre things, too. For an interesting review of this universe of perils for which coverage has been written, see *Innovation and Unusual Risks*, LLOYDS, <https://www.lloyds.com/about-lloyds/history/innovation-and-unusual-risks> (last visited May 10, 2017).

12. Jerry, *supra* note 5, at 260.

13. The Jerry article, *supra* note 5, works through these numbers to give a sense of the enormity of the convergence of insurance and dispute resolution. *See id.* at 270-73.

14. 2016 *Insurance Department Resources Report*, NAT’L ASS’N OF INS. COMM’RS (June 2017), [https://www.naic.org/prod\\_serv/STA-BB-17-01.pdf](https://www.naic.org/prod_serv/STA-BB-17-01.pdf).

15. Daniel Schwarcz, *Redesigning Consumer Dispute Resolution: A Case Study of the British and American Approaches to Insurance Claims Conflict*, 83 TUL. L. REV. 735, 755-56 (2009).

16. *Id.* at 750-54.

17. JAY M. FEINMAN, *DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON’T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT* loc. 54 (2010) (ebook).

to report these numbers, and the NAIC has begun to collect the data. But the reporting and collection are secret, at the insistence of the insurance companies.”<sup>18</sup> In seven states, even aggregated complaint data is unavailable to the public.<sup>19</sup>

That the vast majority of cases submitted to litigation are resolved by settlement is clear enough,<sup>20</sup> but how many of these move through mediation is unknown, and how many of these involve insurance claims is not discernible. Not surprisingly, ambiguities similar to the data on complaints processed by state insurance regulators are also found in the data collected by judicial administrators. Although references to the number of court-connected mediations that occur annually can be found in particular jurisdictions,<sup>21</sup> these numbers are scattered. Since 1975, the Court Statistics Project (CSP), which is a collaborative effort of the Conference of State Court Administrators (COSCA) and the National Center for State Courts (NCSC), has collected, compiled, analyzed, and published state court caseload statistics.<sup>22</sup> This is an important data set, but when a court refers a case to alternative dispute resolution (ADR), the case is recorded as being on “active status” with the court, and if it is resolved through the court-referenced ADR, this disposition is recorded in the “non-trial manner of disposition category,”<sup>23</sup> which includes many other kinds of case dispositions other than ADR.<sup>24</sup> This makes it impossible to calculate the number of successful instances of court-referred ADR in any of the jurisdictions, let alone the number of successful mediations. Because cases involving insurance policies or insurance companies as parties are not a separate category in the “Civil Case Type Definitions,” it is also impossible to know how many cases involve insurance disputes or insurance companies.<sup>25</sup>

18. *Id.* at loc. 56-57.

19. See 2016 Insurance Department Resources Report, *supra* note 15, at 58 (chart listing whether aggregated complaint data is available to the public; the answer is “no” in Delaware, Iowa, Nebraska, New Mexico, Oklahoma, South Dakota, and Tennessee).

20. Data on the precise percentage of filed cases resolved by settlement are elusive, but it is probably safe to assert that the percentage exceeds a majority by a wide margin. Although a very low percentage go to trial (perhaps lower than five percent), it is incorrect to infer that those that are not tried are resolved through a negotiated settlement, given that there are reasons other than trial or settlement that result in a case’s resolution (such as default judgment, dismissal by the court for inaction, dismissal by motion, and dismissal by the plaintiff without prejudice to refile). For more on this provocative question, see John Barkai & Elizabeth Kent, *Let’s Stop Spreading Rumors About Settlement and Litigation: A Comparative Study of Settlement and Litigation in Hawaii Courts*, 29 OHIO ST. J. ON DISP. RESOL. 85 (2014). In the authors’ study of case resolution in Hawaii, 27% of all cases in the study were neither tried nor settled. *Id.* at 110. The study found variation in the types of cases: 44% of contract and 40% of “other” cases were terminated on a non-settled, not-tried basis, but only 11% of tort cases were settled on that basis. *Id.* at 109 (Table 5A).

21. See, e.g., *The Center Statistics: Mediation and Arbitration Statistics*, ALA. CTR. FOR DISP. RESOL., <https://web.archive.org/web/20170814182202/http://alabamaadr.org/web/statistics/index.php> (last visited May 11, 2017) (4378 disputes mediated in Alabama, with 3327 settlements); but see 2016 Court Statistics Report: Statewide Caseload Trends, 2005-2006 Through 2014-2015, JUD. COUNCIL OF CAL. (2016), <http://www.courts.ca.gov/documents/2016-Court-Statistics-Report.pdf>.

22. For a summary of the project, see *Court Statistics*, NAT’L CTR. FOR ST. CTS., <http://www.ncsc.org/services-and-experts/areas-of-expertise/court-statistics.aspx> (last visited May 17, 2017). For a detailed explanation of how the project works, see *State Court Guide to Statistical Reporting*, CT. STAT. PROJECT 1 (Mar. 20, 2017), <http://www.courtstatistics.org/~media/microsites/files/csp/state%20court%20guide%20to%20statistical%20reporting%20v%20point1point2.ashx>.

23. *Id.* at 3.

24. See *id.* at 38. The category includes summary judgment, settlement, ADR, default judgment, dismissal, transfer to another court, bindover, guilty plea/stipulation, nolle prosequi, and all delinquency and dependence non-trial hearings.

25. See *id.* at 5-9 (listing categories and their definitions).

Further, the number of cases resolved through mediation before a lawsuit is filed is not systematically collected anywhere, nor is it apparent how this data would be collected in any kind of reliable format. One of the often-cited advantages of mediation is secrecy for the parties; thus, a wide swath of mediations will not show up under any reporting system. Even where data on filed cases are available, it is not sufficiently granular to show the number of mediations where insurance companies are parties or are in control of the defense of the claim through a policy of liability insurance.

What can be said is that a number of states by statute or court rule require or encourage mediation in some categories of cases,<sup>26</sup> and some of these mandated or encouraged mediations involve insurance claims.<sup>27</sup> Florida, for example, has long had a robust tradition of mandating and encouraging mediation. Under the Florida statute,<sup>28</sup> a court “[m]ust, upon request of one party, refer to mediation any filed civil action for monetary damages, provided the requesting party is willing and able to pay the costs of the mediation or the costs can be equitably divided between the parties,” unless the case falls in one of eight specific categories of litigation.<sup>29</sup> In addition, a court “[m]ay refer to mediation all or any part of a filed civil action for which mediation is not required under this section.”<sup>30</sup> A case involving insurance can fall within the scope of this statute, but Florida also has a statute that requires the Florida Department of Insurance (FDOI) to create a mediation program for disputed first-party property insurance claims, both personal and commercial residential, but not automobile or the liability coverages within property insurance policies.<sup>31</sup> In addition, Florida has a statute encouraging mediation in cases arising out of motor vehicle accidents in which the claim is filed with an insurer and seeks bodily injury damages of \$10,000 or less or for property damages in any amount.<sup>32</sup> In such circumstances, either party may demand mediation of the claim prior to the start of litigation.<sup>33</sup> Because a party injured or damaged by the negligence of an automobile insurance policyholder will not file the claim with the insurer (because

26. See Lydia Nussbaum, *Mediation as Regulation: Expanding State Governance Over Private Disputes*, 2016 UTAH L. REV. 361, 381-83 (2016) (providing a non-exclusive list of mediation mandates, which included agricultural cooperatives and the handlers of their products in Maine, electricity cooperatives and cable operators who erect utility poles in Texas, motor vehicle manufacturers and franchise car dealers in Florida, Texas, Virginia, and Wisconsin, beer manufacturers and their distributors in Maryland, telecommunication carriers and their consumers in Illinois and Michigan, homeowners and mortgage lenders in Hawaii, Washington, and Nevada, builders and owners with respect to construction defects in Washington, California, Hawaii, and Nevada, condominium and planned community associations (upon the request of one party) in Hawaii, gun shooting range operators and neighbors in Vermont, private solid waste facility licensees and host communities in Maine, landlord and tenant eviction disputes in mobile home parks in Vermont and Washington, and archeologists and American Indian tribes in California and Oregon); Holly A. Streeter-Schaefer, *A Look at Court Mandated Civil Mediation*, 49 DRAKE L. REV. 367, 373 n.61 (2001).

27. Nussbaum, *supra* note 27, at 381.

28. FLA. STAT. ANN. § 44.102 (LexisNexis 2005).

29. The categories are landlord-tenant disputes, not including a claim for bodily injury, debt collection, medical malpractice, a claim governed by the Florida Small Claims Rules, a claim properly referable to nonbinding arbitration, and claims where the parties have agreed to an expedited trial or to voluntary trial resolution under the appropriate statutes. FLA. STAT. ANN. § 44.102(2)(a) (LexisNexis 2005).

30. FLA. STAT. ANN. § 44.102(2)(b) (LexisNexis 2005).

31. FLA. STAT. ANN. § 627.7015 (LexisNexis 2018). The regulation for the personal property line is FLA. ADMIN. CODE ANN. r. 69J-166.031 (2018), and the regulation for the commercial property policies is FLA. ADMIN. CODE ANN. r. 69J-166.002 (2018).

32. See FLA. STAT. ANN. § 627.745 (LexisNexis 2015).

33. See FLA. STAT. ANN. § 627.745(1)(a) (LexisNexis 2015).

the tortfeasor is the party and no direct action exists in Florida against the insurer), the scope of this statute involves first-party automobile insurance claims, which include uninsured motorist, underinsured motorist, and property coverages on the insured's vehicle. The statute also mandates that first-party coverages include mediation provisions that "specify in detail the terms and conditions for mediation of a first-party claim."<sup>34</sup> According to publicly available data for the Florida judicial system,<sup>35</sup> Florida trial courts order mediation in approximately 125,000 civil cases annually,<sup>36</sup> but how many of these involve insurance disputes is impossible to know.

Statutes requiring or encouraging insurance mediation exist in a number of other states as well. In Connecticut, California, and North Carolina, state statutes authorize pre-litigation mediation of property insurance claims arising out of mass disasters.<sup>37</sup> The California statute also creates a mediation program for claims arising out of auto collision or physical damage coverage.<sup>38</sup> Oklahoma has a statute requiring the Workers Compensation Commission to develop an ADR program that gives an injured employee the opportunity to obtain benefits on some kinds of claims through an informal procedure that uses a "Commission mediator" who conducts an "informal mediation,"<sup>39</sup> and other states have mediation options or requirements in workers compensation.<sup>40</sup> Washington has a statute that allows an insurer

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34. FLA. STAT. ANN. § 627.745(1)(c) (LexisNexis 2015).

35. The "Florida Courts" website reports data quarterly on alternative dispute resolution and some other elements of the trial court system. See *Uniform Data Reporting*, FLA. CTS., <http://www.flcourts.org/publications-reports-stats/statistics/uniform-data-reporting.stml#ADR> (last visited May 9, 2018). The website has other information about ADR and mediation as well. *Alternative Dispute Resolution*, FLA. CTS., <http://www.flcourts.org/resources-and-services/alternative-dispute-resolution/> (last visited May 17, 2017); *About ADR & Mediation*, FLA. CTS., <http://www.flcourts.org/resources-and-services/alternative-dispute-resolution/about-adr-mediation.stml> (last visited May 17, 2017).

36. The 2014-15 Annual Report of the Florida State Courts reported "approximately 125,000 court-connected mediations take place" each year in Florida." *Florida State Courts Annual Report July 1, 2014 – June 30, 2015*, FLA. CTS. 34 (2015), [http://www.flcourts.org/core/fileparse.php/248/urlt/annual\\_report1415.pdf](http://www.flcourts.org/core/fileparse.php/248/urlt/annual_report1415.pdf). This appears to be the last year in which the Annual Report included this statement. A review of data in the quarterly reports, see *Uniform Data Reporting*, *supra* note 36. It shows in the second quarter of 2017-18 (October to December), 30,765 cases were ordered to an "Alternative Dispute Resolution Program" and sessions were held in 14,095 cases. It is likely that most of these cases were mediations, not arbitrations. This data suggests that approximately 125,000 civil cases are ordered to mediation, but actual mediations occur in only about half of them, presumably because in the other half the cases settle before mediation occurs.

37. See CONN. GEN. STAT. ANN. § 38a-10a (West 2013) (Insurance department may establish a mediation program for any open claim for loss or damage to personal or real property under a personal risk insurance policy, but not auto insurance, or condominium master or unit policy as a result of a catastrophic event for which the Governor has declared a state of emergency); CAL. INS. CODE § 10089.70-83 (West 2006) (creates mediation program for homeowners insurance policy claims involving fire loss or earthquake loss for which the Governor has declared a state of emergency, or a claim arising out of auto collision or physical damage coverage); N.C. GEN. STAT. ANN. § 58 44-120 (West 2013) creates "nonadversarial alternative dispute resolution procedure" for disputed claims, as to cause or amount of loss, arising out of damage to residential property as a result of a disaster proclaimed by the Governor or President; however, does not apply to commercial insurance, motor vehicle insurance or liability coverage in property insurance policies).

38. See CAL. INS. CODE § 10089.70(a)(3) (West 2006).

39. OKLA. ST. ANN. tit. 85A, § 110 (West 2018).

40. See, e.g., FLA. STAT. ANN. § 440.25 (West 2011); TENN. CODE ANN. § 50-6-236 (West 2015) (workers compensation mediators program); MICH. COMP. LAWS ANN. § 418.222 (West 1985) (application for mediation or hearing).



charged with market conduct violations to request mediation of the issues.<sup>41</sup> Washington also has a statute requiring mediation of condominium insurance claims if the claimant (either a unit owner or an association of homeowners) and the insurance company are unable to resolve the claim and one of the parties requests mediation.<sup>42</sup> Oregon has a statute that requires, upon the request of the insured, mediation of environmental claims for which insurance coverage is alleged to be applicable.<sup>43</sup> North Carolina has a statute that allows an insurer to initiate pre-litigation mediation if the insurer has “provided” the policy limits (i.e., given information to the claimant about the applicable policy’s limits of coverage) by filing a request for mediation in the court where “the action may be brought.”<sup>44</sup> A number of states also have statutes requiring that mediation be available for disputes arising out of claims decisions made by health benefit plans.<sup>45</sup>

The reasons that make mediation attractive in many kinds of civil disputes apply with equal force to insurance claims. First, mediation allows the parties to retain an objective, agreed-upon expert in the insurance law field to facilitate settlement through evaluative assessment of the parties’ arguments about the law, the pertinent coverage, and strength of the positions.<sup>46</sup> Second, the expertise of the mediator enables the assessment of the complex issues that arise when detailed policy language meets the facts.<sup>47</sup> Third, when a case is complex (perhaps involving multiple insurers, multiple policies, and many relevant facts), mediation can allow global resolutions that are more difficult and certainly more expensive to obtain in litigation.<sup>48</sup> Fourth, mediation allows insurers to pursue confidential settlements of disputes that could affect the application of policy language in a large number of cases, where adverse results in public litigation would incentivize additional litigation, including the possibility of class actions, and threaten the viability of the policy language in question throughout the market. Fifth, mediation provides insurers with an opportunity to learn more about the plaintiff’s positions, interests, and case—in other words, to engage in a kind of pre-litigation discovery.

On the other hand, situations exist where insurers are not motivated to mediate. First, low-value cases in insurance, just like low-value cases in other settings, do not provide a sufficient return on the investment needed to put the case through mediation. Second, sometimes insurers avoid mediations when multiple insurers

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41. WASH. REV. CODE ANN. § 48.37.120 (West 2007).

42. WASH. REV. CODE ANN. § 64.35.605 (West 2004).

43. OR. REV. STAT. ANN. § 465.484 (West 2013).

44. N.C. GEN. STAT. ANN. § 7A-38.3A (West 2004).

45. See, e.g., TEX. INS. CODE ANN. § 1467.051 (West 2017) (out-of-network health benefit disputes); COLO. REV. STAT. ANN. § 8-43-205 (West 1994); CA. HEALTH & SAFETY CODE § 1368 (2016) (grievances under health care services plans); N.C. GEN. STAT. ANN. § 108D-15 (West 2013) (contested cases involving disputed managed care actions).

46. See Mark J. Plumer, *Mediation of Insurance Disputes: Wise or Waste?*, LEXOLOGY (Aug. 4, 2010), <http://www.lexology.com/library/detail.aspx?g=f7230edd-2b60-4b7c-95c5-fdec5b0a735e>; see also Kenneth R. Feinberg, *Mediation—A Preferred Method of Dispute Resolution*, 16 PEPP. L. REV. S5, S13–14 (1989).

47. See *id.*; see also Irving Levinson, *Parties Should Choose Their Best Mediator*, CHI. DAILY L. BULL. (June 26, 2012), [http://www.adrsystems.com/wpcontent/uploads/2014/08/Levinson.Parties\\_Should\\_Choose\\_Their\\_Best\\_Mediator.2012.pdf](http://www.adrsystems.com/wpcontent/uploads/2014/08/Levinson.Parties_Should_Choose_Their_Best_Mediator.2012.pdf).

48. See Plumer, *supra* note 47; see Levinson, *supra* note 48; see also Greg S. Como & Spencer T. Proffitt, *Due Unto Others Applying the Golden Rule to the Problem of Insufficient Limits*, NANOPDF 44-45 (2013), [https://nanopdf.com/download/due-unto-others-applying-the-golden-rule\\_pdf](https://nanopdf.com/download/due-unto-others-applying-the-golden-rule_pdf).

are on the risk. The questions of allocation among multiple insurers are often collateral to the resolution of the underlying claim, and the prospect of a “mediation within the mediation” on the allocation issues can deter an insurer from proceeding with mediation at all.<sup>49</sup> Third, in situations where the insurer knows it will not increase its last settlement offer, perhaps because discovery is proceeding very much in the insurer’s favor or surveillance has obtained information very damaging to plaintiff’s claim, the insurer may have little interest in promoting mediation. Fourth, most liability policies in most product lines give the insurer the right to control the defense of claims asserted against the insured and to make settlement decisions (and, in some instances, to settle without the consent of the insured), and thus one would expect the insurer to be deeply interested and involved in the decision of whether to mediate. In some product lines, however, such as professional liability and directors and officers liability insurance, “indemnity only” policies are common. The insurer in these instances is likely to be less involved in the defense, and thus will be less involved in the decision whether to mediate.<sup>50</sup> Generally, however, the advantages of mediation make it an attractive method of pursuing resolution of claims not settled through informal negotiation processes, and certainly a dispute resolution alternative worth seriously considering.

## II. BASICS OF INSURANCE LITERACY: CATEGORIES AND STRUCTURE

When an insurer refuses to pay a policyholder’s claim or takes the position that the amount owed is less than what the policyholder contends is the insurer’s obligation under the insurance contract, the dispute is decided by reference to the terms of the insurance contract and the requirements of the principles of insurance law. Attempts to settle such disputes through mediation are not, of course routinely successful. One reason they can fail involves the mediator’s failure to recognize an underlying insurance issue in circumstances where the parties fail to identify or raise it.<sup>51</sup> To avoid a mediation unraveling due to lack of awareness or understanding about the insurance aspects of a case, mediators need a core level of insurance literacy, an understanding of fundamental insurance concepts, and the ability to converse in the vocabulary of the industry. The elements of this core literacy will be discussed throughout this article, but this section discusses two of the most basic ones: the types of insurance coverages mediators most commonly encounter, and the structure of the typical insurance contract.

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49. See text accompanying notes 162-66, *infra*.

50. See Wayne E. Borgeest et al., *Insurance and Mediation*, in FINANCIAL SERVICES MEDIATION ANSWER BOOK 9-2 – 9-3 (2017).

51. See Craig Meredith & Rebecca Westerfield, *Insurance Can Impact Your Mediation*, THE RECORDER (2011), <https://www.jamsadr.com/files/uploads/documents/articles/meredith-westerfield-recorder-2011-05-23.pdf> (“Many [mediations] fail unnecessarily because the case involves insurance coverage issues or disputes among multiple insurers that have not been properly developed or addressed by the date of the mediation. . . . Too often, the mediator is not advised of an insurance issue until well into the mediation and is then faced with a ‘mediation within the mediation.’ At that point, there may be no way to resolve the undeveloped coverage or allocation issues and the mediation fails.”).

### A. Categorizing Insurance

The most common ways of categorizing insurance products and the companies that sell them are by nature of the risk insured, by organizational form of the insurer, and by method of product marketing. For most purposes, categorization by risk, i.e., by the type of peril insured, is the most useful way to sort the insurance business. State insurance statutory codes sometimes have specific definitions of particular lines, and using this vocabulary can be important in some situations, but a more modern approach to categorizing insurance products by risk uses three categories: the personal lines (life, accident, health, disability), where the insurance covers a peril that implicates the well-being of the policyholder; property insurance, which insures a policyholder's interest in property or in income that depends on the existence of property; and liability insurance, which covers a policyholder's risk of being held liable to a third-party, most commonly a victim of the policyholder's tort.<sup>52</sup>

For a mediator's purposes, perhaps the most important method of categorizing insurance involves the distinction between "first-party" and "third-party" insurance, which sorts insurance by reference to the nature of the interest protected by the policy.<sup>53</sup> In first-party insurance, the insurer's promise is to indemnify the insured for *damage to an interest owned or possessed by the insured*. Thus, in first-party insurance, the loss, damage, or injury is suffered directly by the insured to an interest belonging to the insured, and the proceeds are paid to the insured (or some person designated by the insured) to compensate for the loss of or damage to that interest. Property insurance in all its variations is first-party insurance. To be able to purchase a legally valid property insurance policy, the insured must have a relationship to the property (referred to as an "insurable interest") grounded in the law of property rights or an economic interest supporting an incentive to protect the continued existence of property.<sup>54</sup> Life insurance is also first-party insurance, in that the interest protected is that held by the owner of the policy in the life of the insured (realizing that a policyholder may insure his or her own life, in which case the owner and the insured are the same person).<sup>55</sup> Other kinds of personal insurance, such as disability insurance,<sup>56</sup> accidental death and dismemberment insurance,<sup>57</sup> and health insurance,<sup>58</sup> are also first party insurance.

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52. *See id.* at 47-48.

53. *See id.* at 46-47.

54. *See id.* at 233-36.

55. The owner of a policy, who usually insures his or her own life, typically designates a beneficiary to receive the proceeds of the policy upon the owner-insured's death. When someone purchases or owns insurance on the life of another, it is common for the owner to designate himself or herself as the recipient of the proceeds upon the death of the person whose life is insured. Beneficiaries often have an interest in the insured's life, but this is not always the case. Even though third parties receive proceeds upon the death of the insured, the coverage is first-party because it is the policyholder's interest in the insured's life which is protected, with the owner being able to designate that the proceeds be paid to anyone (subject to the important qualification in many states that, for reasons of moral hazard, the owner of a policy on someone else's life can only designate as a beneficiary a person who has an insurable interest in the life of the insured). *See id.* at 287-91, 309-15.

56. *See id.* at 413-17.

57. Meredith & Westerfield, *supra* note 52, at 406-17.

58. *See id.* at 418-22. Health insurance is unique among other kinds of insurance because of the enormous government presence in the area, the social insurance dimensions of the product, and the absence of fortuity with respect to many normal coverages in health insurance plans. *See id.*; *see also* James Kwak, *Why Health Insurance Doesn't Work Like Any Other*, THE WASH. POST (May 11, 2009),

In contrast, in third-party insurance, the insurer's core promise is to indemnify the insured against *loss suffered when the insured becomes liable for injury, loss, or damage suffered by someone else (i.e., a third party)*. It is correct to observe that the insured suffers a loss whenever the insured is required to pay for someone else's damage or injury under some kind of legal obligation external to the insurance policy (such as the law of negligence).<sup>59</sup> Being legally responsible for someone else's loss will diminish one's assets, and liability insurance does protect against this kind of diminution in wealth. But the insured having assets to lose is not a prerequisite to liability insurance providing compensation for a victim's loss. The distinctive feature of liability insurance is that the contract between insured and insurer pays proceeds to unspecified and unknown third parties who might be injured in the future by the insured's conduct. This, of course, is the source of the label "third-party insurance."

In addition to liability insurance's indemnity function, liability insurance addresses another major exposure faced by insureds. Not all claims against an insured for liability to third parties are meritorious; indeed, many are, as some older liability insurance policies described them, "groundless, false, or fraudulent." For these kinds of claims, no indemnity obligation will ever come into existence; the lawsuit brought by the third-party victim alleging the insured's liability will be defeated. In these situations, however, costs, which can be sizeable, in the form of attorney fees and other legal expenses will be incurred in successfully defending the claim. One of the most important benefits of liability insurance is the insurer's promise to provide a defense for the insured against claims asserted within coverage, including when they are false, groundless, or fraudulent. Thus, liability insurance, in addition to providing compensation to third parties for losses for which the insured becomes liable by judgment or settlement, functions as "defense cost insurance" with respect to out-of-pocket expenses an insured would incur in defending against covered claims.<sup>60</sup> Indeed, in some situations the defense cost coverage is more valuable to an insured than the insurer's promise to indemnify.

The most common kinds of policies involved in disputes that go to mediation combine first-party and third-party coverages in the same insurance contract. The

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[http://voices.washingtonpost.com/hearing/2009/05/health\\_care\\_debate\\_warms\\_up.html](http://voices.washingtonpost.com/hearing/2009/05/health_care_debate_warms_up.html); Linda Gorman, *The History of Health Care Costs and Health Insurance*, WIS. POL'Y RES. INST., INC. 7 (2006), <http://www.wpri.org/WPRI-Files/Special-Reports/Reports-Documents/Vol19no10.pdf>; Edmund Haislmaier, *Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market*, THE HERITAGE FOUND. (Apr. 23, 2008), <https://www.heritage.org/health-care-reform/report/health-care-reform-design-principles-patient-centeredconsumer-based>. Because most health insurance is provided as a fringe benefit in the employment setting, the Employee Retirement Income Security Act of 1974 (ERISA) becomes relevant. 29 U.S.C. §§ 1001 et seq. ERISA preempts most state regulation of insurance provided as a fringe benefit in employment and creates an alternative remedial framework, which affects how claims are made, processed, and ultimately reviewed, all of which is relevant to the mediation of such claims. For more discussion, see Joann Dalrymple and Jennifer Danish, *Health and Disability Benefit or Insurance Claims*, in Penn & Goodman, *supra* note 77, at 141-63.

59. The fact that the insured may also suffer injury in the same event or occurrence is irrelevant, except to the extent that the insured's injury might be caused by the comparative negligence of the third party, which would offset the insured's liability to that party. Except for injury or damage for which the third party is responsible, the insured looks to the insured's first-party coverages for compensation for losses not attributable to a third party.

60. See, e.g., *D.R. Horton-Texas, Ltd. v. Markel Int'l. Ins. Co., Ltd.*, 300 S.W.3d 740, 743 (Tex. 2009) ("the duty to defend and the duty to indemnify 'are distinct and separate duties'"); *First Coast Energy, LLP v. Cincinnati Ins. Co.*, 227 F.Supp.3d 1282, 1286 (M.D. Fla. 2017) (applying Georgia law; "The duty to defend is 'separate and independent' from the insurer's duty to indemnify").

homeowners policy, for example, is a policy of first-party property insurance on the insured's home and contents combined with a general liability policy for the insured's non-automobile-related liability exposures. A renters' policy is structured the same way, except that the property coverage is on the insured's personal property, not the physical structure the insured is renting. Automobile insurance<sup>61</sup> is a package of multiple coverages, some of which are required depending on the statutory requirements of the state in which the policy is sold.<sup>62</sup> Insurance for liability for minimum prescribed amounts of bodily injury and property damage is now compulsory in every state (except one),<sup>63</sup> and thus it is correct to understand liability insurance as the major pillar of the automobile policy. An array of first-party coverages is, however, commonly contained in the auto policy as well; these include property damage to the insured's own vehicle (which is divided into two kinds of coverage—events involving an accident or collision, and non-collision events, such as weather, theft, falling trees, etc.),<sup>64</sup> uninsured motorist coverage,<sup>65</sup> underinsured motorist coverage,<sup>66</sup> and medical payments.<sup>67</sup>

As in the personal lines, combinations of first-party and third-party insurance are common in the commercial lines. Sometimes these coverages are packaged together to give an individual operating a business (whose business liabilities will be excluded from coverage in the personal forms) or the business entity the full range of needed protections. The most common arrangement, however, especially with small- and medium-sized businesses, finds the insured purchasing property coverage for business assets, commercial vehicle coverage for any vehicle-related liability exposures, and the Commercial General Liability Policy (CGL) for non-vehicular, business-related liabilities. Although the CGL is the standard general liability policy form for businesses, in recent decades the number of exclusions in the CGL has increased, and the insurance industry has opted to address a number of newly emerging kinds of liability through separate policies instead of by expanding the CGL's scope. This has required many businesses to purchase endorsements to the CGL or separate, freestanding policies to augment the coverage of the CGL.

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61. "Automobile," depending on the language of the policy, generally refers to any motor vehicle used for household transportation, including trucks, vans, and attached trailers. See Personal Auto Policy, ISO PROPERTIES, INC. 3 (2003), [https://assets.pureinsurance.com/pdfs/PURE-Auto-Policy\\_Virginia\\_170525\\_215710.pdf?mtime=20170607201335](https://assets.pureinsurance.com/pdfs/PURE-Auto-Policy_Virginia_170525_215710.pdf?mtime=20170607201335).

62. See *Facts and Statistics: Uninsured Motorists*, INS. INFO. INST., <https://www.iii.org/fact-statistic/facts-statistics-uninsured-motorists> (last visited July 2, 2018).

63. *Id.* Forty-nine states and the District of Columbia have mandatory bodily injury and property damage liability requirements. New Hampshire has a financial responsibility requirement, which is typically satisfied through the purchase of liability insurance.

64. See ROBERT H. JERRY II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 810-12 (6th ed. 2018).

65. *Id.* at 881.

66. Underinsured motorist insurance ("UIM") is closely related to uninsured motorist coverage; UIM provides bodily injury coverage when the at-fault third party's liability limits are less than limits carried by the insured. See *id.* at 850.

67. Medical payments coverage, which is mandatory in a few states, provides reimbursement for medical and hospital expenses incurred in a motor vehicle accident by the insured or any injured occupant of the insured's vehicle. It also covers the insured's expenses in circumstances where the insured is injured in an automobile incident in some other capacity (e.g., as a pedestrian or an occupant of someone else's vehicle). See *id.* at 812.

For example, the modern CGL by its terms excludes many kinds of “cyber-liabilities”;<sup>68</sup> thus, special policies or endorsements are often needed to protect a business from these kinds of risks. Similarly, exposures such as employment liability, directors and officers liability, errors and omissions in design and supervision, and pollution liability are the kinds of risks for which liability policies supplementing the CGL are frequently needed to complete a commercial entity’s risk management program.

### *B. The Structure of an Insurance Policy*

Although variation in policy forms used by different companies is common, almost all policy forms share common structural and organizational characteristics. The typical insurance policy has essentially five different components: the declarations page (sometimes called the “dec page” or “dec sheet”); definitions; the insuring agreement; exclusions; and conditions.

The declarations page is usually the first one or two pages of the policy. This page identifies the parties to the contract, any additional insureds who have the benefit of the coverage, any other payees in the event of loss (such as a mortgagee or a secured creditor), the policy’s effective date, the duration of the policy (typically called the “term” of the policy, which sets forth the time period during which the policy is in force), identification of the risks covered by the policy (such as the name of the person whose life is insured or the location of the insured property), a list of endorsements attached to the policy, the amount or the upper limit of what will be paid in the event a covered loss occurs, the amount of premium to be paid, and limitations on the insurer’s financial obligation (such as deductibles, co-payments, or coinsurance requirements).

All policies have a definitions section that lists important words and phrases in the policy and defines them. This is an extremely important section; it often provides special meanings to terms and phrases found throughout the policy. For example, the coverage provisions are likely to use terms that are specially defined in the definitions section; when this happens, the definitions function much like the coverage provisions themselves, in that the definition itself can create a boundary between what is covered and what is not. Frequently, key definitions are not located in a stand-alone definitions section; sometimes they are dispersed throughout particular coverages, and they can either be in lieu of or supplementary to what is found in the definitions section.

The insuring agreement is a statement of what the insurer promises to do for the insured. As such, it sets forth the insurance company’s core promises to indemnify (or defend, in the case of liability insurance) the insured. In first-party insurance, the policy may be phrased in language of “all risk,” under which the insurer promises to cover all losses suffered to a person or specific property except those specifically excluded. Under this formulation of the insuring agreement, all losses are covered unless specifically excluded. The alternative is referred to as “specified risk” or sometimes “named perils” coverage, where the insuring agreement states that the perils or risks specifically identified in the ensuing paragraphs are covered,

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68. See COMMERCIAL GENERAL LIABILITY COVERAGE FORM (2013), *Millers-POL CGGL1*, lines 1A2p – 1A2p2 Westlaw.

and anything not specifically listed in those paragraphs falls outside the policy's coverage.

Exclusions will ordinarily appear in a separate section after the insuring agreement, but they essentially function as a part of that agreement because they cut back on what is provided by the insuring agreement. Exclusions can be structured to operate in different ways. For example, an exclusion might exclude particular perils or causes of loss (as occurs when the policy excludes loss due to earthquake or flood, or loss due to driving while intoxicated), particular kinds of losses (such as loss due to normal wear and tear, or losses arising out of a business pursuit or workplace activity), losses occurring at a particular place (as is the case when the policy excludes losses that occur outside the United States or losses that occur when property is located outside the home), or losses to particular kinds of property (as is the case when the policy excludes, for example, jewelry, airplanes, or pets from the coverage). The term "exception" is sometimes used to describe a provision that cuts back on an exclusion, thereby bringing a risk or some portion thereof back within the coverage (hence the description of text as constituting "an exception to the exclusion"), although sometimes "exception" is used to describe language that is equivalent to an exclusion.

Conditions are provisions that require a particular fact or particular circumstances to exist as a prerequisite to coverage. These provisions run a large gamut, including such things as the premiums due having been paid, claims processing provisions (such as notice of loss, or proof of loss, or cooperation obligations) being satisfied, and the existence of an insurable interest. In addition, the conditions section also typically includes provisions that describe how the parties' obligations are to be implemented with respect to various foreseeable situations, such as the exercise of subrogation rights and paying proceeds to mortgagees or secured parties. In this respect, some conditions function as rules of conduct for the contract's performance; if these conditions are not substantially performed, or are unfulfilled in some material respect, coverage that would have otherwise existed might be discharged.<sup>69</sup>

These five components do not describe everything that might be found in an insurance policy. Endorsements are additional forms that are sometimes attached to a policy upon issuance and that modify, expand, extend, or reduce the coverage in some way. Riders are similar to endorsements, but normally the term "rider" is used to describe a document that conveys the substance of an amendment to an existing policy, which thereupon becomes a part of a policy. A binder is a temporary contract of insurance typically given to the insured at the time of application. The substance of binders varies, and sometimes they are not given at all, but the idea is that the insurer extends temporary coverage while it reviews the application and makes a decision whether to issue a permanent, or regular, policy. Binders have value to applicants during the time that an application is pending, but they also benefit the insurer, as applicants are less likely to withdraw the application or seek

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69. Under basic contract law principles, an express condition in a contract must be strictly satisfied for the conditioned duty to be due and owing, but this principle is subject to a number of mitigating doctrines. In insurance law, it is rare for strict satisfaction to be required as a prerequisite to the insurer being required to pay proceeds. Instead, to equalize bargaining power between insurers and insureds (in the ordinary insurer-consumer situation where standardized forms are almost always deployed), a materiality standard of some nature is ordinarily applied so that the insurer's duty to perform will not be excused on account of some minor nonsatisfaction of the condition.

coverage with a different insurance company if the applicant receives temporary coverage in the meantime.

### III. FRAMING THE SUBSTANCE OF INSURANCE DISPUTES DURING MEDIATION

#### A. *Interest and Position Alignment*

One of the hallmarks of mediation is that “it permits the parties to move away from the limitations of positional bargaining . . . and towards an examination of their underlying interests, which fosters an elaboration of a much wider array of acceptable, or even creative solutions.”<sup>70</sup> To aid the parties in this examination of interests and to encourage meaningful self-assessment of positions, it is incumbent on the mediator to understand if, how, and the extent to which the parties’ interests align. The starting place for understanding interest and position alignment in insurance mediation involves the distinction between first-party and third-party insurance.

##### 1. *First-party disputes*

In a first-party insurance dispute, the interests of the insured and the insurer are directly opposed; no third-party is making a claim on the proceeds in this kind of dispute.<sup>71</sup> Thus, for the mediator, the dynamic of the first-party insurance dispute is functionally equivalent to that found in any dispute between two parties, and especially to any dispute involving contract rights. Claimants in first-party insurance disputes are policyholders or persons who by virtue of some relationship to a policyholder<sup>72</sup> claim entitlement to proceeds under the policy. Generally, the interests implicated in a first-party insurance dispute are entirely monetary; the insured desires payment of proceeds, and the insurer disputes the right to proceeds or the amount claimed.

Occasionally, nonmonetary interests enter the picture. For example, in some cases an insurer’s interest may be in drawing sharp lines on what it will pay for a loss in order to deter other policyholders from making similar claims. This interest brings external considerations to bear on whether a particular insured’s claim should be paid in a particular amount. To take an example from the insured’s perspective, it is possible that the insured’s dominant interest is in having property repaired, as opposed to receiving a monetary settlement. Although the value of a repair can be measured in dollars, the fact that the insured’s actual interest is having the repairs performed opens the door to creative solutions that incorporate different means

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70. *ADR Suitability Guide (Featuring Mediation Analysis Screen)*, INT’L INST. FOR CONFLICT PREVENTION & RESOL. 19 (2001), <https://www.cpradr.org/resource-center/toolkits>.

71. Life insurance, even though third-party beneficiaries are frequently making claims on the contract made by a policyholder and an insurer, is consistent with this observation. See Meredith & Westerfield, *supra* note 52. A beneficiary, who is not a policyholder, will make a claim that is opposed to the position of the insurer, but the beneficiary occupies the status of a claimant by virtue of the policyholder’s designation of the beneficiary to receive the proceeds, which would go to the policyholder’s estate absent the designation.

72. Examples of the latter include household members who are not named insureds or individuals or firms identified under loss-payable clauses or “additional insured” clauses.



through which the desired repairs might be accomplished. In the ordinary case, however, first-party insurance disputes are about dollars, which means that disputes ordinarily present as zero-sum negotiations and not as disputes with “win-win” settlement opportunities.

Because attempted settlements of first-party insurance disputes tend to be zero-sum games, the parties’ tendencies in such disputes are to resort to positional bargaining. Absent a *bona fide* claim for bad faith liability, which creates the possibility of extracontractual liability,<sup>73</sup> policy limits set the upper boundary for what an insurer can be obligated to pay for a claim. Thus, the plaintiff’s objective is to secure the largest sum possible up to those limits, and the insurer’s aim is to limit the amount of proceeds paid, subject to the constraint that the insurer must be careful not to elevate its interests over the insured’s or to unreasonably or recklessly deprive the insured of the security for which the insurance was purchased, either of which has the potential to generate liability in excess of the policy limits.

In the first-party dispute, the parties’ positions are likely to fit within a standard configuration. The insured will allege that the insurer’s performance of its contract obligations is deficient and falls short of the insurer’s obligations under the policy. In rebuttal, the insurer will allege, perhaps in the alternative, that (a) no duty is owed the insured; or (b) the extent of any duty owed is less than that the insured demands. If the insurer claims no duty is owed, the defense will likely be framed in one or more of the following positions. First, the claim is not covered because the loss (a) is not within the policy’s coverage-granting provisions, (b) falls within an exclusion to a coverage grant, (c) did not occur during the term of the coverage, or (d) is a product of concurrent covered and excluded causes, thereby taking the loss outside the coverage. Second, the policyholder’s conduct renders the policy invalid because the policyholder (a) misrepresented a material fact at the time of the application, (b) committed fraud or false swearing during claims processing, or (c) in the case of life insurance, killed the *cestui que vie* in circumstances where the policyholder secured the policy on the life of the decedent while intending to bring about the death. Third, the nonsatisfaction of a condition discharges the insurer’s duty to perform, as when, for example, the policyholder (a) unreasonably delayed in providing the insurer with notice of a loss (which, as most jurisdictions further require, caused prejudice to the insurer); (b) submitted a defective proof of loss (which, as most jurisdictions further require, caused prejudice to the insurer); (c) materially fails to cooperate with the insurer during claims processing; or (d) fails to pay a premium when due.<sup>74</sup> This is not an exhaustive list of defenses, but it includes the most prominent categories of arguments upon which an insurer commonly relies when arguing that no duty is owed to the insured.

Some situations exist where the insurer’s argument will be framed to dispute only a portion of the insured’s claim, not the entirety of it. In this situation, the positions of the insurer and insured are coextensive with respect to a portion of the claim and are opposed on the remainder. Examples of this kind of framing include

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73. See JERRY & RICHMOND, *supra* note 65, at 147-60.

74. Under contract theory, the nonpayment of a premium may be the insured’s duty, a condition to the insurer’s duty, or both. Nonsatisfaction of the condition discharges the insurer’s duty to pay proceeds. Similarly, failure to perform the duty constitutes a material breach, which serves as the failure of a constructive condition to the insurer’s duty to pay proceeds. For more explanation, see RESTATEMENT (SECOND) OF CONTRACTS §§ 237, 241, 242 (AM. LAW INST. 1981).

the insurer's arguments that (1) the extent of the insurer's obligation has been incorrectly valued because the damage to the insured's interest has been calculated incorrectly; (2) the extent of the insurer's obligation has been incorrectly valued because overlapping coverage with policies issued by other insurers reduces the insurer's obligation more than the insured's position allows; or (3) the policy's limits operate to reduce the insurer's obligations below the amount claimed by the insured.

## 2. *Third-party disputes*

The possible alignments of interests and positions in third-party insurance disputes are more diverse and more complicated. When the liability insurer defends the insured against claims brought by a third-party, the claimant and the insured have opposing interests, and the insured's and the insurance company's interests are aligned to the extent of a shared desire to defeat or minimize the third-party's claim. Indeed, since any judgment or settlement will be paid with the insurer's money (up to the policy limits), the insurer is highly motivated to resolve claims in a manner that protects the insured's interests. A closer look, however, shows that this alignment only goes so far, and the interests of insured and insurer sometimes diverge in the third-party dispute. This divergence can have dramatic implications for the mediator's efforts to facilitate a resolution of the plaintiff's claim.

A maxim in insurance litigation is that insurance companies do not like to appear before juries. This explains why summary judgment is so important to insurance companies when claims are made directly against them and why settlement is so common when an insurer's motion for summary judgment is denied. In the first-party situation, if a settlement cannot be reached and the insured continues to pursue the claim, the insurer cannot avoid trying the case in the presence of a jury. Thus, in mediation of first-party cases, insurers are likely to be highly motivated to achieve a reasonable settlement. In third-party insurance, except in a few states where direct actions by a claimant against the insurer are permitted or in some other states where direct actions are permitted in specific situations,<sup>75</sup> the litigants who will be in the presence of a jury are the parties to the underlying dispute—the plaintiff-claimant and the insured who is alleged to have caused the plaintiff's loss. The insurer is not a party to the action. It is profoundly different to be a deep-pocket, corporate defendant in the jurors' presence than it is to be an entity in the background that, although controlling the defense and paying any resulting judgment, is out of the jurors' sight and hopefully out of their minds. Thus, the dynamic of mediation where the insurer's role presents as the liability insurer of the defendant is very different from the dynamic in first-party insurance disputes where the insurer is a defendant-party.<sup>76</sup>

75. See *Insurance Direct Action Statutes*, WESTLAW (Nov. 2017), [https://1.next.westlaw.com/Document/Icb8ddac65b5611de9b8c850332338889/View/FullText.html?transition-Type=UniqueDocItem&contextData=\(sc.Category\)&userEnteredCitation=0110+SURVEYS+16](https://1.next.westlaw.com/Document/Icb8ddac65b5611de9b8c850332338889/View/FullText.html?transition-Type=UniqueDocItem&contextData=(sc.Category)&userEnteredCitation=0110+SURVEYS+16).

76. See, Jeff Kichaven, Selected Topics in Mediating Insurance Cases, in Timothy H. Penn & Judith F. Goodman, eds., *Resolving Insurance Claim Disputes before Trial* 36 (2018) (“[I]n the typical case, what we actually have is two simultaneous mediations. One is the mediation between the third-party plaintiff and the defendant/policyholder, qua defendant, regarding liability, and the other is the mediation between the defendant/policyholder, qua policyholder, and its carrier, regarding coverage, allocation, and, ultimately, whether the two of them together can finance a settlement that the third-party plaintiff will accept”).

One way to understand the different settlement dynamic in first-and third-party insurance is to examine the nature of the insurer's duties in each category of insurance. In first-party insurance, the overarching duty of the insurer to the insured is to indemnify the insured for any loss the insured suffers to a covered interest due to a covered peril. This is the promise for which the insured bargains, and it is security that comes with protection against the consequences of covered losses that the insured seeks. In third-party insurance, the insurer's duty to indemnify the insured against financial exposure to third parties is also a coverage that the insured seeks and highly values, but unlike property insurance where the amount of damage the insured might suffer is limited by the value of the property or the insured's interest in it, or unlike life insurance where the amount of coverage provided by the insurer is stipulated in the policy, an insured's liability to third parties is potentially infinite, and thus the insured's interest in being protected against liability to third parties is likewise potentially infinite. If an insured is liable to a third party, that liability will have to be paid out of the insured's own assets; thus, liability insurance essentially protects—or indemnifies—the insured against loss that takes the form of making payments to third parties to whom, either by judgment or settlement, the insured is found to be liable.

Protection against the financial impact of settlements or judgments in a claimant's favor is not the insured's only interest protected in third-party insurance. When an individual or firm is sued, it is necessary to mount a defense—or else acquiesce in a judgment—and the expenses of a legal defense can be considerable. Even if the claim being asserted is groundless or fraudulent, the fact that the party against whom the claim is asserted will prevail and will have no obligation to pay a judgment is little consolation when it comes to the expenses incurred in defending against the claim. Thus, protection against the risk of incurring defense costs when a claim is asserted against the insured is an extremely important aspect of the coverage provided by liability insurance.

Thus, the insurer's duties in liability insurance are twofold. The insurer assumes a duty to indemnify the insured in the event the insured is held liable to a third party on a claim alleging liability within the policy's coverage. In addition, the insurer assumes a duty to defend the insured against the claim.<sup>77</sup> The sources of both duties are contractual; the insurer undertakes to indemnify and to defend by virtue of promises made in the insurance policy itself. Thus, it is fair to describe liability insurance as "litigation insurance," a kind of coverage that protects insureds against the financial costs associated with being sued, including judgments or settlements in favor of parties asserting covered claims.

In most situations, the interests of the insurer and the insured are perfectly aligned. This is because in most cases, the third-party's claim is within the policy limits and no question exists about whether the claim is covered. In settlement discussions with the claimant, the insurer is playing with its own money, and, absent a non-monetary interest that the insured wants the insurer to protect, the insured has no stake in what decisions the insurer makes about how to spend its money. The insured in these situations is very likely to acquiesce fully in the insurer's settlement decisions.

To maximize the recovery, which is ordinarily the plaintiff's overarching interest, the plaintiff will frequently seek to drive a wedge between the insurer and

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77. See *JERRY & RICHMOND*, *supra* note 65, at 750-87.

insured by exploiting points at which their interests may diverge. For example, if the plaintiff makes a claim for damages in excess of the policy limits, and then makes a settlement offer at or very near the limits, the insured's interest will be avoiding a judgment in excess of the policy limits because the insured will be personally responsible for the excess. Thus, the insured will pressure the insurer to accept the offer. If a reasonable insurer would value the claim at this amount or more, the insurer should accept that offer. However, if the insurer believes the value of the claim is below the policy limits, the insurer may desire to take the position that the settlement offer should be rejected and the claim litigated—which puts the insured at the risk of an excess judgment for which the insurer will have no responsibility. In this situation, the insurer that exercises control of the defense is playing with both its money and the insured's money. To reconcile the differing interests of the insurer and insured in this situation, courts have embraced a principle, stated in various ways in different jurisdictions, that requires the insurer to act reasonably and in good faith in response to the settlement offer by taking the insured's interest into account (such as, for example, by measuring the insurer's response against what a reasonable insurer would do if no policy limits existed), which essentially asks what a reasonable insurer would do if it were playing only with its money.

The same dynamic exists, with the same potential existing for the plaintiff to drive a wedge between the insurer's and insured's interests, if the plaintiff's complaint combines covered and noncovered claims. It is settled insurance law that the insurer owes a duty to the insured to defend the insured in lawsuits that involve a mix of covered and noncovered claims, but the insurer is not obligated to indemnify the insured for damages attributed to noncovered claims. The insured will, as with a complaint seeking a recovery in excess of the policy limits, desire that the insurer settle all claims, both covered and noncovered, for a sum within the policy limits, whereas the insurer will value its indemnity risk according to the value of the covered claims. As with the rule where a plaintiff seeks damages in excess of the policy limits, insurance law places a responsibility on the insurer to act as would a reasonable insurer in the same circumstances.

When a mediator is handling a case where the insurer's and insured's interests diverge, the mediator needs to be alert to the dynamic that inheres in what is commonly called the "tripartite relationship."<sup>78</sup> The liability insurance contract gives the insurer not only the right to control the defense but also the right to select the attorney who will represent the insured in the defense of the underlying claim. Thus, the tripartite relationship can be understood as a triangle in which the three sides consist of (a) the liability insurance policy, which constitutes a contract between the insured and the insurer—the performance of the duties on this side of the triangle are measured by reference to the terms of the insurance policy itself; (b) the contract, i.e., the retainer agreement, between the insurer and defense counsel, pursuant to which the attorney agrees with the insurer to provide legal services for a third party (the insured) for which the attorney will be compensated by the insurer; and (c) the contract, i.e., the retainer agreement, between the defense counsel and the insured under which the attorney agrees to provide legal services for the insured according to and within the limits of the retainer agreement and the insured consents to this representation in accordance with the terms in the agreement.

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78. *See id.* at 750-87.

When the plaintiff's claim is covered and within the policy limits, the insured may have no particular interest in how the defense is conducted, and thus the insured will not have reason to question defense strategy or how defense counsel performs. If, however, coverage for the plaintiff's claim is in doubt, a risk exists that damages in excess of the policy limits might be awarded, or the insured is concerned about loss history and premiums, publicity, or precedent (which is more likely to be the situation when the insured is a commercial entity), the insured has a greater stake in how defense counsel undertakes the representation. This may extend beyond questioning defense counsel's strategies and tactics to a lack of trust in defense counsel, who may seem through the insured's optic to be favoring the insurer's interests over the insured's. The mediator needs to be alert to this complex dynamic, realizing that it has implications for the positions taken in settlement negotiations and for how such negotiations may unfold.

### *B. The Roles and Implications of Intermediaries*

In the insurance business, the term "distribution channel" refers to the method through which an insurance company presents its products to the public.<sup>79</sup> Usually, insurers use intermediaries to accomplish this, and these intermediaries fit into one of two categories: (a) "captive agents," sometimes called "exclusive agents," who market only the products of one company; and (b) "independent agents," who are "brokers" with authority to sell the products of many insurers (but not the products of companies that rely on exclusive, captive agent distribution channels). Both are "agents" in the sense of the meaning of "agent" in the law of principal-agent relations (generally referred to as the "law of agency"), but captive agents typically have more authority to bind the insurance company they represent than an independent agent has with the respect to the companies that agent represents. Some companies use direct mail, the telephone, and especially the Internet to reach potential customers, and these direct-sale methods bypass the traditional intermediary distribution channel. Companies that use captive agents and direct-sales methods are called "direct writers," and companies that use brokers and managing general agents<sup>80</sup> are called "agency writers."

Whenever an intermediary becomes involved in an insurance sale or renewal, which is almost all of the time, the potential exists for any of a wide variety of legal issues to arise. Sometimes the agent or broker becomes a party to an action due to something the broker or agent did (or failed to do). Whenever the intermediary undertakes to perform services for an applicant or an insured, the intermediary owes duties to that person, and the theories under which breaches of duty by an intermediary can be asserted are varied.<sup>81</sup>

One theory is violation of the professional's duty of care, which is essentially a malpractice-oriented tort theory. Its essence is that one who holds oneself out as

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79. For more discussion, *see id.* at 56-58.

80. A "managing general agent" is a specialized kind of insurance broker who has, relative to the typical broker, some degree of underwriting authority from an insurer. This type of agency tends to be found in highly specialized lines of coverage or in geographically remote and underpopulated regions of the country where the insurer does not want to establish, typically for economic reasons, a branch or a company office. *Id.* at 201-04.

81. *Id.* at 197-224.

having professional skills is expected and obligated to perform at a level commensurate with the skills represented. A common fact pattern involves the intermediary's failure to provide adequate advice or explanation about the need for a particular coverage or policy, which causes the insured to purchase the wrong kind of coverage, and a loss occurs which would have been covered had the correct kind of coverage been purchased. Another common fact pattern involves the intermediary undertaking to acquire insurance for an individual or firm, failing to do so, and a loss occurs which would have been covered had the coverage been procured. Another theory is grounded in the law of contract: the intermediary enters into a contract with a prospective insured to acquire coverage (or a particular policy) and fails to do so, or makes a promise to procure such coverage, does not perform it, and the promisee justifiably relies on the intermediary's promise by not taking steps to procure coverage. If a loss subsequently occurs that would have been covered if the intermediary's promise had been performed, it is possible that the promisee will pursue a damage claim against the intermediary.

The fact that an agent or broker is a defendant in an action under mediation is not in and of itself remarkable, except that the mediator should recognize that an errors and omissions (E&O) policy is likely to be in the background. This policy serves as the intermediary's liability insurance policy, and the same considerations that apply in any case where liability insurance is present apply with equal force in this situation.<sup>82</sup> Thus, when claims for loss are brought directly against an intermediary for lack of fulfillment of a professional care duty or a promise, the plaintiff is seeking to obtain compensation for loss, not out of the risk pool organized by the insurance company for similarly situated insureds and their risks, but instead out of the risk pool organized by the E&O insurer that organizes similarly situated agents and brokers and insures them against the consequences of their failure to comply with professional care duties or promises made in the context of their professional activities.<sup>83</sup>

What may be pertinent when an insurance company is resisting the presence of coverage and the intermediary is not a party is the possibility that an intermediary actually sits at the vortex of the dispute. Under general agency law, an agent owes the principal a duty to serve the principal with due care and to act only within the scope of the agent's authority.<sup>84</sup> This includes obeying all reasonable instructions given by the insurer with respect to the agent's performance of its undertakings. If these duties are violated and the agent's principal is damaged as a result, the agent is liable to the principal for the damage. In the context of insurance, this means that the risk of liability to the applicant or insured is essentially shifted to the intermediary (and the intermediary's E&O insurer) when the intermediary breaches a duty

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82. One qualification to this observation is that E&O policies ordinarily contain a "consent to settle clause," which requires an insurer to seek an insured's approval prior to settling a claim for a specific amount, and some variation on what is called the "hammer clause." The hammer clause provides that if the insured does not give consent to the insurer's recommended settlement, the insurer will not be liable for additional sums needed to settle the case or for defense costs that accrue from the point after the insurer made its settlement recommendation. The consent to settle apparatus can produce significant complications in a mediation. For more on the consent to settle clause, see Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1172-85 (1990).

83. *Id.* at 1207-08.

84. See *id.* at 1205-07; Douglas R. Richmond, *Insurance Agent and Broker Liability*, 40 TORT TRIAL & INS. PRAC. L. J. 1, 56 (2004).

owed the insurer (the principal) or acts outside the intermediary's scope of authority.

Courts have recognized limits on the insurer's ability to shift the risk of liability, and this has occurred in situations other than those where the intermediary is found not to have breached a duty or not to have acted outside its scope of authority. For example, when the intermediary's breach or unauthorized act has led to coverage that the insurer would have issued anyway (i.e., the insurer would have accepted the insured's application for coverage in the absence of breach or an unauthorized act), courts have found that the intermediary's conduct did not cause the insurer's loss.<sup>85</sup> Similarly, when intermediaries' errors have led to coverage at a lower premium than what the insurer would otherwise have acquired, intermediaries have been held liable only for the difference in premium amounts.<sup>86</sup>

Simply because an insurer has a legal right to shift a loss to the intermediary does not mean that the insurer will do so. Insurers invest a great deal of time, effort, and resources in assembling an agency workforce, and the knowledge among that cohort that the insurer is seeking to saddle the agents with the costs of mistakes made in producing business is likely to lead to lower morale in the workforce, increased placement of business by brokers with other carriers, and some movement of the agents to replace their agency relationship and affiliate with other carriers instead.

The foregoing observations are relevant to a mediator in an insurance case for this reason. Although the facts might suggest an opportunity to bring an intermediary into the discussion in order to provide another resource for building a settlement solution, the insurer, despite what may appear at first glance to be another source of proceeds to contribute to a settlement amount, may strongly oppose bringing an E&O insurer into the mix for reasons related to maintaining the strength of its distribution channels. That being said, a mediator should be alert to the possibility that the conduct of an intermediary may be a contributing factor in the case being mediated, and that this may be relevant to the dynamic of the disagreement or the steps that may be available or appropriate for forging a settlement.

### C. Implications of Contested Coverage

Many different points exist at which a dispute between insurer and insured, or between third-party claimant and the insured-insurer tandem resisting the claim, can arise, but the most basic of all of them is the question of whether coverage exists. Without coverage, a loss is outside the scope of the insurer-policyholder contractual relationship, the insured receives no benefit to offset the loss, and the insurer has no obligation to pay proceeds. In many conflicts involving insurance contracts, coverage is the essence of the dispute and is preliminary to all other issues. Thus, although it is incumbent on the parties to inform the mediator well in advance of the mediation of any coverage issues that may preclude settlement, the mediator should take steps early in the communications with the parties to confirm the presence or absence of a coverage dispute. The implications of disputed coverage for a mediation are explored in this subsection.

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85. See JERRY & RICHMOND, *supra* note 65, at 206.

86. *Id.*

*1. The insurer's interests in protecting coverage language*

When an insurer loses an argument that coverage does not exist, the consequences to the insurer can go well beyond the particular case in which the argument is lost. Avoiding these consequences is very important to insurers for at least two reasons. First, insurers as rational economic actors set the contours of their risk pools and the premiums charged for admission into those pools based on careful assessment of coverage and price. Whenever a claim is made that, if allowed, would extend coverage beyond what the insurer contemplated when it determined the premium needed to be charged to pay for expected losses, cover the insurer's overhead, and allow for a reasonable profit (if a stock company), the insurer's underwriting assumptions are threatened. This means the insurer faces a risk that premiums charged will not be adequate to cover the expanded risk that accompanies an unanticipated extension of coverage. Thus, in defending against a particular claim, the insurer's interests may include defending the underwriting assumptions that apply to all policies, not just the claim made by a single insured with regard to a particular loss. This can affect the settlement dynamic of an individual case; a mediator should be alert to the possibility that protecting underwriting objectives will be one of the insurer's interests in settlement discussions.

A second reason involves the significance of a negative result for prior and subsequent claims. It is probable that an insurer that loses a case due to defeat on a coverage question took the same position on coverage in prior cases without resistance from the insureds making those claims. For the insurer, then, a risk exists that those insureds, or some subset thereof, whose claims were denied for the same reason and are not barred by a statute of limitations or a policy's contractual limitations period, will be assembled into a class that seeks to take advantage of the policyholder decision through the machinery of a class action. In this kind of case, the insurer's exposure will greatly exceed that confronted in the single case, perhaps in breathtaking proportions. In addition, insurers know that skilled counsel for policyholders will seek discovery in subsequent cases on how the insurer previously addressed coverage issues in prior cases. Thus, the precedential impact of a settlement on future cases is very important to insurers.<sup>87</sup> This potential secondary effect of a negative outcome in an individual coverage case affects the settlement dynamic in that case, and the mediator needs to be alert to this possible dynamic.

The foregoing considerations may be so significant as to affect whether an insurance dispute involving a coverage question ever reaches mediation at all. Drafting clear policy language that gives predictable results for both prior and future losses is difficult, but insurers are very good at it. In addition to the costs of developing policy language (or paying for the right to use forms drafted by insurance company associations), insurers must seek approval of regulators in the states where the insurer intends to use the forms. Thus, insurers are interested in defending policy language to which they have made commitments in underwriting and setting rates. Moreover, in most cases, insurers are confident about the meaning of policy language, and thus are not inclined to negotiate what a policy means after the loss has occurred. If the underlying facts are undisputed and the claim can be decided

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87. Confidentiality of mediation outcomes is discussed in more detail in the text accompanying notes 131-132, *infra*.



on a summary judgment motion, insurance companies are unlikely to agree voluntarily to submit a coverage dispute to mediation. Moreover, an insurer confident of its position on coverage may be interested in litigating the case in order to establish a precedent that will control future cases involving the same claim. On the other hand, if the insurer is less certain about its prospects on a coverage question, it may be interested in avoiding a negative outcome that creates a precedent for other similar claims, and thus may be more highly motivated to settle during (or before) mediation. The mediator who understands and is sensitive to this dynamic will be better able to contribute to the mediation in ways that enhance the likelihood of a successful outcome.

Given insurers' strong interest in defending their positions on the scope of coverage, it is not surprising that insurers have a very strong interest in words and defending what, from an insurer's perspective, are their "plain meaning." As a result, coverage questions that go to mediation are typically addressed in evaluative, not facilitative, mediations. Accordingly, insurers will insist on mediators with expertise in the legal principles that apply to coverage disputes (in other words, mediators who "know the coverage")—in other words, mediators who are skilled in close reading of policy text, have the experience to understand it, know (or can easily ascertain) the legal principles used in the relevant jurisdiction to determine the meaning of contracts generally and insurance policies specifically, and know the relevant case law establishing those principles. Indeed, the success of the mediator in producing a satisfactory resolution in a coverage dispute turns predominantly on the mediator's credibility as an expert interpreter of policy language. For insurers, coverage disputes have answers; these are not the kind of disputes that lend themselves to give and take among the parties in the search for a compromised meaning.

Mediations where meaning is contested are rarely simple affairs. The words of the policy, obviously, matter, but even in a contract protected by the parol evidence rule,<sup>88</sup> words do not exist in isolation. Sometimes policy language beyond that which the parties put in issue is important. In a coverage dispute, the dispute is initially framed by the opposing parties who are focusing on the application of particular language in the policy; the mediation briefs will almost certainly reference that language as part of the parties' efforts to educate the mediator and persuade the opposing side. The mediator, however, should not assume that the language upon which the parties initially focus is the policy's only relevant language. For example, definitions found in another part of a policy are often critical to understanding the disputed meaning of text, assessing the strength of the parties' positions, and ultimately determining the most likely disposition of the case if the case is not settled. Thus, the mediator should always insist on receiving a copy of the full policy, should review it in advance, and should be prepared to put any relevant questions to counsel that suggest different arguments for how the policy should be interpreted.

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88. Under the parol evidence rule, a writing that qualifies as an "integrated" agreement discharges (or preempts) prior (or contemporaneous) inconsistent agreements, and a writing that is "completely integrated" discharges (or preempts) prior (or contemporaneous) agreements within its scope, even if consistent. This essentially gives a writing primacy over oral or written agreements that one side to a dispute contends are part of the parties' overall agreement, notwithstanding the other side's claim that the writing is the parties only agreement. For more on the rule, see Lawrence A. Cunningham, *Toward a Prudential and Credibility-Centered Parol Evidence Rule*, 68 U. CIN. L. REV. 269 (2000); Eric A. Posner, *The Parol Evidence Rule, the Plain Meaning Rule, and the Principles of Contractual Interpretation*, 146 U. PA. L. REV. 533 (1998).

## 2. *Liability claims when existence of coverage is unresolved*

One of the more complex situations in insurance law involves liability claims brought by a plaintiff in a situation where coverage is disputed by the insurer and insured. In some cases, the mediator will be asked only to mediate the underlying tort case; in others, the insurer and insured may bring only the coverage issue before the mediator; and in still others, both liability and coverage will be presented to the mediator, and the mediator essentially deals with two disputes. In this latter situation, the underlying liability dispute is essentially a shell in which the coverage dispute is embedded—effectively a “mediation within a mediation.” Maneuvering through a dual mediation is especially complex and presents a number of challenges for both the parties and the mediator.

Anytime a claim is made against an insured and the insured’s coverage is in doubt, the insurer has four alternatives. One is to defend the case without reserving a right to contest coverage later. The law is settled that an insurer which defends without reservation to contest coverage later waives its coverage defenses, and taking this approach makes sense only if the insurer is willing to concede the existence of coverage. A second is to disclaim coverage and refuse to defend. This alternative makes sense only if the insurer is certain of the merit of its coverage defense. If the insurer disclaims coverage, refuses to defend, and is mistaken in its assessment of coverage, the insurer breaches the duty to defend, and severe consequences will follow. The breaching insurer, in addition to losing the ability to control the defense and settlement of the claim, will be held liable for damages that include the costs of defense, the amount of any judgment or settlement, in some jurisdictions the amount of any settlement above the policy limits, and potentially extracontractual damages for bad faith failure to defend.

A third alternative is for the insurer to initiate a separate action in which the insured is a defendant<sup>89</sup> and the insurer seeks a declaratory judgment that no coverage exists. This approach will resolve the coverage question (assuming the action proceeds to judgment), but it does not resolve what happens in the underlying action, which has no guarantee of being stayed pending the resolution of the declaratory judgment proceeding. A great deal of jurisdictional variance exists in how courts manage declaratory judgment actions when the underlying liability case is pending, but the declaratory judgment alternative is a viable option in many situations.<sup>90</sup>

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89. Whether third-party plaintiffs should be included in a declaratory judgment action as interested parties receives different answers from courts in different jurisdictions. See Shanda K. Pearson, *Insurance 101: Considerations for Declaratory Judgment Actions*, ABA: SEC. ON LITIG., INS. COVERAGE (Aug. 1, 2012), <http://apps.americanbar.org/litigation/committees/insurance/articles/mayjune2012-insurance-101.html>.

90. In some situations in some jurisdictions, insurers are allowed to proceed with a declaratory judgment action while defending the underlying action under a reservation of rights (the fourth approach). In other situations in some jurisdictions, pursuing both approaches simultaneously is prohibited. See, e.g., *Britamco Underwriters, Inc. v. Cent. Jersey Invs., Inc.*, 632 So.2d 138, 141 (Fla. Dist. Ct. App. 1994) (where facts common to coverage and underlying tort actions do not exist, insurer may litigate the coverage case at the same time the underlying liability action proceeds); *Montrose Chem. Corp. v. Super. Ct.*, 861 P.2d 1153, 1162 (Cal. 1993) (en banc; discussing appropriateness of staying action for declaratory relief pending resolution of underlying liability action). For more discussion, see Ellen S. Pryor, *The Tort Liability Regime and the Duty to Defend*, 58 MD. L. REV. 1, 24-25 (1999).

The fourth approach, and the one which is most commonly deployed, involves the insurer defending under a reservation of rights. Under this approach, the insurer appoints an attorney for the insured, and this attorney's responsibility is to defend the insured against the claims made by the plaintiff in the underlying action.<sup>91</sup> If the underlying action is successfully defended, the matter is resolved without a need for further action by either insured or insurer. If the plaintiff obtains a judgment against the insured in the underlying action, the insurer can then decide, with the advice of a second attorney whose sole responsibility is to give an opinion to the insurer about the viability of any coverage defenses, whether to initiate an action to seek a judicial declaration that coverage does not exist.

Thus, if a mediation occurs while the underlying dispute is being defended under the insurer's reservation of rights to contest coverage, two intertwined disputes are involved: the underlying action where the insured's exposure for liability and damages is at issue; and the coverage action where the question of whether the insured has access to insurance proceeds to pay any resulting liability that may be owed the plaintiff. From the perspective of plaintiff and plaintiff's counsel, two cases must be won in order to recover unless the insured is a high-asset defendant: liability must be established in the underlying dispute, and coverage must be established in the dispute between insured and insurer.

When both coverage and liability are unresolved, the mediator seeking to lead the parties to a settlement needs to be aware of a number of substantial complexities this situation presents. First and foremost, it is incumbent on the mediator to resolve the question of "who brings the authority to settle."<sup>92</sup> The insurer will retain counsel to defend the merits of the underlying suit, and evaluation of coverage will be kept separate and distinct from the defense attorney. This firewall between merits and coverage means that the separated attorneys will not communicate with each other, and they often arrive at a mediation without having sorted out negotiation strategy and settlement authority. If the mediator fails to ask about this in advance and the "two faces" of the insurer have not resolved these questions, the mediation will begin without being ready for launch. The solution is straightforward, but it is one that a mediator unfamiliar with insurance law and how insurance policies work might easily miss: in the pre-mediation phase, the mediator should ask, as part of making sure that all appropriate parties will be present and represented (or available), who will come to the mediation with settlement authority.

Beyond the question of authority, depending on what facts are disputed, the insurer's potential coverage defense may be fundamentally at odds with the insured's defense in the underlying liability action. Imagine, for example, a case in which the plaintiff alleges the insured physically injured the plaintiff. If the insured intentionally inflicted the injury, the insurer has no obligation under the policy, and thus the insurer may wish to argue intentional wrongdoing in the coverage action. But this would be inconsistent with the insured's claim that no liability is owed to

91. Jurisdictions vary in the answer to the question of who counsel represents; counsel represents the insured, but whether counsel can represent the insurer and insured as co-clients receives different answers in different jurisdictions. For more discussion, see JERRY & RICHMOND, *supra* note 65, at 752-54.

92. See E-mail from John C. Trimble, Partner, Lewis Wagner LLP, to Robert H. Jerry II, Professor of Law, University of Missouri-Columbia School of Law (July 1, 2018) (on file with author) (an experienced insurance mediator stating that "[t]he most confounding issue for counsel and for the mediator in a mediation that is a mix of coverage and merits is *who brings the authority*. Does the coverage file for the insurer decide whether to settle or does the merits side decide? There is no correct answer. It is a case by case issue"; emphasis original).

the plaintiff because the insured acted in self-defense—or even more so if the insured wishes to argue that the injury was inflicted negligently, so that the insured’s liability for damages will be covered by the policy.

How the mediator can best navigate this complexity has no obviously correct answer. However, it is critical that the mediator appreciate this dynamic. A mediator who is aware of and sensitive to it can assist the parties in making informed decisions about whether to combine the cases in mediation or to mediate them separately, in which event the question of what order in which the issues are mediated becomes important.

Because of the challenges inherent in mediating a dispute where at the outset both liability and coverage are unresolved, the mediator may wish to explore pre-mediation of the coverage controversy before mediation of the liability case begins. This avoids the possibility that the discussion of coverage will consume the first hours of the mediation, which may prevent the underlying case from having sufficient time for discussion before the allotted time for mediation is exhausted. As two experienced mediators have observed, pre-mediation may serve to “streamline the mediation of the main case by resolving the coverage and allocation issues or devising a process for doing so.”<sup>93</sup>

### *3. Claims in excess of the policy limits*

A variation on disputes in which the insurer claims that the loss is entirely outside the coverage are cases in which the plaintiff makes a claim against the insured in excess of the policy limits. Absent facts that fit within one of the rules under which extracontractual liability can be imposed on an insurer, policy limits cap the insurer’s obligation to pay proceeds, which means that a loss is not covered to the extent it exceeds the limits. That portion of a judgment or settlement exceeding the policy limits is the insured’s obligation, and the insured, absent some kind of post-judgment settlement with the plaintiff, is required to pay the excess with personal assets. The insured’s interest in avoiding a noncovered excess judgment can come into conflict with the insurer’s interest in how the claim should be defended or settled; this is because the insurer’s and insured’s non-overlapping exposures may lead to different assessments of the risks involved in taking a claim to trial.<sup>94</sup>

This does not mean that when the plaintiff’s claim is within the policy limits, all conflicts between insurer and insured disappear. However, the likelihood of conflict is greatly reduced when only the insurer’s money and none of the insured’s

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93. See Meredith & Westerfield, *supra* note 52. To illustrate, assume the insurer defends under a reservation of rights because it believes there is a 75 percent probability that it will prevail on its coverage defense. Assume further that in the plaintiff’s underlying tort action against the insured, there is a 50 percent chance of a \$100,000 verdict and a 50 percent chance of a zero verdict. The settlement value of this case should be \$50,000, but the rational insurer who perceives a 75 percent chance of prevailing in the coverage case should be willing to pay no more than \$12,500 to settle the case (assuming the absence of defense and coverage litigation costs, which will adjust the figure upward). If the insured has collectible assets, the plaintiff should not settle the case for this amount. Thus, when a plaintiff’s claim exceeds the policy limits, the insurer’s and insured’s interests in settlement are not aligned absent the application of a rule of insurance law that imposes additional liability on the insurer if it disregards the insured’s interests in settlement negotiations.

is at stake. With within-limits claims, the insured is much less likely to be concerned about how the insurer defends and resolves the lawsuit. In fact, in some cases, getting the insured's attention and cooperation when the insured has no exposure is the most difficult problem the insurer faces. In a situation where the insured's noncooperation is material and substantial, this behavior on the part of an insured can become the basis for the insurer taking the position that it owes no obligation under the policy; this is because one of the insured's promises to the insurer in the liability insurance contract is to cooperate fully with the insurer in defending the claim. This eventuality is rare, however, and the common scenario in the overwhelming number of cases involves the plaintiff making a claim within the policy limits, the insurer's and insured's interests being aligned in the defense of the claim, the insured having no conflict with the insurer as long as the settlement is within the policy limits, and the insurer attempting to settle the case as inexpensively as possible for some amount within the limits.

When the plaintiff's claim exceeds the policy limits, the calculus changes. Because the insurer's liability is capped at the policy limits, the insured, unlike the situation with within-limits claims, now has a financial stake in the outcome, and the interests of the insurer and insured are no longer coextensive. The insured does not want to litigate and run the risk of a judgment exceeding the policy limits, because the insured will be personally responsible for the excess. The insured, concerned about an excess judgment, is likely at that point to demand that the insurer offer to settle for the policy limits. The insurer, however, has maximum exposure equal to the policy limits, and as a rational economic actor is not influenced by the prospect of an excess judgment. If the insurer thinks the case for liability is weak, the insurer may prefer to litigate the case.<sup>95</sup>

Thus, the insured greatly values any settlement at or below the policy limits. When the insured's and insurer's interests are not aligned, the plaintiff, through counsel, ordinarily will seek to exploit the mismatch. For example, the plaintiff will consider making settlement demands that motivate the insured to place pressure on the insurer to settle by paying policy limits. If the insured, due to the plaintiff's pressure, finds it necessary to retain personal counsel at the insured's own expense, this will complicate the insurer's defense to some extent and increase defense costs somewhat. How defense counsel appointed by the insurer to represent the insured responds to these pressures is complicated by the fact that, although owing allegiance to the insured, the attorney's future business depends on the insurer being pleased with the attorney's conduct of the defense.

Several principles of insurance law address the complexities of this dynamic, and a description of all of them is beyond the scope of this discussion.<sup>96</sup> The most

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95. A low-limits hypothetical illustrates the point. If the insurer and insured both place the risk of a plaintiff's judgment on the question of liability at 20 percent, the policy limits are \$200,000, the plaintiff's claim if successful has a 100 percent chance of being valued at \$1 million, the insured faces a 20 percent probability of being personally responsible for \$800,000 of the judgment if the case is not settled (which equates to an expected loss of \$160,000), whereas the insurer faces maximum exposure as \$200,000 and an 80 percent probability of winning the case and having no liability (which equates to an expected loss of \$40,000). In these circumstances, the insurer, if not required to factor the insured's interests into its assessment of the claim, will be more likely to reject a settlement offer that would be reasonable from the insured's perspective and more willing to take the case to trial.

96. For more discussion, see JERRY & RICHMOND, *supra* note 65, at 750-87. See also Sharon K. Hall, *Confusion Over Conflicts of Interest: Is There A Bright Line for Insurance Defense Counsel?*, 41 DRAKE

important principle addressing claims exceeding policy limits places a duty on insurance companies to take the insured's interests into account when responding to settlement offers. This principle is variously phrased in different jurisdictions: an insurer is required to treat the insured's interests as if they were the insurer's own; the insurer must respond to settlement offers as if there are no policy limits; or the insurer must give equal weight to the insured's interests; or some similar formulation. Although nuanced differences exist among these different tests, the common theme is that the insurer, having reserved in the insurance policy the right to control settlement decisions, cannot disregard the insured's interests when making those decisions.

To summarize, the excess demand situation presents difficult challenges for the mediator in supervising the negotiation. It is important to understand that when a plaintiff makes a claim in excess of the policy limits, the interests of the insured and insurer no longer fully overlap, and this has the potential to affect the positions taken by the parties during settlement negotiations. Moreover, the likelihood that the plaintiff through counsel will seek to exploit this divergence is high. One possible option for the mediator in this situation is to create a "mediation within the mediation,"<sup>97</sup> which means taking the insurer and insured aside to engage in separate conversations about the conflicting interests in their relationship, in the hope of arriving at an agreed strategy for negotiating against the claimant.

#### *4. Consent judgments and assignment of rights*

Whenever the insured confronts the risk of an excess judgment or receives notice from its insurer that a defense will be provided under reservation because the existence of coverage is in doubt, the insured is in a perilous situation. The insured gives up control of the defense but is at risk for potentially significant liability outside the coverage or beyond the policy limits. Most courts to have considered this issue (and in one state the legislature) have recognized a mechanism through which an insured can reach an agreement with the potential plaintiff to eliminate the insured's risk.<sup>98</sup> This mechanism has no necessary relationship to mediation, and it can be deployed without regard to whether mediation is planned or expected. For purposes of this discussion, the mechanism exists as a possible "best alternative to a negotiated agreement"<sup>99</sup> for the insured. Insurers are aware of this option, and insureds know that it is available if the plaintiff is willing. This mechanism is part of the environment in which a mediation of a liability insurance claim occurs, and it is important for a mediator handling such a case to be aware of it and to understand its basic features.

The mechanism has two key elements. First, the plaintiff and the insured agree to an entry of a consent judgment in the amount of the policy limits (or higher). To

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L. REV. 731 (1992); Douglas R. Richmond, *Lost in the Eternal Triangle of Insurance Defense Ethics*, 9 GEO. J. LEGAL ETHICS 475 (1996).

97. See Samuel F. Barnum & James Laflin, *Resolving the Trilemma Within the Cumis Triangle: A Progressive Negotiation Strategy*, 10 CAL. INS. L. & REG. REP. 68 (1998); see also Jill Berkeley, *Advertisement to the Policy Limits and Beyond*, ABA: INS. COVERAGE LITIG. (2013), <http://apps.americanbar.org/litigation/committees/insurance/articles/septoct2013-beyond-policy-limits.html>.

98. For more discussion, see Douglas R. Richmond, *The Consent Judgment Quandary of Insurance Law*, 48 TORT TRIAL & INS. J. 537 (2013).

99. See note 140 *infra*.

satisfy the judgment, the plaintiff promises to execute only against insurance proceeds to which the insured is entitled and not against the insured's personal assets. Second, the insured assigns to the plaintiff all of its rights against the insurance company, including claims for bad faith. After entering into this agreement, the plaintiff ordinarily brings an equitable garnishment action against the insurer, and the coverage issues are litigated in the context of that action. From the insured's perspective, this mechanism may be the best alternative to protecting its interests: the insured essentially negotiates an agreement with the plaintiff where the plaintiff foregoes a claim against the insured's personal assets in exchange for receiving the insured's right to proceeds under the insurance policy. The consent judgment settles the insured's liability to the plaintiff, which leaves the only disputed issue as whether the claim is covered. Once executed, this agreement essentially pits the plaintiff against the insurer, with the insured—who is the party to the mediation—leaving the picture. A mediator in a case involving a coverage dispute or claim exceeding the policy limits needs to be aware that the insured may have, through the device of consent judgment and assignment of rights, an exit strategy that can be played in the midst of a mediation.

### 5. Coverage disputes outside the liability context

Coverage disputes are possible in first-party insurance disputes, but they typically have fewer complications than what commonly occurs in liability insurance. In life insurance, disputes about whether a death has occurred are extremely rare. Only in highly unusual circumstances, such as an unexplained disappearance of the insured, is it likely for the insurer and the insured's estate or beneficiaries to disagree about whether a death has occurred. Occasionally a dispute can arise about whether the insured's death resulted from suicide because such deaths are not covered under standard policy forms if they occur within two years of the policy's issuance.<sup>100</sup> Whether a beneficiary is disqualified from obtaining benefits due to participation in bringing about the insured's death is sometimes, but rarely, the basis for a dispute.<sup>101</sup> Accidental death coverage is more prone to dispute because of unresolved questions of what caused the insured's death. Similarly, claims on disability insurance policies sometimes run into the question of whether the insured is "disabled" within the meaning of the policy's language.<sup>102</sup> Property insurance disputes often involve questions of whether the damaged property fits within the policy's definition of covered property, and questions of whether a covered cause is the source of the loss are common. In these situations (and others that might be offered as examples), the dispute is bilateral (i.e., policyholder vs. insurer), and thus lacks the complexities that arise when a plaintiff, policyholder, insurer, and defense counsel are all involved in the resolution of the claim.

#### D. Validity of the Policy

Whether an insurance policy provides coverage is distinct from the question of whether the insurance policy is valid. This distinction ultimately comes from the

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100. *See id.*

101. *See JERRY & RICHMOND, supra* note 65, at 380-93.

102. *See id.* at 413-17.

structure of contract law itself, where rules divide into categories which, insofar as relevant here, determine (a) whether a contract was formed,<sup>103</sup> (b) if formed, what are the terms of the contract and what do they mean,<sup>104</sup> and (c) once formed, whether there are circumstances that render the contract invalid.<sup>105</sup> Thus, rules that address the scope of the contractual obligations are different from rules that address a contract's validity. In insurance, this distinction is important, because rules that involve scope of obligations determine the existence of coverage, whereas rules that speak to validity determine the enforceability of the contract's terms. When validity of an insurance policy is questioned, the issues essentially involve whether circumstances have arisen that justify unwinding the contract and putting the parties in the position they occupied before the policy was issued.

Validity arguments in insurance law arise in many different ways. The law of insurable interest requires the policyholder to have an insurable interest in the life or property insured as a prerequisite to the policy's validity.<sup>106</sup> At the time a person or firm seeking insurance submits an application to the insurer, the applicant is required to make a number of representations about facts and circumstances relevant to the insurer's decision whether to undertake the risk. A large body of statutory and case law address under what circumstances misrepresentations by the applicant allow the insurer to rescind a policy previously issued.<sup>107</sup> Similar issues can arise when the insurer defends against the insured's claim based on fraud,<sup>108</sup> concealment,<sup>109</sup> or the insured's breach of a warranty set forth inside the text of the policy.<sup>110</sup> A number of claims processing requirements are set forth in policies, including notice of loss provisions,<sup>111</sup> proof of loss provisions,<sup>112</sup> cooperation obligations,<sup>113</sup> and more,<sup>114</sup> and any of these can be the basis for the insurer's claim that the policy provides no coverage because of the nonoccurrence of one of these conditions to coverage. Under the reasoning that a contract will become unenforceable if its consideration fails,<sup>115</sup> the policyholder who fails to pay a premium when due will be unable to insist upon the insurer's performance if a covered loss occurs.<sup>116</sup>

Depending on the facts of the particular case, any of these insurance law subjects has the potential to become part of a dispute between the insured and the insurer, and thus any of them can make an appearance in a mediation. Although the legal principles that decide validity are different from those used to decide coverage, the stakes on a validity issue are equally important.

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103. See RESTATEMENT (SECOND) OF CONTRACTS §§ 9-110 (AM. LAW INST. 1981).

104. See *id.* §§ 200-30.

105. See *id.* §§ 151-96; 208.

106. See JERRY & RICHMOND, *supra* note 65, at 208-14.

107. See *id.* at 641-60.

108. See *id.* at 658-63.

109. See *id.*

110. See *id.* at 643.

111. See JERRY & RICHMOND, *supra* note 65, at 489-99.

112. See *id.* at 682-86.

113. See *id.* at 520-27.

114. See *id.* at 504-10.

115. See *id.* at 475.

116. See JERRY & RICHMOND, *supra* note 65, at 475-89.



*E. Valuation*

Disagreements about the pre-loss value of damaged property and the extent of loss are among the most common of all disputes in first-party insurance. The foreseeability of these disputes has resulted in most property insurance policies including an “appraisal” provision, which offers both the insurer and the insured the option to demand the use of an alternative dispute resolution procedure to resolve the valuation disagreement.<sup>117</sup> In some states, appraisal provisions are required by statute.<sup>118</sup> When one of the parties demands appraisal, the process will usually involve individuals who have expertise in property valuation and loss assessment to make a determination about the amount of loss. The result is ordinarily binding, which means the process more closely resembles arbitration than mediation. In fact, in some states, courts have held that the appraisal proceeding is subject to state statutory rules regulating insurance arbitration.<sup>119</sup>

If an insurance dispute involving a question of valuation is submitted to mediation before appraisal has been invoked, the mediator’s role is essentially to facilitate the parties’ negotiation and provide guidance and support as appropriate to encourage a settlement. For each party, an option exists to cease the settlement discussion and submit the valuation dispute to a binding process resembling arbitra-

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117. For a detailed discussion about appraisal in property insurance, see Timothy Gray, G. Brian Odom & Shannon M. O’Malley, *Benefits, Pitfalls, and Trends in Property Insurance Appraisal*, 44 BRIEF 20 (2015). In the HO-3 form published by the Insurance Services Office (ISO), the appraisal provision reads as follows:

If you and we fail to agree on the amount of loss, either may demand an appraisal of the loss.

In this event, each party will choose a competent and impartial appraiser within 20 days after receiving a written request from the other. The two appraisers will choose an umpire. If they cannot agree upon an umpire within 15 days, you or we may request that the choice be made by a judge of a court of record in the state where the “residence premises” is located. The appraisers will separately set the amount of loss.

If the appraisers submit a written report of an agreement to us, the amount agreed upon will be the amount of loss. If they fail to agree, they will submit their differences to the umpire.

A decision agreed to by any two will set the amount of loss. Each party will:

1. Pay its own appraiser; and
2. Bear the other expenses of the appraisal and the umpire equally.

In no event will an appraisal be used for the purpose of interpreting any policy provision, determining causation or determining whether any item of loss is covered under this policy. If there is an appraisal, we still retain the right to deny the claim.

*Homeowners HO 00 02 05 11 and HO 00 03 05 11*, MILLERS STANDARD INS. POLICIES ANNOTATED, 7th ed., § 1.4-F (Westlaw).

118. These states include California (CAL. INS. CODE § 2071), Connecticut (CONN. GEN. STAT. ANN. § 38a-307), Iowa (IOWA CODE ANN. § 515.109), Louisiana (LA. STAT. ANN. § 22:1311), Maine (ME. REV. STAT. tit. 24-A, § 3002), Michigan (MICH. COMP. LAWS ANN. § 500.2833), Minnesota (MINN. STAT. ANN. § 65A.01), New Hampshire (N.H. REV. STAT. § 407:22), New Jersey (N.J. STAT. ANN. § 17:36-5.20), New York (MCKINNEY’S INS. LAW § 3404), North Carolina (N.C. GEN. STAT. ANN. § 58-44-16), Oklahoma (OKLA. STAT. ANN. tit. 36, § 4803), Pennsylvania (40 PA. STAT. ANN. § 636), Rhode Island (27 R.I. GEN. LAWS ANN. § 27-5-3), and Virginia (VA. CODE ANN. § 38.2-2105).

119. See, e.g., *Giulietti v. Conn. Ins. Placement Facility*, 534 A.2d 213, 217 (Conn. 1987); see also *Covenant Ins. Co. v. Banks*, 177 Conn. 273, 279-80 (1979) (holding that state arbitration statutes apply to appraisal proceedings).

tion, which if not pursued leaves litigation as a last resort. Accordingly, the mediator in such a case needs to understand that for both parties, the best alternative to a negotiated agreement is likely to be taking the disagreement to a panel of appraisers.

In some states, statutes declare that some kinds of property insurance policies are “valued policies.” This means that when the insured property suffers a total loss (and in a few of these states, a partial loss also), the policy limits are stipulated as the value of the property and this amount (or in the event of partial loss, a pro rata amount) is paid as proceeds, assuming the loss is within coverage and the contract is not subject to an invalidating cause. Valued policy statutes do not settle questions of the existence of coverage, causation, or the timing of the loss involving the policies to which the statutes apply, but they do settle the question of how much loss was suffered by the insured.<sup>120</sup>

In addition, in other kinds of first-party insurance, such as life insurance, accidental death and dismemberment insurance, and disability insurance, the policies stipulate what the insurers will pay in the event a covered loss occurs. The term “valued policy” is reserved for property insurance policies that are subject to the valued policy statutes, but the policies in these other kinds of first-party insurance function in essentially the same way.

#### *F. Mediation Outcomes as Precedents*

In any settlement negotiation, the parties are likely to refer to judgments, verdicts, and, if known, settlements in other cases with similar facts in order to support the parties’ positions. Thus, in helping move the parties toward settlement, the mediator needs to be alert to the possibility that the outcome in the instant case might be used as a precedent in a future case, and that this fact itself might be a barrier to resolution.<sup>121</sup> This tendency applies not only to settlement amounts but also to insurers’ relinquishment of legal positions based on nonsatisfaction of conditions, defenses to coverage, and other policy terms. Insureds who are not repeat players in litigation are likely to have less concern about precedent, but many attorneys who represent the insureds will be repeat participants in litigation against insurers, and they may view certain outcomes as setting the baselines for future settlement discussions in other cases.

To reduce the risk of non-settlement due to fear of precedential impact, the mediator should stress the confidentiality that attaches to the mediation and direct the parties toward an agreement that proscribes disclosure of any of the settlement discussions or the results.<sup>122</sup> In addition, in the negotiation conversations themselves, the mediator may be able to allay the insurer’s concerns by stressing the unique features of the case and alignment of the parties’ interests that make it unlikely the circumstances will be confronted in a future dispute.<sup>123</sup>

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120. See Christine G. Barlow, *Not All Fire Insurance Policies are the Same: Valued vs. Non-Valued*, PROP. CASUALTY 360 (Dec. 12, 2016), <http://www.propertycasualty360.com/2016/12/12/not-all-fire-insurance-policies-are-the-same-value?page=2&slreturn=1501454143>.

121. See Borgeest *et al.*, *supra* note 51, at 9-38 to 9-40.

122. *Id.* at 9-39.

123. *Id.* By the same token, the mediator should be mindful of the confidentiality restrictions applicable to disputes in which the mediator has been involved in the past, as the mediator cannot offer these results as rationales for particular outcomes in the case under consideration.

### G. Implications of Insurers' Potential Bad Faith Liability

Avoiding the losing end of a claim for bad faith is among the highest priorities of any insurance company. Suits against insurance companies for bad faith performance of insurance contracts has been a prominent feature of insurance law for almost fifty years, but articulating a clear definition of “bad faith” remains elusive. Its essence involves an insurer failing to perform one of its duties to the insured without a reasonable basis for its conduct, usually with knowledge of its duties or in reckless disregard of them.<sup>124</sup> Breaching the duty can make the insurer liable for attorney fees, punitive damages, and any other damage proximately flowing from the breach, which, depending on the jurisdiction, may include emotional distress damages and, in the case of liability insurance, the amount of any excess judgment and in some jurisdictions the loss of coverage defenses.<sup>125</sup> Contract law limits a party aggrieved by a breach to recovering the value of the contract performance, a limited range of consequential damages, and punitive damages only if the breach of contract constitutes an independent tort.<sup>126</sup> In insurance law, if the insurer is determined to have acted in bad faith, the policy is essentially “uncapped” and the potential recovery for the aggrieved insured (or, in liability insurance, the plaintiff to whom the insured’s rights are assigned) is theoretically infinite. This is why some jurisdictions have placed statutory limits on extracontractual recoveries against insurers.<sup>127</sup>

In most interactions between the insurer and the insured, bad faith is not an issue.<sup>128</sup> In the context of the millions of insurer-insured interactions annually, it is rare when the insurer makes a major misstep amounting to bad faith or makes a coverage determination so plainly wrong as to suggest recklessness or deliberate disregard of the insured’s interests. If such circumstances are present, the insurer’s motivation to escape the review of the jury and settle the case is high, and the likelihood of the case being available for mediation is low. Thus, insurers rarely pay damages for bad faith (or pay punitive damages) under settlements reached in mediation. That is not to say, however, that insurers are unconcerned about the potential for bad faith liability in any insurance dispute. Wariness of bad faith liability influences insurers’ behavior in all aspects of claims processing and in settlement negotiations. In addition, the prospect of a recovery for bad faith is the driver of the decisions, behaviors, and demands of plaintiffs, who commonly strategize as to how to “set up” the insurer for vulnerability to a bad faith judgment.<sup>129</sup> In short, the insurer’s concerns about extracontractual liability will influence the positions taken by insurers in mediation, and an effective mediator needs to understand and be alert to this dynamic.

One other aspect of bad faith’s relevance to mediation deserves mention. Confidentiality of mediation discussions is a fundamental assumption of the mediation

124. See JERRY & RICHMOND, *supra* note 65, at 147-48.

125. See *id.*, at 149-51; see also Constance A. Anastopoulos, *Bad Faith: Building A House of Straw, Sticks, or Bricks*, 42 U. MEM. L. REV. 687, 699-700 (2012).

126. *Id.*

127. See Victor E. Schwartz & Christopher E. Appel, *Common-Sense Construction of Unfair Claims Settlement Statutes: Restoring the Good Faith in Bad Faith*, 58 AM. U. L. REV. 1477, 1482-94 (2009).

128. See Bruce A. Friedman, *A How-to Guide for Insurance Coverage Mediators*, LAW 360 (Apr. 15, 2013), <https://www.law360.com/articles/432554/a-how-to-guide-for-insurance-coverage-mediators>.

129. For example, see Steven Plitt & John K. Wittwer, *A Critical Review of the Practice of Setting up Insurance Companies for Bad Faith*, 31 NO. 9 CAL. TORT REP. 1 (2010).

process, and it is difficult to imagine an effective mediation process that does not embrace this premise with respect to all communications within a mediation.<sup>130</sup> Nevertheless, some parties have argued, and some courts have recently considered, the questions of whether a settlement position taken by an insurer in mediation can be used as evidence in bad faith litigation against the insurer. An affirmative answer to the question presupposes that a settlement position asserted by the insurer in bad faith falls outside the confidentiality that normally attaches to mediation.<sup>131</sup> Whether an insurer's positions in mediation that would constitute bad faith outside mediation are protected by confidentiality in subsequent litigation is an open question in many jurisdictions.<sup>132</sup> Wherever the specter of possible bad faith liability for the insurer looms, the dynamic of settlement discussions will be affected.

#### IV. PROCEDURAL ASPECTS OF MEDIATING INSURANCE DISPUTES

In addition to the various aspects of substantive insurance law that affect mediation of disputes and require the mediator's awareness and understanding, insurance has implications for the *process* of resolving disputes that similarly require the mediator's awareness and understanding.

##### *A. Timing*

A skilled lawyer in any kind of representation exercises judgment on questions of timing throughout the process, e.g., when to communicate positions, undertake investigations and request information, file motions, make demands, propose settlement, and so on. When to mediate is one of those questions, and how it is answered can make all the difference as to whether mediation will ultimately succeed.<sup>133</sup> As a general proposition, mediation is premature (i.e., less likely to succeed) if the lawyers have not done enough fact investigation to have a solid sense of the parties' interests and the strengths and weaknesses of the parties' positions. Yet waiting too long to mediate is likely to reduce the odds of a successful outcome

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130. See, e.g., *Foxgate Homeowners Ass'n, Inc. v. Bramalea California, Inc.*, 25 P.3d 1117 (Cal. App. 2001) (holding that state statute is an unqualified bar to disclosure of communications made during mediation absent an express statutory exception); Anne M. Burr, *Confidentiality in Mediation Communications: A Privilege Worth Protecting*, 57 APR DISP. RESOL. J. 64 (2002).

131. See Jay M. Zitter, *Construction and Application of State Mediation Privilege*, 32 A.L.R. 6, 285 (2008); Richard F. Ziegler, *Where Are the Risks? An Assessment of Recent Developments in Mediation Confidentiality*, 34 ALTERNATIVES TO HIGH COST LITIG. 161 (2016).

132. Ziegler, *supra* note 132, at 171-72. In an interesting twist on the issue, in *Milhouse v. Travelers Commercial Ins. Co.*, 982 F.Supp.2d 1088, 1104-09 (C.D. Cal. 2013), the court, in ruling on post-trial cross-motions for a new trial, ruled that the insured-plaintiff's objection to the admission into evidence of mediation statements offered by the insurer to disprove the plaintiff's allegations of bad faith was untimely. In a dictum, however, the court said that if the objection had been timely, it would have overruled on the ground that due process entitled the insurer to offer the statements to refute the allegations of its bad faith behavior.

133. See Dorcas Quek Anderson, Eunice Chua & Ngo Tra My, *How Shoul the Courts Know Whether a Dispute is Ready and Suitable for Mediation? An Empirical Analysis of the Singapore Courts' Referral of Civil Disputes to Mediation*, 23 Harv. Neg. L. Rev. 265 (2018) (concluding that timing of referral and the stage of litigation at the time of referral are among the most important factors affecting mediation outcomes); Rebecca Westerfield, *When is the Right Timing for a Mediation*, 22 ABTL Rpt. 1, 1 (Summer/Fall 2013) ("Timing . . . is key . . . The critical path to success in mediation should take as much focus and discipline in planning as trial strategy").

because positions tend to harden as more costs are incurred in discovery and litigation preparation and the opportunities for contentious pre-trial interactions increase.<sup>134</sup> In that circumstance, mediation is unlikely even to occur unless a court orders it.

If the parties' agreement to mediate is premature, one of the mediator's tasks will be to guide the parties through the steps they should take to get the case ready for a successful mediation.<sup>135</sup> Insurance companies are well versed in the cadence of litigation and are unlikely to err by agreeing to mediate prematurely, but court-ordered mediation could produce that situation. A review of the manner in which insurance companies process claims helps explain why insurers rarely agree to mediation prematurely. In addition, understanding the basics of insurance claims processing is helpful to any mediator handling cases involving insurance.

The processing of an insurance claim involves four steps: receipt; investigation; verification; and decision. In almost all cases, a claim first comes to the attention of the insurance company through a notification made by the insured. In first-party insurance, the insured (or in the case of life insurance, a beneficiary) will notify the insurer that a loss has happened and that a claim will be made. In third-party insurance, the insured typically is the first to notify the insurer that an occurrence has happened and that a third-party is or will soon be seeking compensation through the policy. This notification sometimes will be made to the intermediary who sold the policy, but if that happens, the intermediary will refer the insured to a claims processing department within the insurer's organization. When the notification occurs, a claim file will be established, and a number or other identifying designation will be assigned to that file.

In insurance law, a set of legal principles has developed on whether the insured's notice of loss meets the policy's condition that the notice be given "as soon as practicable," "within a reasonable time," or some similar verbiage. Insurance companies rarely deny coverage because of late notice, and in most jurisdictions the insurer will not be excused from performance unless the lack of timely notice causes prejudice to the insurer, which in most states the insurer bears the burden of proving.<sup>136</sup>

In the intake, the claim will be reduced to, most likely, a digital record, which will then result in someone in the claims processing department determining whether the insured is, in fact, an insured, and whether there is a valid policy of insurance applicable to the claim. At this point, a review will probably occur to

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134. For example, if no plan to mediate is made and one of the parties files a summary judgment motion, the filing party is probably going to decline to mediate until the court rules on the motion. Yet in some situations this may not be the case; perhaps the motion was filed in order to gain leverage in negotiation (i.e., in mediation). Alternatively, if the motion would resolve only some of the issues in dispute, mediation may be appropriate on the other issues. In other words, the tactical question for the lawyer is how much litigation risk should be incurred before mediating. See Rebecca Westerfield, *supra* n.55, at 1.

135. Having a "good sense of timing and sequencing" is often listed as a desirable quality or skill in mediators. For example, see *Improving Civil Mediation: Recommended Considerations for Civil Mediators in Private Practice*, ABA SEC. OF DISP. RESOL. (2008), [https://www.google.com/url?sa=t&rcrt=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKewiv7LDykdLdAhXC51MKHV6KCgoQFjAAegQIBBAC&url=http%3A%2F%2Fapps.americanbar.org%2Fdch%2Fthedl.cfm%3Ffilename%3D%2FDRO20600%2Fsitesofinterest\\_files%2Fmediators pamphletweb.pdf&usq=A0vVaw3g44m4eWpG-agAA32WKNr](https://www.google.com/url?sa=t&rcrt=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKewiv7LDykdLdAhXC51MKHV6KCgoQFjAAegQIBBAC&url=http%3A%2F%2Fapps.americanbar.org%2Fdch%2Fthedl.cfm%3Ffilename%3D%2FDRO20600%2Fsitesofinterest_files%2Fmediators pamphletweb.pdf&usq=A0vVaw3g44m4eWpG-agAA32WKNr).

136. See JERRY & RICHMOND, *supra* note 65, at 490-99.

assess the magnitude of the claim; if it only involves property damage and is very small, it is likely to be routed to a process that seeks to resolve it through exchanges of correspondence. If it involves bodily injury or large property damages, the claim will be assigned to an adjuster. The adjuster is the person who has responsibility to monitor the claim, investigate and evaluate it, and ultimately receives and possesses authority to settle it up to whatever amount is thought appropriate given the amount of loss and the circumstances under which it occurred.

At this point, if the claim is not a small one to be resolved through a simplified process, the adjuster will take steps to investigate the claim. The adjuster will ordinarily first take the insured's statement. In liability insurance, the adjuster will also interview the claimant and any pertinent witnesses. The adjuster will seek to collect official documents (such as accident reports) and when bodily injury is involved, records that substantiate the scope and severity of the injuries claimed.

In first party insurance, the insured will have an obligation under the policy to submit a "proof of loss," which is a sworn statement that goes into more detail about the loss than the initial notice and itemizes the particular items of property damages, the amount of the damage, and other key facts.<sup>137</sup> The proof of loss will serve as a basis for additional evaluation and investigation. In liability insurance especially, but also in first-party claims processing, the adjuster may undertake an "examination under oath" (commonly referred to as an "EUO"), which in addition to furthering the investigation serve the purposes of impressing on the parties and witnesses the importance of providing truthful information.<sup>138</sup> An EUO can also be a useful tool in challenging a proof of loss when fraud is suspected.

When all relevant, obtainable facts are gathered and the investigation is closed, the claim is valued. The process of valuing a claim is proprietary with insurers, but the factors that form the basis for the calculation are essentially the same that a factfinder (court or jury) would use in deciding what damages are appropriately awarded for the claim. Many companies now use algorithms processed by computers, and this technology-driven "data analytics" process is the core of the analysis in the valuation decision.<sup>139</sup> Normally, these algorithms establish a band in which a settlement value should land, and the adjuster uses experience and personal knowledge to arrive at a particular number. For example, the plaintiff's counsel's skill, willingness to try cases, knowledge of insurance law, ability to assert positions based on creative and novel arguments more difficult and time-consuming to rebut, and record of accomplishment influence the amount of a claim's settlement value. If this information is not captured in the data analytics (which are constantly improving<sup>140</sup>), the adjuster will factor a personal assessment into the determination of settlement value. An adjuster's authority to settle cases without seeking approval from a higher level within the company will be set at a level commensurate with the adjuster's experience. As a general rule, smaller cases are resolved at the adjuster's level; as exposures become larger, the adjuster must obtain settlement authority by working through higher levels of supervisory authority.

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137. *Id.* at 489-93.

138. *Id.* at 493-98.

139. See David Goguen, *Using Colossus Software to Calculate Settlement Value*, ALL ABOUT CAR ACCIDENTS BY NOLO, <http://www.all-about-car-accidents.com/colossus.html> (last visited Oct. 1, 2018).

140. See Scott Henck, *Using Predictive Analytics to Reduce Claim Duration and Costs*, CLAIMS J. (2016), <http://www.claimsjournal.com/news/national/2016/05/25/271106.htm>.

Insurance adjusters' behaviors carry forward the insurer's objectives in claims settlement. They are motivated to keep payouts low, but they are mindful that failure to settle will result in litigation costs for the insurer and the inability to close the reserves for the claims. Thus, adjusters seek to negotiate settlements at the lowest amounts possible that avoid the need for litigation, realizing that a point exists where litigation is a preferable alternative to a negotiated settlement.<sup>141</sup> Time is also a variable. Adjusters are assigned workload completion objectives, and they are expected to meet efficiency targets, meaning an adjuster is expected to resolve a certain number of cases in a defined period of time. Each case, however, receives its own particularized assessment, with the amount of time put into a file corresponding to the size and complexity of the file. Policy limits are always a cap on what the insurer will pay, and the settlement range will also be influenced by the assessment of the plaintiff's likelihood of recovery at trial.

In most situations, the outcome of the investigation and evaluation stages is that the claim is resolved through a process of negotiation instead of in a contested proceeding.<sup>142</sup> Numerous reasons exist for settlement being an attractive outcome to the parties in both the first-party and the third-party contexts. The insurer avoids the costs of litigation and the risk of uncertain outcomes in both contexts. In the third-party setting, the insured may not care about these risks for claims within the policy limits, but if the potential liability exceeds the policy limits, settlement gives the insured security in the face of the risk of an excess judgment. Some insureds have personal or reputational interests to protect, especially in the third-party setting, and a settlement creates an opportunity for confidentiality, including the avoidance of the public dissemination of negative information that occurs in a public trial. The litigation process is rarely speedy, and an insured or a third-party plaintiff who needs financial resources to compensate for the out-of-pocket expenses associated with a claim benefits from a settlement and quicker compensation. This "negotiation dance" normally occurs throughout the investigation and evaluation stages, and then, if no resolution emerges during those stages, proceeds in earnest when the fact gathering and evaluation is completed. As with other kinds of disputes, it is when negotiation does not produce a resolution that one or more of the parties may decide that mediation is desirable.

Given the manner in which claims processing works, insurers tend to disfavor mediation in the early stages of a dispute. It is important to insurers that investigation proceed far enough to give the insurer an informed sense of the strength of the

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141. In negotiation parlance, this is called a "BATNA" – the "best alternative to a negotiated agreement." This sets a boundary for the range in which a party is willing to agree to settle a dispute. With the insurance negotiation being, ordinarily, solely about money, the BATNA for the insurer will be litigating a case instead of settling it at a particular amount (and all amounts higher than that amount). See ROGER FISHER & WILLIAM URY, *GETTING TO YES: NEGOTIATING WITHOUT GIVING IN* 97-106 (2d ed. 1991); Russell Korobkin, *Bargaining Power as Threat of Impasse*, 87 MARQ. L. REV. 867 (2004) (explaining how "relative bargaining power stems entirely from the negotiator's ability to, explicitly or implicitly, make a single threat credible: 'I will walk away from the negotiating table without agreeing to a deal if you do not give me what I demand.'").

142. In what may still be the most significant study of the settlement of automobile insurance claims, Professor Ross concluded that "more than 95 per cent of all bodily injury claims made against insured automobile drivers are settled by negotiation. Even among those claims represented by an attorney and accompanied by formal suit papers, the majority result in negotiated settlements." H. LAURENCE ROSS, *SETTLED OUT OF COURT: THE SOCIAL PROCESS OF INSURANCE CLAIMS ADJUSTMENT* 141 (1970).

claim.<sup>143</sup> Insurers make settlement decisions based on their assessment of the known facts, how a neutral factfinder is likely to assess the facts, how the law translates the facts into a legal obligation, and the range in which the likely remedy will rest. Because insurance adjusters' job performances are evaluated based on cumulative results across cases, when the file is under-developed in an individual case, an adjuster ordinarily will be conservative in estimating the settlement range and the reservation point,<sup>144</sup> which reduces the likelihood of the existence of a bargaining zone in which a deal might be reached.<sup>145</sup> An adjuster's settlement recommendation needs written documentation and the support of factual evidence, which usually appear in the later stages of investigation. The larger the claim and the higher the demand, and the larger the amount being considered by the insurer for the settlement strategy, the more elaborate the evaluative process and the longer it takes to secure settlement authority.<sup>146</sup>

In some cases, some insurers, if they have gathered sufficient reliable information to arrive at a reasonably informed estimate of their likely exposure, are motivated to move toward mediation more quickly. In these situations, the possibility of settlement, which terminates discovery into the insured's (and sometimes the insurer's) files and depositions of the witnesses, is sufficiently attractive to outweigh the benefit of more investigation and additional evaluation of the facts.<sup>147</sup> For the insurer, the calculus compares confidence in the estimate of potential exposure based on current information (with the accompanying benefits of quick resolution) versus the benefits of increased confidence in predicting exposures gained from further investigation (and more expense and legal process). As a general rule, however, insurers are likely to have more interest in mediation when the file is more fully developed, and insurers are unlikely to submit voluntarily to mediation if the investigation is so incomplete as to impair the insurer's assessment of possible exposures.

The timing of mediation is usually controlled by the parties, but this is not the situation when mediation is court-ordered (although timing is not beyond the parties' ability to influence, realizing that many courts are sympathetic to parties' *bona fide* representations about the need for time to gather and evaluate facts before proceeding with mediation). Thus, whether by error of the parties or premature referral by a court, the potential exists for mediation to be out of step with its optimal timing,

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143. See Edward Susolik, *Insurance Strategies for Mediation and Settlement*, *ADVOCATE* (June 2013), <http://www.callahan-law.com/Articles-and-Expert-Advice/Insurance-Strategies-Advocate-June-2013.pdf>.

144. A reservation point, or reservation value, is the best offer a negotiating party will make from the perspective of the other party. For a party against whom a claim is brought, it is the highest payment the party will make to settle a claim. For a claimant, it is the smallest amount the claimant will accept to settle the claim. For more discussion, see Noah G. Susskind, *Wiggle Room: Rethinking Reservation Values in Negotiation*, 26 *OHIO ST. J. ON DISP. RESOL.* 79 (2011).

145. A bargaining zone is created when the parties' reservation points have overlapped which creates a series of points at which both sides would find a deal to be advantageous compared to no agreement. Thus, if seller is willing to sell as long as the price is \$100 or more, and the buyer is willing to buy as long as the price is \$130 or less, the bargaining zone is \$30 and a deal should be reached somewhere at or between \$100 and \$130.

146. Meredith & Westerfield, *supra* note 52.

147. Email from John Trimble, Partner, Lewis Wagner LLP, to Robert H. Jerry, II, Professor of Law, University of Missouri-Columbia School of Law (July 1, 2018) (on file with author) (experienced insurance mediator states that he is "finding insurers who are willing to get to mediation faster to avoid discovery of their files and their people" and to "take a run at settlement").



and in that situation the mediator can play a useful role in helping guide the parties' preparation for the mediation, which may make a positive outcome more likely.

Last but not least, the mediator in an insurance case should be especially mindful of the importance of giving an unsuccessful mediation a defined ending point. The flip side of the foundational premise that mediation communications are confidential<sup>148</sup> is that communications outside of mediation are not confidential and can be offered as evidence in subsequent litigation. Thus, it is important that the mediator, at the conclusion of an unsuccessful mediation, clearly identify in a writing provided to the parties the date and time when the mediation process ended. Giving the duration of the mediation a clear boundary eliminates the possibility of subsequent disagreement over whether a particular statement or communication occurred during or after the mediation, which determines whether it is protected under the cloak of confidentiality. This is especially important when the insured claims that the insurer has breached the duty of good faith in settlement discussions; settlement offers made during mediation are presumably confidential, but those made outside the context of mediation are not.<sup>149</sup>

### B. Mediator Selection and Co-Mediators

Selecting the right mediator is, obviously, a matter of great importance to the parties,<sup>150</sup> and something that is outside the mediator's control. One aspect of mediator selection may, however, be something a mediator could have reason to raise in some cases. Co-mediators<sup>151</sup> are increasingly common in mediations where multiple issues exist and call for different kinds of expertise. The manner in which co-mediators interact with each other and the parties can vary as widely as do the styles of individual mediators, but it is common in co-mediation for the mediators to focus on different aspects of the same case. In insurance cases where a coverage issue exists alongside the underlying dispute, co-mediation enables one mediator with insurance law expertise to focus on the coverage issue while a second mediator handles the question of the validity or value of the underlying claim. In low value claims where the expense of mediation is already an issue, retaining a second mediator may not satisfy the parties' return on investment calculus. Yet if the parties

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148. See Burr, *supra* note 131.

149. This is why when an unsuccessful mediation is over, the insured or the plaintiff will send the insurer a settlement demand reiterating the last offer. When an offer is made and left open for a reasonable period of time after the mediation, the insurer's refusal to settle can be used in support of a claim for bad faith failure to settle. In this instance, the basis for the claim is not what happened during the mediation but is instead what happened outside the mediation. This contrasts with merely reciting positions, offers, or rejections that happened during the mediation; this is not appropriate, as statements made during the mediation are confidential.

150. See, e.g., Peter Michaelson, *Neutral Selection: Some Guidance from a Neutral*, 32 ALTERNATIVES TO HIGH COST LITIG. 85 (2014); Arthur A. Chaykin, *Selecting the Right Mediator*, 49 DISP. RES. J. 58 (1994).

151. See Joe Epstein & Susan Epstein, *Co-Mediation*, 35 COLO. LAW. 21 (2006); Lee Rosengard, *Learning from Law Firms: Using Co-Mediation to Train New Mediators*, 59 DISP. RESOL. J. 16, 18 (2004) ("co-mediation, the use of two neutrals working together, is not unknown. It has found favor in the area of family dispute resolution, where two experienced mediators in different disciplines each bring their own expertise to the process. It has also been used in medical malpractice disputes, where lawyers from the plaintiffs' bar and the defense bar join together in assisting parties in analyzing their claims, and occasionally in highly complex commercial disputes.").

do not consider the option of co-mediation for a dispute in which it would be appropriate, it may behoove the mediator to raise the possibility of co-mediation to improve the odds of settlement.

### *C. Pre-Mediation Information Sharing*

Success in a mediation presupposes a reasonably free flow of information among the parties and the mediator. Although protection of confidences, bargaining strategies, and bottom lines are to be expected, most successful mediations involve the development of some measure of trust between the parties and with the mediator. Critical to the establishment of trust between the parties is the parties' belief that opponents are providing appropriate information to each other about claims and defenses and that the information is accurate.

Information-sharing is an important element of the mediation session itself, but information sharing begins well before the parties meet with and begin the process of supervised negotiation. This is especially important in insurance mediation, given that insurance companies make settlement decisions based on assessments of the known facts and circumstances of the case.<sup>152</sup> If an insurer has not received all requested information in the course of its investigation and claim evaluation, the insurer's settlement authority for the case will be lower, thereby reducing the likelihood of a bargaining zone where a deal can be reached. Moreover, timing is important because insurers process large case volumes, and the decisionmakers in any particular case have finite time to review the case file. It is important that the claimant give the insurer its demand well before the mediation begins, so that the insurer can assess this request in light of the information at its disposal; this is something that a mediator may need to influence if it does not happen automatically.

This counsels the mediator to encourage the parties not only to share information but also to do so well in advance of the actual mediation. This guidance applies to submission of the mediation briefs as well.<sup>153</sup> In some cases, a mediator may wish to encourage the parties to go beyond sharing and to submit joint documents. The potential benefit of this strategy is the creation of common reference points for the parties, which may help settlement discussions by building a base of mutual understandings, convincing the parties that collaborative conversations are possible, and helping the parties find a starting place on a path toward resolution.<sup>154</sup> If the mediator's monitoring of the information exchange reveals that sharing has been deficient, the mediator may need to ask the parties to revisit their positions with regard to disclosures. Alternatively, the mediator should not be reluctant to suggest the possibility of sharing information with the mediator on a confidential

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152. See Borgeest et al., *supra* note 51, at 9-9 (commenting on the information flow between defense counsel and the insurer, "[p]rior to mediation, insurers will need to understand the litigation posture, risks and costs. . . . Typically, in advance of the mediation, insurers ask for a report that details the strengths and weaknesses of the case, the procedure status, and the insured's exposure, usually in terms of potential liability and amount. Insurers may also seek a summary of fees and costs incurred to date, as well as a litigation budget going forward should the mediation prove unsuccessful . . . . If the case is significant enough, insurers may also want to review copies of key discovery documents (including deposition transcripts) and motions as well as significant legal authority that may govern future motions. Copies of the mediation briefs are also typically provided to insurers.").

153. Susolik, *supra* note 142. See Kichaven, *supra* note 77, at 38-39 (discussing preparation of briefs in mediations involving insurance).

154. *Id.*; see also Van Osselaer, *supra* note 5, at 7.

basis. The mediator, by conveying a commitment to receiving and learning what counsel wants the mediator to know and listening to how counsel thinks the mediator “can best handle the situation,”<sup>155</sup> may be able to influence counsel toward making good judgments about pre-mediation information sharing.

Although the mediator can influence information sharing, the parties acting through their lawyers have ultimate control over what information is provided to each other and to the mediator. The parties also decide what restrictions to place on the mediator’s ability to disclose information to the other side. Whatever success the mediator may have in encouraging adequate pre-mediation information sharing between the parties, the pre-mediation disclosure *to the mediator* must be adequate to enable the mediator to understand the facts, the issues in the case, the identities of the parties and their interests, and the parties’ relationships.<sup>156</sup> Thus, it is of vital importance that the mediator succeed in getting both the insurer and the insured to provide the mediator with all documents necessary to enable the mediator to prepare adequately for the settlement discussions. These will include all applicable policies and preferably a chart of policy excerpts relevant to the issues in the case. Also, this disclosure needs to occur far enough in advance of the mediation to enable the mediator to prepare adequately.

#### *D. Notice, Availability, and Nonparticipating Parties*

As a general proposition, mediation succeeds only if all the parties necessary to a settlement participate in the settlement conversation either directly or through counsel, but this proposition needs elaboration in third-party insurance disputes. The liability insurer controls the insured’s defense and settlement strategies but is not a party if the claim is litigated. Thus, when liability claims covered by insurance are mediated, all parties need to be present, and the insurer needs to be at least available for consultation. Mere availability will not be sufficient in jurisdictions

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155. Van Osselaer & Bayer, *supra* note 5, at 7.

156. *Id.* One caveat on the foregoing is that ordinarily the details regarding coverage disputes between the insurer and insured are not shared with the plaintiff claiming the insured’s liability, but how this is handled depends on the case. Sometimes the existence of a coverage dispute will influence the plaintiff to settle for a lower amount. However, copies of claims correspondence and other information about disagreements over coverage are typically not shared with the plaintiff. See Borgeest et al., *supra* note 51, at 9-22.

where the insurer's physical attendance (via a representative) is required by a procedural rule or by a local court rule.<sup>157</sup> Ordinarily, a mandatory attendance requirement, can be waived by a court<sup>158</sup> and sometimes by the mediator, but this varies by jurisdiction.<sup>159</sup>

It is often said that a representative of a liability insurer (whether primary or excess) *should* be present at every mediation, given that witnessing the mediation process helps educate the insurer about the dynamics of the case and the factors affecting settlement negotiations.<sup>160</sup> This, however, is neither practical nor expected, and it does not happen in most cases.<sup>161</sup> High-value cases provide most of the exceptions. It is critical, however, that an insurer representative with authority to make settlement decisions always be accessible throughout the mediation at least by phone. If an adjuster represents the insurance company, the adjuster will need permission from a supervisor to obtain increased settlement authority, and, thus, it is important that this supervisor be available throughout all of the mediation. One of the items on the mediator's preliminary matters checklist must be confirming that all insurers needed for a resolution will be present or easily accessible by phone.

When an insured's liability for a claim is covered by multiple insurance policies issued by various insurers, having all insurers involved is even more important.<sup>162</sup>

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157. See, e.g., FLA. R. APP. P. 9.720 (requiring attendance at mediation by “[a] representative of the insurance carrier for any insured party who is not such carrier’s outside counsel and who has full authority to settle without further consultation”); U.S. DIST. CT. RULES W.D. OKLA., LCvR16.3(b)(3) Court-Ordered Mediation (“Unless otherwise directed by the designated mediator, the following shall attend any mediation ordered by the court: . . . (3) Insurers and/or subrogors. Insurers and/or subrogors of any party shall attend the mediation.”).

158. This authority is part of the inherent authority of courts, both state and federal, to exercise discretion to manage their processes and procedures, and the cases and parties appearing before them, to ensure that judicial business is conducted so as to achieve the efficient administration of justice. See generally Daniel Meador, *Inherent Judicial Authority in the Conduct of Civil Litigation*, 73 Tex. L. Rev. 1805, 1805-08 (1995). For examples of the exercise of this discretion, see, e.g., *Novel v. Zapor*, U.S. Dist. Ct., 2015 WL 12732845 (S.D. Ohio 2015) (having previously granted motions of two defendants not to appear at mediation in person, denying motions of plaintiff and a third defendant for leave not to appear in person); *Carbino v. Ward*, 801 So.2d 1028, 1029 (Fla. App. 2001) (in upholding sanctions for non-attendance at mediation, referring to absence of arrangements made with court in advance of absence); Once attendance is ordered, the bar for obtaining a waiver is very high. See *Chancey v. Hartford Life & Acc. Ins. Co.*, 844 F.Supp.2d 1239, 1241-42 (M.D. Fla. 2011) (explaining that showing of “extraordinary circumstance” by insurer to excuse attendance is either “almost insurmountable” burden or one that outweighs “the burden on the parties, the court, and the public of losing a mediation at which each party is physically present”; also explaining that merely entertaining the requests for waiver is a burden on courts);

159. See, e.g., Local Rule 33-1(c)(1), U.S. Court of Appeals for the Eleventh Circuit (“Counsel must, except as waived by the mediator in advance of the mediation date, have the party available during the mediation”); but see *Perry v. GRP Financial*, 674 S.E.2d 780, 785-86 (N.C. App. 2009) (mediator lacked authority under court rule to excuse a party’s attendance and allow participation by phone).

160. See Borgeest et al., *supra* note 51, at 9-13.

161. This is not to say that the appearance of an insurer by phone has no consequence. As Borgeest et al. explain, “It is much easier to say no when one is thousands of miles away on a phone.” *Id.* at 9-14. In most cases, however, the representative who is present will not have unlimited settlement authority, and calls to the home office will be necessary during the course of the mediation. *Id.*

162. In the commercial setting, it is common for policyholders to have “towers” of coverage, where various insurers provide various layers of coverage. These arrangements add great complexity to a mediation and the implications can vary greatly from case to case. A plaintiff may find itself negotiating separately with several different insurer representatives. Although it is common for the excess layers to “follow the form” of the first layer, this is not always the situation, and it is possible that coverage might narrow at the higher layers. Some excess policies “attach” only when the underlying policy limits are exhausted by payment by the insurer; however, in other instances, the insurer’s payment of a portion of

Disputes over settlement responsibility are common in multiple insurer scenarios, and little is accomplished if an agreement is reached on the underlying liability, but no agreement exists on which insurers will contribute to it and in what amounts. The law is settled that when multiple insurers are liable for a judgment or settlement, an insurer who pays the judgment or settlement may seek reimbursement from a responsible insurer through equitable subrogation or contribution.<sup>163</sup> It is unlikely, however, that one or some of the insurers on the risk will agree to pay a full settlement with the understanding that they can pursue other responsible insurers for contribution or indemnity.<sup>164</sup> Thus, when a mediation with multiple responsible insurers commences, it may be wise for the mediator to get the responsible insurers either to agree that all the participating insurers are present or at least to reach an agreement on how settlement will occur in the absence of participation in the mediation of responsible insurers.<sup>165</sup> This is tantamount to setting up a “mediation within a mediation,” and this approach should be considered in a multiple insurer case if the insurers do not come to the mediation with an agreement on how settlement responsibility will be allocated.<sup>166</sup>

Mediators should be alert to the phenomenon that some insurers prefer not to attend mediations because of a concern that their presence will signal to the claimant that the case has value, thereby encouraging the claimant to set a higher reservation point or make higher settlement demands.<sup>167</sup> This concern is probably exaggerated, given that most plaintiffs know about the existence of insurance, learn about the defendant’s coverages during discovery, and in the federal courts, receive the information as part of the parties’ initial disclosures under Rule 26 of the Federal Rules of Civil Procedure.<sup>168</sup> If, however, this concern appears to be deterring the needed presence of insurance company representatives, the mediator might consider working with the parties to “order” all insurers to be physically present, which should have the effect of diluting any signal attributed to an insurer’s voluntary choice of whether to attend.<sup>169</sup>

Of course, before an insurer can pay a claim or participate in a conversation about resolving it, the insurer must know about it. Although an insured is responsible under the terms of policies for giving timely notice of a loss or claim as a condition of coverage,<sup>170</sup> this language is not needed to incentivize insureds to inform insurers of claims or losses. It is in the interests of insureds in first-party

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the limits with the remainder funded by the insured at that level is sufficient to trigger the next layer of coverage. To be effective, a mediator needs to understand how the layers are assembled, as these details will matter to which insurers are willing or can be convinced to contribute to a settlement. For more discussion, *see id.* at 9-34 to 9-38.

163. *See* 1 STEVEN PLITT & JORDAN ROSS PLITT, PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 8:2 (West 2018).

164. This is sometimes called “pay and chase”. Most insurers would prefer not to settle instead of paying and chasing. Meredith & Westerfield, *supra* note 52.

165. *See id.*

166. *CPR Mediation Procedure*, INT’L INST. FOR CONFLICT PREVENTION & RESOL., <https://www.cpradr.org/resource-center/rules/mediation/cpr-meditation-procedure> (last visited May 7, 2017).

167. *See* Borgeest et al., *supra* note 51, at 9-12 to 9-14.

168. Fed. R. Civ. Pro. 26(a)(1) on “Initial Disclosure” provides: “Except as exempted by Rule 26(a)(1)(B) or as otherwise stipulated or ordered by the court, a party must, without awaiting a discovery request, provide to the other parties: . . . (iv) for inspection and copying as under Rule 34, any insurance agreement under which an insurance business may be liable to satisfy all or part of a possible judgment in the action or to indemnify or reimburse for payments made to satisfy the judgment.”

169. *See* Borgeest et al., *supra* note 51, at 9-14.

170. *Id.*

insurance and both insureds and third-party victims in liability insurance to identify all potential sources of coverage; thus, the circumstances in which potentially responsible insurers will be unaware of a claim are rare. Also, insurers are motivated to identify any other insurers who are on the risk in order to reduce their shares of the responsibility to pay proceeds. In the liability insurance setting, it is common for plaintiffs' counsels to require a financial affidavit as a condition to settlement, which requires the insured to verify that no additional insurance policies exist that may apply to the loss.<sup>171</sup> Also, most, if not all states, have a rule of procedure that, like the corresponding federal rule, requires disclosure at the outset of litigation of all insurance policies that might provide coverage for part or all of the judgment.<sup>172</sup> In short, in most situations, it is unlikely that a potentially responsible insurer will be overlooked.

Some kinds of common fact patterns, however, carry more likelihood that a potentially responsible insurer might be overlooked. When a liability-producing event does not occur in an instant but instead occurs continuously over an interval spanning multiple policy years,<sup>173</sup> the possibility that multiple insurers are responsible for the risk increases. This type of accident can trigger coverage under multiple policies issued by different insurers in different policy periods over many years, and in these circumstances, some insurers providing coverage for the loss in question may not be notified of the claim and thus do not become involved in negotiations aimed at resolving it.<sup>174</sup> In addition, many common kinds of accidents often implicate multiple coverages from multiple insurers, and the complexity of the situation creates risk that an applicable coverage will be overlooked. A vehicular collision may seem simple, but even a simple case becomes complicated if the drivers of the vehicles are not the owners, the permission to operate one or more of the vehicles is ambiguous, the vehicle is being operated for an employer's business purposes in circumstances where the employer has multiple layers of coverage that may apply, and so on. As noted earlier, a plaintiff has a strong incentive to identify and make claims against every conceivable insurer that might provide coverage to a potential defendant, but it behooves the mediator to inquire into whether these efforts have been thoroughly pursued.

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171. Kevin J. Willging, *Liability Policy Limits: Defending the Excess Verdict Bad Faith Claim*, 11 No. 1 IN-HOUSE DEF. Q. 76 (2016).

172. See, e.g., FED. R. CIV. P. 26(a)(1).

173. Examples include a malfunctioning x-ray machine producing excess radiation exposure to its operators over an extended period of time, see *Kress v. City of Newark*, 86 A.2d 185 (N.J. 1952); a slow leak from a tank holding a toxic chemical that pollutes soil or water over an extended period of time, see *Quincy Mut. Fire Ins. Co. v. Borough of Bellmawr*, 799 A.3d 499 (N.J. 2002) (toxic chemicals in landfill leaching over time into groundwater is an accident); asbestos exposure over a long period of time, see *Plastics Engineering Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d 613 (Wis. 2009) (continuous exposure to asbestos); or exposure to sound transmissions over an extended period of time, see *DCB Const. Co., Inc. v. Travelers Indem. Co. of Ill.*, 225 F.Supp.2d 1230 (D.C. 2002).

174. This is only the beginning of the complexities that arise when multiple insurers are at risk over a period of many years. With a large exposure, disputes can arise about which policies are triggered, and the legal rules on how to allocate proceeds vary from jurisdiction to jurisdiction. Whether and how the insured should share in the allocation for any uninsured years is another matter on which rules are inconsistent. Lastly, the terms of coverage, policy limits, deductibles or self-insured retentions, and copayment requirements can change from year to year, which is relevant to which insurers are responsible for what share of a loss. Even when one insurer has issued all the policies on covered policy years, limits, deductibles, retentions, and copayment requirements can vary, which can create much complexity in determining the insurer's responsibility to pay proceeds.

In sum, if all the potentially responsible insurers are not on notice about the claim or are not aware that the case has progressed to mediation, the case is not ready for mediation.<sup>175</sup> Although claimants have good reason to pursue all available insurance coverages, it is important that the mediator inquire into whether all potentially responsible insurers are present or available. If the parties to the mediation realize once a mediation is underway that other parties who need to be involved in the settlement conversation are not present, the mediation will likely terminate; thus, the mediator's inquiry should occur at the beginning of the mediation.

### *E. Sophistication Imbalance*

That the playing field is not level in conflicts between insurers and insureds who purchase standardized forms has long been recognized. Samuel Williston, one of the most important contracts scholars of the twentieth century, famously described the insured as a “shorn lamb driven to accept whatever contract may be offered on a ‘take-it-or-leave-it’ basis.”<sup>176</sup> Beyond Williston's metaphorical use of the imagery of slaughter, signs existed in the common law in the early twentieth century that insurance contract disputes are decided with a more aggressive application of contract law rules than occurs when the dispute arises out of a contract resulting from a negotiation between parties with equal power and footing.<sup>177</sup> In the commercial world, many situations exist where sophisticated parties represented by counsel negotiate the terms of insurance coverage under conditions of equivalent bargaining power. In cases where the insured is a consumer, however, imbalance in sophistication between insurer and policyholder is virtually certain. Insurers are repeat players with expertise, and lawyers retained to represent their interests will ordinarily have considerable knowledge about the structure of insurance policies, coverage, and claims processing. Insureds rarely have such sophistication or are in a position at the point of sale to retain counsel to provide it. As a pro-policyholder advocacy group succinctly puts it, “insurance company employees are trained in negotiation, mediation, and litigation techniques and policyholders are not.”<sup>178</sup> Ideally, this imbalance is corrected in mediation when the insured is represented by a lawyer knowledgeable about the substance of insurance law and the process through which insurance disputes are resolved, but this is not assured and does not always

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175. See Meredith & Westerfield, *supra* note 52.

176. 7 SAMUEL J. WILLISTON, WILLISTON ON CONTRACTS, § 900, at 19-20 (3d ed. 1961). This is a particularly significant passage because Professor Williston was a “classicist” in the arc of contract law doctrine. He championed plain meaning and a very formal approach to the parol evidence rule, but he acknowledged the challenges of standardized forms generally and their use in insurance specifically, and he predicted that insurance law would evolve into a special kind of contract law that gave the “shorn lambs” more protections than would the ordinary rules of general contract law.

177. See 16 SAMUEL J. WILLISTON, WILLISTON ON CONTRACTS § 49:15 (4th ed. 2017) (“In other words, insurance policies, while contractual in nature, are certainly not ordinary contracts, and should not be interpreted or construed as individually bargained for, fully negotiated agreements, but should be treated as contracts of adhesion between unequal parties. This is because, except perhaps in the case of group insurance, or other policies negotiated between large companies and insurers, insurance contracts are generally not the result of the typical bargaining and negotiating processes between roughly equal parties that is the hallmark of freedom to contract”).

178. *A Policyholders Guide to Mediations*, UNITED POLICYHOLDERS, <https://www.uphelp.org/pubs/policyholders-guide-mediation> (last visited May 8, 2017).

occur. The problem is especially acute when the insured is proceeding pro se.<sup>179</sup> Concern about sophistication imbalance presumably underlies a California statute that instructs the mediator to “determine prior to the mediation conference whether the insured will be represented by counsel at the mediation.”<sup>180</sup> If the insured is represented by counsel, the insurer may be also; but “[i]f the insured is not represented by counsel at the mediation conference, then no counsel [for the insurer] may be present.”<sup>181</sup>

Sophistication imbalance in a mediation makes the mediator’s role more difficult. The unsophisticated insured’s lack of understanding means the mediator must be prepared to make some effort to explain insurance law concepts and insurance policy content to the insured and the insured’s counsel.<sup>182</sup> When the mediator suspects or knows about imbalance, among the first questions the mediator should put to the insured and counsel are queries designed to test whether that side understands the legal rules implicated in the case. These conversations will ordinarily occur in caucus to avoid reinforcing the imbalance and potentially upsetting the settlement dynamic. As for working with the insurer’s representatives, sophistication imbalance manifests itself in a different set of challenges. Insurers are normally very confident about their positions and are sometimes dismissive of positions and arguments offered by unsophisticated opponents. The mediator needs to be aware of this dynamic and prepared to engage in informed questioning to convince the sophisticated party of the need to engage fully in the negotiation conversation the mediator seeks to promote.

One possible manifestation of sophistication imbalance appears in the possibility that the insured may come into the mediation with unrealistic expectations. One important role of an insured’s counsel is to manage these expectations, but in some situations, this is extremely difficult to accomplish. For example, as explained earlier, the likelihood that an insurer will agree to pay extracontractual damages in a mediation is low. Depending on counsel’s experience, this may not be understood by plaintiff or its counsel, and thus a mediator’s guidance may be needed to shape the plaintiff’s expectations. In the third-party setting, the plaintiff may bring into the mediation an expectation that the full policy limits will be available to compensate the plaintiff’s loss, but many reasons exist why this may not be so. The policy limits will cap the plaintiff’s recovery on a claim against an insolvent or low-asset defendant, absent the presence of a basis for extracontractual recovery (which is unlikely). Yet if multiple claimants exist, prior settlements with other claimants will reduce the available limits, and even if a particular plaintiff is first in line, the insurer will likely seek a below-limits settlement in order to preserve some proceeds for other known claimants. If the plaintiff’s claim is a mix of covered and noncovered claims, the potential exists that some portion of a settlement might be allocated to noncovered claims for which the insured would have responsibility, and the insured’s financial inability to pay those claims may become relevant. Similarly,

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179. A mediator faces special challenges anytime a party in a mediation appears pro se. For more discussion, see, e.g., Michael T. Colatrella Jr., *Informed Consent in Mediation: Promoting Pro Se Parties’ Informed Settlement Choice While Honoring the Mediator’s Ethical Duties*, 15 *Cardozo J. of Conflict Res.* 705 (2014); Stephanie Klein, *Mediating, Judging with Pro Se Parties: A Balancing Act*, *Mediate.com*, Mar. 2016, at <https://www.mediate.com/articles/KleinS1.cfm> (visited Nov. 21, 2018).

180. CAL. INS. CODE § 10089.80 (West 2006).

181. *Id.*

182. See Friedman, *supra* note 129.



most plaintiffs will have a basic understanding of the notion of policy limits, but may not understand how a limit functions, i.e., whether it is an aggregate limit (for all claims arising out of all occurrences or accidents in the policy limit), an occurrence limit (which limits the proceeds available to all claimants arising out of one accident), or an individual limit (which limits the proceeds available to a single claimant arising out of one accident). In short, a plaintiff's or an insured's unrealistic expectations may arise from many different kinds of misunderstandings about insurance. The mediator needs to be mindful of this possibility and may need to manage this expectation directly or encourage the claimant's counsel to do so.

#### V. A CONCLUDING THOUGHT

Most people asked to imagine a legal relationship, event, or transaction not involving insurance in some manner have difficulty doing so. Most point to the vast majority of disputes between the state and those charged with crimes in the criminal justice system; these ordinarily do not involve insurance *directly* (the world of insurance fraud and crimes motivated by the existence of insurance notwithstanding), but many results of criminal conduct involve losses that are covered by some kind of insurance. In the world of civil law, the question is even more challenging. Examples exist, but they are far more difficult to identify than transactions that do involve insurance. Thus, now and forever, transactions will yield disputes, and most will involve insurance in some way. Those disputes will move through the levels of the “dispute resolution pyramid,”<sup>183</sup> and some of them will find their way to mediation, where a mediator will be asked to deploy dispute resolution skills in the attempt to forge an agreement between or among the parties. Insurance will not always affect the negotiations in a mediation, but when it does, positive outcomes are more likely if the mediator carries a *vade mecum* in the pocket—i.e., if the mediator has some degree of insurance literacy, realizing that insurance, even if it is not the subject of the dispute, frequently determines and propels the parties' interests, goals, and behaviors.

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183. See Richard E. Miller & Austin Sarat, *Grievances, Claims and Disputes: Assessing the Adversary Culture*, 15 LAW & SOC'Y REV. 524, 544 (1980-81) (explaining that disputes stabilize or escalate depending upon many factors, and articulating the concept of “dispute pyramid”).