Below-Limits Settlements and the Coverage Obligations of Excess Insurers – The Diminished Reach of Zeig

By: Angelo G. Savino and Matthew N. Klebanoff*

Insureds often agree to settle with one or more insurers for less than the full policy limits. In doing so, the insured obtains the certainty of coverage (even if it receives less than the full amount of coverage potentially available), the parties can avoid costly coverage litigation, and the insurer benefits to the extent that it is ultimately responsible for an amount less than the full policy limits. This situation seems to work to the benefit of all concerned except when one or more excess insurers refuse to provide coverage on the ground that the underlying insurance has not been properly exhausted as a result of the below-limits settlement.

After a series of successful challenges to the purported exhaustion of underlying policies by below-limits settlements, the tide has turned strongly in favor of excess insurers. The once bedrock case of *Zeig v. Massachusetts Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928) is increasingly being distinguished by courts (including most recently a federal district court within the Second Circuit) that are refusing to read *Zeig* for the proposition that a below-limits settlement of an underlying policy with the insured "filling the gap" (i.e. making up the difference between the full underlying policy limit and the below-limits settlement amount) automatically exhausts the underlying policy. Instead, the trend of recent cases has been to hold that below-limits settlements coupled with gap filling by insureds is insufficient to trigger coverage under excess policies.

Zeig

In *Zeig*, the insured collected less than the full limits of the underlying policy due to settlement with the underlying insurer. The excess insurer denied coverage on the ground that the below-limits settlement failed to exhaust the underlying policy. The excess policy required that the underlying insurance be "exhausted in the payment of claims to the full amount of the expressed limits."[1] The court held that the settlement exhausted the primary insurance because there was "no need of interpreting the word 'payment' as only relating to payment in cash." According to the *Zeig* court, the term "payment" is often used to mean "satisfaction of a claim by compromise, or in other ways."[2] The court held that the excess insurer's construction of the policy, in which it argued that it was necessary for the insured to actually collect the full amount of the underlying policy before excess coverage was triggered, was "unnecessarily stringent" and would only serve to inhibit settlement and promote litigation.[3] Additionally, because the excess insurer was credited for the difference between the below-limits settlement amount and the primary limits such that the excess insurer "was only called upon to pay such portion of the loss as was in excess of the [full] limits" of the primary policy, the court held that the insurer had "no rational interest" in whether the insured collected the full amount of the

Continued on page 12

*Angelo G. Savino and Matthew N. Klebanoff are attorneys in the Global Insurance Practice Group at *Cozen O'Conner*.

1 *Zeig*, 23 F.2d at 666.

2 *Id.*

3 It is common today for excess policy exhaustion language to include the condition that payment be in "cash" or "legal currency." Although not expressly recognized in any reported opinion interpreting such policy language—including cases that discuss *Zeig*—such language appears to be a response from insurers to the court's ruling in *Zeig* and its broad conceptualization of the term "payment." For instance, the following exhaustion language appears in a recent Fifth Circuit decision discussed in greater detail below: "[exhaustion occurs only after] (a) all Underlying Insurance carriers have paid *in cash* the full amount of their respective liabilities, (b) the full amount of the Underlying Insurance policies have been collected by the plaintiffs, the Insureds or the Insureds' counsel, and (c) all Underlying Insurance has been exhausted." *Citigroup, Inc. v. Federal Ins. Co.*, 649 F.3d 367, 372 (5th Cir. Aug. 5, 2011) (emphasis added).

Hypertext citation linking was created by application of West BriefTools software. BriefTools, a citation-checking and file-retrieving software, is an integral part of the Westlaw Drafting Assistant platform. West, a Thomson Reuters business is a Premier Section Sponsor of the ABA Tort Trial & Insurance Practice Section, and this software usage is implemented in connection with the Section's sponsorship and marketing agreements with West. Neither the ABA nor ABA Sections endorse non-ABA products or services. Check if you have access to West BriefTools software by contacting your Westlaw representative.

Below-Limits Settlements...

Continued from page 3

primary policy.[4] This reasoning, however, seems more grounded in matters of public policy and the *Zeig* court's subjective sense of fairness rather than in the language of the insurance contract.

The flip-side of *Zeig*, and what is increasingly being recognized by courts across the country, is that when the exhaustion language of an excess policy is clear, the underlying policy will not be deemed fully exhausted when the parties settle for less than the full policy limits. As many courts have pointed out, the Second Circuit expressly acknowledged as much in *Zeig*.[5] In recent years, a trend has developed in which courts are finding standard excess policy exhaustion language to be unambiguous and are requiring that underlying insurance be exhausted by actual payment (up to the policy limits) of an underlying insurer before the excess policy attaches.

Citigroup

A recent decision from the U.S. Court of Appeals for the Fifth Circuit illustrates the typical method of inquiry that courts take to determine proper exhaustion of underlying insurance. In *Citigroup, Inc. v. Federal Ins. Co.*, 649 F.3d 367 (5th Cir. Aug. 5, 2011) (Texas law), the court held that certain excess D&O policies were never triggered because the underlying insurance was not properly exhausted pursuant to the terms of the excess policies' unambiguous exhaustion language. The *Citigroup* decision marks the second occasion that a federal appellate court has expressly limited the scope and application of *Zeig*.[6] In *Citigroup*, the court held that the excess policies' exhaustion language unambiguously required that the primary insurer actually pay its full limit of liability before the excess coverage would be triggered. The court determined that the insured's below-limits settlement failed properly to exhaust the underlying insurance under the terms of all four excess policies at issue.

Citigroup, the insured, had a fairly sophisticated insurance program consisting of three layers of "integrated risk" coverage issued by ten insurers that provided a total of $200 million in coverage. It had (1) a $50 million primary policy, (2) $50 million in second-layer excess coverage (made up of two $25 million policies), and (3) $100 million in third-layer excess quota-share liability coverage issued by several insurers.

Citigroup sought coverage for two underlying actions in which the plaintiffs alleged violations of the California Unfair Business Practices Act (as well as various common law counts for fraud and misrepresentation), and another action filed by the Federal Trade Commission alleging violations of various truth in lending statutes.[7] Citigroup eventually settled the underlying actions for $240 million after incurring $23 million in defense costs. All of the insurers initially denied coverage, but Citigroup and the primary insurer later entered into a settlement whereby the primary insurer paid Citigroup $15 million of its $50 million limit of liability in exchange for a release from all claims. Citigroup then filed suit in Texas state court against its excess insurers. The suit was removed to federal court. Though Citigroup initially filed suit against all excess insurers, it later settled with the two second-layer excess carriers for undisclosed amounts.[8] At the end of the day, Citigroup gave up $35 million in primary coverage and an undisclosed portion of the second excess layer by way of the settlements, as well as all $100 million in third-layer excess coverage as a result of the coverage action.

Because the exhaustion language of the excess policies at issue differed, each policy was examined separately to determine whether it unambiguously precluded coverage as a result of the insured's below-limits settlement. One excess policy provided that coverage attached only after "(a) all Underlying Insurance carriers have paid in cash the full amount of their respective liabilities, (b) the full amount of the Underlying Insurance policies have been collected by the plaintiffs, the Insureds or the Insureds' counsel, and (c) all Underlying Insurance has

4 *Id.*

5 *See id.* at 666 ("It is doubtless true that the parties could impose such a condition precedent [of actual collection of the full amount of underlying insurance] to liability upon the policy, if they chose to do so.").

6 In *U.S. Fire Ins. Co. v. Lay*, 577 F.2d 421 (7th Cir. 1978), the court held that an insured's below-limits settlement with its primary insurer discharged any obligation owed by an excess insurer. Rejecting the insured's reliance on *Zeig*, and notwithstanding policy language providing that the excess insurer's liability would not attach "unless and until the insured, the company in behalf [sic] of the insured, or the insured's underlying insurer, has paid the amount of the retained limit." *Id.* at 423. The court explained as follows:

> We can conceive of good reasons for an excess carrier to be unwilling to accept liability unless the amount of the primary policy has actually been paid. A settlement for less than the primary limit that imposed liability on the excess carrier would remove the incentive of the primary insurer to defend in good faith or to discharge its duty, to represent the interests of the excess carrier.

Id. The *Lay* decision, however, never gained much traction in the courts, and is rarely discussed.

7 *Citigroup*, 649 F.3d 367.

8 Additionally, its claims against two of the third-layer quota-share excess carriers proceeded to arbitration and were stayed pending the *Citigroup* court's ruling. Citigroup's claims against another third-layer excess carrier were time-barred.

been exhausted." The court held that the policy "clearly explains that exhaustion occurs through payment, in cash, and of the full amount of the underlying insurer's limit of liability."[9] The court found it particularly revealing that part (b) referred to the "full amount" of the underlying insurer's limit of liability, and that if liability attached for a below-limits settlement, such language would be rendered meaningless.[10]

Similarly, one of the other excess policies provided that: "The Insurer shall only be liable to make payment under this policy after the total amount of the Underlying Limit of Liability has been paid in legal currency by the insurers of the Underlying Insurance as covered loss thereunder." As with the first excess policy, the court found that the policy unambiguously provided for how the underlying policy was to be exhausted—namely, through payment in the "total" amount of the limit of liability paid in legal currency.[11]

The exhaustion language in a third policy, which provided that coverage attached "only after any Insurer subscribing to any Underlying Policy shall have agreed to pay or have been held liable to pay the full amount of its respective limits of liability as set forth in Item 5. of the Declarations," was also determined to be unambiguous.[12] The court held that because the primary insurer paid the insured "less than the 'full amount' of its $50 million limit of liability," the primary insurance was not exhausted and thus coverage under the excess policy was not triggered. Again, the "full amount" language was deemed significant.

The fourth policy provided that coverage would attach "in the event of the exhaustion of all of the limit(s) of liability of such 'Underlying Insurance' solely as a result of payment of loss thereunder." The insured argued that exhaustion occurred upon the payment of *any* loss (*i.e.* $15 million out of $50 million in primary coverage). The court disagreed, explaining that:

> similar to the other policies, the Steadfast policy requires that "all" of the underlying insurer's limits of liability be exhausted before coverage attaches. Thus, settlement for less than the underlying insurer's limits of liability does not exhaust the underlying policy. *See Utica Nat'l Ins. Co. of Tex., 141 S.W.3d at 202*; *see generally Qualcomm, Inc., 73 Cal. Rptr 3d at 778-79*. Furthermore, the use of the phrase "payment of loss" establishes that the underlying insurer must make *actual* payment to the insured in order to exhaust the underlying policy. Although not binding on this court, the district court's reasoning in *Comerica v. Zurich American Insurance Co., 498 F. Supp. 2d 1019 (E.D. Mich. 2007)*, is persuasive and supports our interpretation. In *Comerica*, the district court interpreted the phrase "payment of losses" to mean that *actual* payment of losses by the underlying insurer was necessary to trigger the excess coverage. The district court noted that "settlements that extinguish liability up to the primary insurer's limits, and agreements to give the excess insurer 'credit' against a judgment or settlement up to the primary insurer's liability limit are not the same as *actual* payment." *Id.* at 1032 (emphasis added). Thus, the district court concluded in *Comerica* that, when a policy requires "payment" to trigger coverage, actual payment must be made, and settlement does not meet this requirement. *Id.*[13]

The court went on to hold that because the policy required the insurer to make a payment equal to "all" of the underlying insurers' limits of liability, the settlement for less than $50 million did not trigger the excess insurer's policy. Accordingly, the Fifth Circuit affirmed the district court's grant of summary judgment in favor of the excess insurers due to the lack of exhaustion of the underlying primary insurance under the unambiguous exhaustion language of all four excess policies.

Comerica

As noted above, the Fifth Circuit in *Citigroup* relied heavily on *Comerica, Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019 (E.D. Mich. 2007) to support its own exhaustion analysis. In *Comerica*, the insured bank, Comerica, settled various securities fraud class action lawsuits for $21 million. Comerica was insured under a primary policy with limits of $20 million, and under an excess policy also with limits of $20 million. Initially, the primary carrier disputed coverage for several

9 *Id.* at 372.

10 Notably, the exhaustion language at issue in *Zeig* also contained the "full amount" terminology that the *Citigroup* court found to be significant. *See Zeig*, 23 F.2d at 666 (requiring underlying insurance be "exhausted in the payment of claims to the *full amount* of the expressed limits") (emphasis added). *Zeig* also recognized that other cases had construed this term to require collection of the full primary limits but rejected a construction it deemed too "burdensome" to the insured. *Id.*

11 *Id.*

12 *Id.*

13 *Citigroup*, 649 F.3d at 373.

reasons, but ultimately agreed to indemnify Comerica in the amount of $14 million as a compromise, which the parties agreed would fully exhaust the primary policy. Comerica made up the remaining $6 million of the primary layer, and then turned to its excess carrier for reimbursement of the remaining $1 million it paid in settlement plus an additional $2.6 million it paid in defense costs. The excess insurer, however, refused to indemnify Comerica for two reasons. First, the excess carrier took the position that the damages alleged in the underlying complaints under the Securities Act of 1933 were not covered under the terms of the primary policy, and therefore were not covered under the terms of the follow-form excess policy. Second, the excess insurer asserted that the primary insurance had not been properly exhausted.

Comerica initiated coverage litigation against its excess insurer. The excess policy contained the following exhaustion provision:

> [The excess] policy does not provide coverage for any loss not covered by the "Underlying Insurance" except and to the extent that such loss is not paid under the "Underlying Insurance" solely by reason of the reduction or exhaustion of the available "Underlying Insurance" through payments of loss thereunder. [14]

As part of the settlement of the underlying primary policy, the primary insurer agreed to pay $14 million "towards the settlement of the underlying litigation," and it was further agreed that "the [primary] policy shall be deemed fully exhausted and is null and void and has no force or effect whatsoever."[15] The court, applying Michigan law, held that the excess policy's exhaustion language was unambiguous, and agreed with the excess insurer that the primary policy had not been properly exhausted due to a lack of actual payment of losses by the primary insurer. Therefore, the court granted summary judgment to the excess insurer.

Comerica raised three arguments, all of which the district court rejected. First, the court disagreed with Comerica's position that the excess insurer repudiated its contract when it asserted that that the securities claims were not covered under the terms of its policy. Comerica argued that it was justified in settling the underlying suits as it saw fit, thus excusing Comerica from meeting the excess policy's exhaustion requirement. The court held that the excess insurer's position was more accurately characterized as "a belief that Comerica had not yet fulfilled the condition precedent" of exhaustion, and that the excess insurer's position that the claims were not covered did not amount to an "absolute and unequivocal declaration of an intention not to perform." Most importantly, though, the court concluded that the excess insurer's alleged repudiation did not cause Comerica's failure to exhaust its primary policy. Instead, the court concluded that the primary insurer's coverage arguments and refusal to pay its limits caused Comerica not to fulfill the exhaustion requirement by seeking a compromise.

Second, the court rejected Comerica's *Zeig*-based public policy argument that the excess insurer should be required to pay for any amounts above the $20 million primary layer (*i.e.* after Comerica had made up the $6 million gap) because to hold otherwise would cause delay, inhibit settlements, and encourage litigation. Comerica, relying on *Zeig*, insisted that its own payment "filled the gap" and served as the "functional equivalent of exhausting the primary policy limit" because the excess insurer would not be exposed to any greater liability than if the primary insurer had paid its full limit of liability. The court pointed out, however, that the cases that follow *Zeig* generally rely on an ambiguity in the definition of "exhaustion" or a lack of specificity in the excess policy as to how the primary insurance is to be exhausted.

In contrast, the court explained that a different result occurs in cases when policy language addressing exhaustion is more specific as to how underlying insurance is to be exhausted.[16] The court held that the policy language at issue in *Comerica* unambiguously required that "the primary insurance be exhausted or depleted by the actual payment of losses by the underlying insurer."[17]

---

14 *Comerica*, 498 F. Supp. 2d at 1032.

15 *Id.* at 1025-26.

16 *See id.* at 1031 (citing *Danbeck v. Am. Family Mut. Ins. Co.*, 629 N.W.2d 150 (Wis. 2001) ("While the 'settlement plus credit' approach to exhaustion has the same practical effect as payment of full policy limits, it is not consistent with the plain language of the policy, which unambiguously requires exhaustion '*by payment of judgements* [sic] *or settlements*,' not 'settlement plus credit.'") (emphasis in original); *Wright v. Newman*, 598 F. Supp. 1178 (D. Mo. 1984) (holding that exhaustion language requiring underlying insurers to "have admitted liability for . . . their Limit(s) or unless and until . . . and only after the [underlying insurers] have paid or been held liable to pay the full amount of . . . their Limit(s)" required exhaustion by actual payment)).

17 As part of its analysis, the *Comerica* court stated that "[i]n *Zeig*, an excess insurance contract required that the underlying policy be exhausted but was silent about whether the full amount of the underlying policy needed to be collected or actually paid out before the excess policy was triggered." *Id.* at 1029. However, a closer look reveals that the excess policy in *Zeig* required that the underlying insurance be "exhausted *in the payment of claims to the full amount of the expressed limits*." *Zeig*, 23 F.2d at 666 (emphasis added). Instead, it appears that the *Zeig* court made a policy-based decision that it was fairer to permit the insured to enter a below-limits settlement and then fill the gap rather than to enforce this language of the excess policy.

Significantly, the court characterized Comerica's election to enter into a below-limits settlement with its primary carrier as a deliberate strategic decision. The court pointed out that Comerica could have litigated its coverage dispute with its primary carrier, which could have resulted in Comerica losing all coverage or could have resulted in Comerica securing the full amount and benefit of its primary coverage. As the court aptly explained:

> Comerica seeks the certainty that its settlement brought and the benefit of coverage from its excess carrier as if it had won its dispute with the primary insurer, despite language in the excess policy to the contrary. No public policy argument says that Comerica may have its cake and eat it too.

Finally, the court rejected Comerica's argument that the Insuring Agreement of the excess policy rendered the policy's "exhaustion by payment of loss" requirement ambiguous. The Insuring Agreement stated:

> The Insurer shall provide the Insured(s) with excess insurance coverage over the Underlying Insurance as set forth in Item 3. of the Declarations during the Policy Period set forth in Item 4. of the Declarations.[19]

According to Comerica, because the foregoing provision contained no instruction or requirement that the primary insurer itself must pay losses, such an omission rendered the policy's exhaustion requirement ambiguous. The court disagreed, explaining that the parties "could not have been clearer about their intentions" that exhaustion must occur "solely . . . through payments of loss thereunder."[20]

Finally, the court concluded that Comerica's reliance on other policy provisions that allowed Comerica to fill the gap in certain instances (such as insurer insolvency, misalignment of policy periods or lapsed insurance) actually *undermined* Comerica's position that it should be allowed to fill the gap. The court reasoned that because the policy specifically provided certain instances when filling the gap was contemplated and permissible, and because "the present scenario [was not] among the circumstances in which gap payments by the insured would be acceptable," Comerica was not permitted to fill the gap.

The court's reasoning in *Comerica* underscores a larger point that all too often goes unnoticed in cases in which exhaustion is at issue. The *Zeig* court expressed its view that a below-limits settlement followed by the insured filling the gap places the excess insurer in the same position it would be in had the underlying insurer paid its full policy limits. But is this actually the case? A fundamental aspect of insurance is that as risk decreases, so too does the premium. To assume that when an insured fills the gap is, in the words of Comerica, the "functional equivalent" of exhausting the primary policy, in fact, represents a fundamental misunderstanding of the nature of insurance. Insurers write coverage based on risk. In the case of excess insurance, risk (and therefore premium charged) is calculated based on the nature and terms of the underlying coverage—*i.e.* the risks covered *and not covered* by underlying insurance. When an insured seeks to fill the gap, coverage is either disputed or unavailable, and thus filling the gap actually seeks to superimpose "coverage" where none may exist. As long as the exhaustion language is clear, to allow an insured to fill the gap is to re-write the nature and degree of risk assumed by an excess carrier. The *Comerica* court recognized this.[21]

Other Cases

To be sure, courts in the eight decades since *Zeig* have allowed below-limits settlements to trigger excess insurers' policies.[22] The more recent trend of authority, however, suggests a departure from *Zeig*. For example, in *Great Am. Ins. Co. v. Bally Total Fitness Holding Corp.*, No. 06 C 4554, 2010 WL 2542191 (N.D. Ill. June 22, 2010), the court noted that the *Zeig* rationale is confined to interpretation of ambiguous policy language and held that the insured's filling the gap did not trigger excess coverage when the policy required "actual payment [by] underlying insurers." Additionally, in *Qualcomm,*

18 *Id.* at 1032.

19 *Id.* at 1028.

20 *Id.* at 1033. The insured relied on, *Pereira v. Cogan*, No. 04 Civ. 1134, 2006 WL 1982789, an unpublished decision that involved the interpretation of similar policy language. In *Pereira*, the court held that, although the insurers' interpretation of the exhaustion language requiring "actual payment" was reasonable, it could not conclude that it was the only reasonable interpretation. *Id.* (citing *Zeig*, 23 F.2d 665). However, as the *Comerica* court highlighted, the *Pereira* court failed to articulate "what other interpretation there could be, and this [*Comerica*] Court [was] unable to discern one." *Comerica*, 498 F. Supp. 2d at 1033.

21 *See id.* at 1304 ("To find the [excess] policy ambiguous would essentially require a holding that parties simply cannot contract for an excess policy to be triggered only upon full, actual payment by the underlying insurer.").

22 *See, e.g.*, *Rummel v. Lexington Ins. Co.*, 945 P.2d 970, (N.M. 1997) (interpreting "[liability] shall not attach unless and until the Insured's Underlying Insurance has paid *or has been held liable to pay* the total applicable underlying limits" and explaining that it would be "senselessly redundant for this phrase to also connote the idea of payment in full, in cash"); *Walbrook Ins. Co. v. Unarco Indust., Inc.*, No. 90 C 5111, 1994 WL 411404 (N.D. Ill. Aug. 3, 1994) (interpreting "[liability] shall not attach unless and until *the Assured*, or the Assured's underlying insurers, shall have paid the amount of the underlying limits on account of such occurrence" and reasoning that the "Assured" was permitted to pay limits in lieu of the insurer under plain language).

Inc. v. Certain Underwriters at Lloyds, 161 Cal. App. 4th 184, 196-97 (Cal. App. Ct. 2008), the court rejected the insured's *Zeig*-based public policy arguments and noted that the rationale of favoring settlements "cannot supersede plain and unambiguous policy language" requiring actual payment. More recently, the court in *JPMorgan Chase & Co. v Indian Harbor Ins. Co.*, 2011 NY Slip Op 51055(U) (N.Y. Sup. Ct. May 26, 2011), reasoned that *Zeig* is only applicable when exhaustion language is ambiguous and cited *Bally,* 2010 WL 2542191 and *Qualcomm, Inc.*, 161 Cal. App. 4th at 198.

A recent decision in the Southern District of New York confirms the diminished reach of *Zeig—even within the Second Circuit.* In *Federal Ins. Co. v. Estate of Irving Gould,* No. 10 Civ. 1160, 2011 WL 4552381 (S.D.N.Y. Sep. 28, 2011), several lawsuits were filed against the former officers and directors of now-bankrupt Commodore International Limited (the manufacturer of the classic Commodore 64 computer). Faced with several insurer insolvencies and mounting liabilities, the insured defendants sought a declaration that coverage was triggered under two excess policies once the aggregate amount of the insured defendants' losses exceeded the limits of underlying insurance, regardless of whether the underlying insurers (some of which were insolvent) had actually paid such underlying claims. Notwithstanding the insured defendants' reliance on *Zeig*—which the court found to be inapposite under the facts presented in the first instance—the court held that the plain exhaustion language of the excess policies required actual payment of losses by the underlying insurers.[23] The court stated:

> "The express language of these policies establishes a clear condition precedent to the attachment of the Excess Policies. In each policy, the excess coverage is not triggered until the underlying insurance is exhausted 'solely as a result of payment of losses thereunder.' . . . [C] overage does not attach until there is *payment* of the underlying losses."[24]

Significantly, the court expressly distinguished *Zeig*, noting that "here the Excess Insurers have a clear, bargained-for interest in ensuring that the underlying policies are exhausted by actual payment," and that to hold otherwise could encourage inflated settlements by essentially requiring the solvent excess insurers to "drop down" to cover those periods for which the insured now remained liable due to insolvencies of various insurers. Thus, even a court within the Second Circuit has backed away from applying *Zeig* when exhaustion language is clear and unambiguous.

Conclusion

In conclusion, courts analyzing coverage in the context of below-limits settlements are scrutinizing more closely than ever the specific language requirements in excess policies regarding the manner in which underlying policies will be considered exhausted so as to trigger an excess policy. The trend has turned decisively away from a broad reading of *Zeig* and toward greater reliance and enforcement of the specific language in the excess policies. Although the *Zeig* analysis may still prevail when the excess policy is deemed ambiguous regarding the method of underlying exhaustion, the evolution of excess policy language and a judicial focus on applying the policy language as written has rendered that situation increasingly rare.

Insureds seeking the certainty of coverage often look to settle with lower-level insurers in exchange for accepting less than the policy limits, but it is imperative for insureds to consider the full implications of any such settlement—especially in the context of a sophisticated insurance program with multiple layers of coverage. Settlements certainly help to avoid litigation; but as the cases discussed above indicate, settlements can also become the very subject of litigation if not done correctly, and may render excess insurance coverage unavailable.

23 *See id.*

24 *Id.* (emphasis in original).

VISIT US ON THE WEB AT:
http://www.americanbar.org