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New Appleman Insurance Law Practice Guide

Volume 3: Separate Insurance Lines
Chapter 39 UNDERSTANDING MULTIPLE INSURER SITUATIONS
IV. UNDERSTANDING HOW COURTS ALLOCATE LIABILITY AMONG CONSECUTIVE INSURERS.

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39.12 Examine Approaches to Allocation.

Jurisdictions vary as to how to apportion a loss among multiple insurers, and insureds, where a progressive injury extends across multiple policy periods. Courts typically subscribe to one of two allocation theories: (1) pro rata apportionment; or (2) joint and several liability. The method selected may dramatically affect allocation results.

The key differences to these two approaches concerns how loss is apportioned to impaired years, sometimes referred to as "orphan shares." Policyholders prefer the joint and several approach because it allows the policyholder to maximize its coverage and avoid having to pay for self-insured or impaired years. Conversely, insurers prefer pro rata allocation because the responsibility to pay for impaired years remains with the insured.

Legal Topics:

For related research and practice materials, see the following legal topics:
Insurance LawClaims & ContractsCoinsuranceGeneral OverviewInsurance LawGeneral Liability InsuranceCoverageTriggersContinuous TriggersInsurance LawGeneral Liability InsuranceCoverageTriggersMultiple TriggersInsurance LawGeneral Liability InsuranceMultiple Insurers

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39.13 Understand Various Pro Rata Approaches.

Pro rata allocation spreads the loss across the entire trigger period and assigns liability shares on a proportionate basis. This theory recognizes that a portion of a progressive injury will occur outside any individual policy period and, therefore, does not "saddle" one insured with the entire loss. Courts apply several pro rata theories, including prorating the loss by time, by limits, by time and limits, by layers, by equal shares and other methods. The time-based approach tends to be the most common pro rata method used.

39.13[1] Injury-in-Fact.

39.13[1][a] Understanding Injury-in-Fact Approach. This approach apportions loss based on the amount of injury or damage that took place during each contract period or uninsured period. The insurer is liable for only that damage that took place during the period of its policy.

39.13[1][b] Supporting Rationale for Injury-in-Fact. Most liability policies require that the bodily injury or property damage take place during the policy period, regardless of when the occurrence took place. This approach most closely follows the requirements of such policies and comports with the injury-in-fact trigger theory applied by many jurisdictions.

Cross Reference:

See § 39.15[1] below.

39.13[1][c] Key Criticism of Injury-in-Fact Approach. Although this approach most closely tracks the policy language, it is often difficult to determine how much injury occurred during each period. Courts have therefore devised other pro rata theories to fairly apportion the injury among triggered carriers.

Courts that have adopted an injury-in-fact or "actual injury" trigger have found that pro rata by time-on-the-risk is an adequate substitute for the actual injury rule when the precise amount of damage in each period is indeterminable [*see, e.g.,* N. States Power Co. v. Fid. & Cas. Co. of N.Y., 523 N.W.2d 657, 662-63 (Minn. 1994) ; *Consol. Edison Co. of N.Y. v. Allstate Ins. Co.*, 98 N.Y.2d 208, 225 (2002)].

Consider:

Some courts have sought to measure the amount of injury or damage by the volume of waste generated

or goods produced. For example, in Uniroyal, Inc. v. Home Ins. Co. [707 F. Supp. 1368 (E.D.N.Y. 1998)], the court apportioned damages in proportion to the respective volumes of Agent Orange delivered by the insured to the military during each policy year. Arguably, theories other than injury-in-fact are only applied when it is not possible to determine the amount of injury during each period.

39.13[2] Time-on-the-Risk.

39.13[2][a] Understanding Time-on-the-Risk Approach. The time-on-the-risk approach apportions the loss based on the amount of time each insurer is on the risk relative to the total number of years of triggered coverage. Time based apportionment assumes that the amount of damage sustained was equal in each year. Pro rata by time assigns loss without regard to liability limits.

Example:

Assume the insured sustains a $10 million loss for an injury that continued for 10 years. Each year is assigned $1 million of the loss. Thus, if Carrier A insured the policyholder for three years, and Carrier B for seven years, then Carrier A's share would be $3 million, and Carrier B's share would be $7 million.

Consider:

It is common to assign a percentage share to each insurer in calculating each insurer's monetary share. One such formula used is A/B x C = D. In this equation, A is each insurer's time-on-the-risk, B is the total period over which liability is allocated, C is the total damages to be allocated, and D is damages allocated to each individual insurer. This formula is sufficient if the loss is subsumed within the first layer of coverage. Where multiple layers of coverage are involved, however, this formula needs to be modified. When calculating each insurer's respective share, it is preferable to perform a two-step process. First, determine the yearly allocation by dividing the damages by the number of triggered years. Next, determine each carrier's share by vertically exhausting each triggered year. This method is preferable to the alternate method of assigning a percentage share of the loss to each carrier because it better accounts for the likelihood that a policyholder's coverage profile may differ from year-to-year, with varying primary and secondary policy limits and attachment points. The straight percentage approach becomes difficult to implement where both primary and excess policies are implicated in a given year.

Strategic Point--Insurer:

In jurisdictions applying a pro rata by time approach, high excess insurers may be able to obtain a dismissal on justiciability grounds where it can be demonstrated that the damages, once apportioned, will never reach the excess carrier's attachment point [*see* Consol. Edison Co. of N.Y. v. Allstate Ins. Co., 98 N.Y.2d 208 (2002)].

Consider:

In coverage litigation involving multiple insurers, carriers will sometimes assert cross-claims for contribution and indemnification against one another. Co-defendant carriers may sometimes use this as a basis for preventing a settling carrier from being dismissed from a multi-party insurance litigation. Since under a pro rata method each insurer is liable for only its proportionate share of the loss, it appears that the assertion of such cross-claims should not impair the settling carrier's ability to obtain a dismissal, insofar as no carrier should be required to pay more than its proportionate share of the loss in the first instance.

Strategic Point--Excess Insurer:

High excess carriers will often argue for horizontal exhaustion, such that all SIRs, deductibles, primary and lower excess policies are to be exhausted before there is any apportionment to an excess policy.

Cross Reference:

See the discussion of the by-layers approach in § 39.13[5] below.

39.13[2][b] Supporting Rationale for Time-on-the-Risk. Time-on-the-risk emphasizes that the allocation of loss to any given policy is to be proportionate to the damage suffered during that policy's term. It assumes that a progressive injury takes place at a constant rate. Where an injury occurred over 10 years, it is assumed that 10% of the injury occurred each year. If the constant rate assumption is correct, the time-on-the-risk reflects the often elusive injury-in-fact.

Time-on-the-risk recognizes that part of a progressive injury will occur outside of any given policy period. Although it is difficult to establish the actual amount of loss sustained during an individual policy period, the time-on-the-risk approach affords an equitable and efficient means of allocating indemnification obligations, highlighted by its ease of application. This approach refuses to import tort notions of joint and several liability into an insurance contract and instead concludes that liability must be individual and proportionate.

39.13[2][c] Key Criticism of Time-on-the-Risk Approach. Critics of this approach argue that a policy with low limits of liability may be responsible for the same share of the loss as a policy with higher limits, despite the disparity in premiums collected. Where injury spans several decades, available liability limits (and premiums collected) were substantially lower in earlier years than in later years, yet those earlier policies are assigned the same prorated share of the loss as later policies. This criticism, however, does not account for the effects of inflation. When one considers liability limits and premiums in inflation adjusted terms, the discrepancy between limits and premiums in early and later years shrinks considerably. For example, a dollar in 1960 may be worth nearly three times as much as a dollar in 1980.

Insured's Perspective:

A policyholder with enough insurance in one or several policy periods to cover a loss in full would still be allocated a share of the loss if there were any periods of no insurance or too little insurance.

39.13[3] By-Limits.

39.13[3][a] Understanding By-Limits Approach. The by-limits approach apportions the loss based on the relative liability limits of each insurance policy. Under this approach, the sum of each carrier's limits is divided by the sum of the total limits of all triggered policies and then multiplied by the amount of the insured's loss.

Example:

Assume the insured sustained a $10 million loss for an injury that continued for 10 years. Carrier A provided coverage for five years, with liability limits of $1 million for each policy. Carrier B provided coverage for four years, with limits of $2 million for each policy. Carrier C provided coverage for one year, with liability limits of $7 million. The sum total of all coverage is $20 million. Carrier A will be assigned 5/20ths of the loss ($2.5 million), Carrier B, 8/20ths ($4 million), and Carrier C, 7/20ths ($3.5 million).

Compare:

Under time-on-the-risk, Carrier A would be responsible for $5M, as each year would be assigned $1 million. Carrier C's share would decrease significantly.

39.13[3][b] Supporting Rationale for By-Limits. This method rejects the notion of joint and several liability and spreads the risk across the entire trigger period. Unlike pro rata by time, pro rata by limits is driven by the relative amount of risk each insurer has assumed. In other words, it assigns a higher percentage share of the damages to a carrier

that provided higher liability limits on the presumption that the carrier collected a higher premium.

39.13[3][c] Key Criticism of By-Limits Approach. A by-limits allocation assigns a disproportionate share of the damages to insurers with higher limits and makes those insurers liable for damages incurred outside of their policy periods. This can result in excess carriers paying before the primary policy beneath it is exhausted [*see* N. States Power Co. v. Fid. & Cas. Co. of N.Y., 523 N.W.2d 657, 662 (Minn. 1994)].

The limits based approach operates on a flawed premise; the cost of insurance does not necessarily increase in proportion to limits. Rather, time is usually the best indicator of the amount of premium collected [Cont'l Cas. Co. v. Med. Protective Co., 859 S.W.2d 789, 792 (Mo. Ct. App. 1993)]. This is illustrated in the above example, where Carrier C, who was only on the risk for one year, paid more than Carrier A, who was on the risk for five years. It is unlikely that Carrier C, even though issuing a higher liability limit, would recover more in premiums in one year than did Carrier A over a five-year period.

The limits based approach also potentially includes participation from excess insurers whose policies may not otherwise be implicated under a time-based approach. This approach is more commonly used where the loss involves concurrent insurers, as opposed to consecutive insurers.

39.13[4] Time and Limits.

39.13[4][a] Understanding Time and Limits Approach. The proration by years and limits method, also known as the hybrid approach, applies pro rata allocation based on the extent of risk assumed, multiplied by years of coverage. The leading jurisdiction following this approach is New Jersey. The New Jersey Supreme Court first developed the time and limits approach in Owens Illinois Inc. v. United Ins. Co. [138 N.J. 437 (1994)] and later refined it in Carter-Wallace, Inc. v. Admiral Insurance Co. [154 N.J. 312 (1998)] to address how loss should be apportioned among primary and excess insurers in a given year.

Example:

Assume a $10 million loss over a nine year trigger period. Carrier A provided the first three years of coverage in the amount of $2 million per year; Carrier B provided the next three years with limits of $3 million per year; and Carrier C provided the last three years with limits of $4 million per year. The total amount of coverage is $27 million. Apportioning the loss to each year, 2/27ths would be assigned to years 1 through 3, 3/27ths would be assigned to years 4 through 6, and 4/27ths would be assigned to years 7 through 9. Thus, Carrier A would be assigned 6/27ths of the loss ($2.2 million), Carrier B would be assigned 9/27ths ($3.33 million), and Carrier C would be assigned 12/27ths of the loss ($4.44 million).

Under the time-on-the-risk method, each year would be assigned 1/27th of the total.

Consider:

Under *Carter-Wallace*, if excess policies are implicated, each year is vertically allocated beginning with the primary policy and proceeding upward through each succeeding layer. For example, assume primary coverage of $100,000, first layer excess of $200,000, and second layer excess of $450,000. If the loss allocated to a specific year is $325,000, the primary insurer would pay $100,000, the first layer excess policy would pay $200,000 and the second layer excess policy would pay $25,000. This modification addresses one of the leading drawbacks of the pure limits approach; it ensures that primary coverage in a given year will be exhausted before excess carriers in that year are required to pay.

Consider:

There is essentially no difference between the time and limits approach and a pure by-limits approach, where only one layer of coverage is implicated. Differences emerge, however, when excess layers of

coverage are included in the allocation.

39.13[4][b] Supporting Rationale for Time and Limits Approach. The time and limits approach, like the time-on-the-risk approach, recognizes the inequity of permitting a policyholder who has decided to "go bare" for certain periods to recover as though it had been continually covered. In departing from a pure time-based approach, this method assigns a greater portion of costs to years in which greater amounts of insurance were purchased. The hybrid approach purports to be more consistent with the economic realities of risk retention and risk transfer.

The New Jersey Supreme Court presented other reasons in support of the time and limits approach (and in rejection of joint and several liability). These reasons, guided by public policy concerns and making the most efficient use of resources, include: (1) providing incentives for parties to engage in responsible conduct; (2) not providing disincentives to parties to acquire insurance when available to cover their risks; (3) promoting simple justice; (4) respecting the distinction between primary and excess coverage; and (5) introducing a degree of certainty and predictability to loss allocation [Owens-Illinois, Inc. v. United Ins. Co., 138 N.J. 437, 472-76 (1994)].

39.13[4][c] Key Criticism of Time and Limits Approach. In many cases, the time and limits approach will yield results similar to a pure limits-based approach. Thus, the same criticisms apply, mainly that it may cause certain carriers in years where there are higher liability limits to pay a disproportionate share of the loss. This may be compounded in the time and limits approach because payment responsibility depends on the proportion a carrier's limits bear to the total limits in a given year, rather than the total limits of all years. This inequity can be illustrated by the following example:

Example:

Assume a $5 million loss is spread over a two year period. In year one, the insured obtains a $1 million primary policy from Carrier A. In year two, it obtains a $1 million primary policy from Carrier B and an $8 million excess policy from Carrier C. Under the time and limits approach, 1/10th of the loss will be assigned to the first year and 9/10ths to the second year. Thus, Carrier A is apportioned $500,000, Carrier B $1 million, and Carrier C $3.5 million. Even though Carriers A and B collected the same premium for the same amount of insurance, Carrier B was required to pay its full limits, while Carrier A was not. Thus, the fact that the insured opted to procure an excess policy in year two affected Carrier B's payment obligation, even though Carrier B's primary policy was written without regard to the procurement of the excess policy.

Another criticism of the time and limits approach is that liability limits must be artificially assigned for years where the insured failed to obtain insurance in order to achieve an apportionment to the insured. In essence, the court must determine the appropriate amount of insurance the insured should have purchased during the gap period. This concern does not exist in a pure time-based allocation.

39.13[5] Layers.

39.13[5][a] Understanding Layers Approach. The layers approach fully exhausts the limits of each policy in each layer of coverage before any policy in a higher layer must respond. Thus, under this approach, all self-insured retentions must first be exhausted, then all primary policies, then all first layer excess policies, and so on. The layers approach is also known as horizontal exhaustion.

39.13[5][b] Supporting Rationale for Layers Approach. The rationale for this approach is that permitting payment from an excess policy before exhausting a primary policy would undermine the purpose of excess insurance. Courts employing this approach typically rely on the language of excess "other insurance" clauses, which provide that coverage shall begin only after the exhaustion of any applicable primary policy.

Cross Reference:

See § 39.08[2] above for a discussion of excess "other insurance" clauses.

39.13[5][c] Key Criticism of Layers Approach. While this approach may have validity when distributing loss among concurrent carriers, it is counter-intuitive when applied among consecutive insurers. Excess policies are generally written above a specific underlying policy. Respecting coverage layers is appropriate in an individual year but makes less sense across a number of years where the amount of insurance purchased by a policyholder will vary over time. "Other insurance" clauses are designed to prevent multiple recoveries when concurrent policies provide coverage for a given loss. They do not resolve the question of the extent to which each triggered policy provides indemnity where successive policies are triggered. Consequently, the layers approach may disproportionately distribute the loss to certain carriers that issued higher limits. This is unfair because higher limits do not necessarily equate to higher premiums.

Example:

Assume a policyholder purchased $20 million of coverage for each of three years as follows:

Year One:		Year Two:		Year Three:	
Carrier A:	$1 MM primary	Carrier A:	$1 MM primary	Carrier A:	$1 MM primary
Carrier B:	$1 MM first layer excess	Carrier B:	$1 MM first layer excess	Carrier C:	$19 MM first layer excess
Carrier B:	$3 MM second layer excess	Carrier B:	$3 MM second layer excess		
Carrier B:	$15 MM third layer excess	Carrier B:	$15 MM third layer excess		

A $15 million loss would be apportioned as follows:

$3 million to Carrier A; $2 million to Carrier B; $10 million to Carrier C. Carrier C is apportioned most of the loss, even though it issued the same amount of excess coverage in a given year as Carrier B, and when total limits for all three years are considered, only half the amount of Carrier B. Carrier B is afforded a windfall at the expense of Carrier C simply because Carrier B opted to divide its $19 million of excess coverage into three separate policies. This approach places form over substance and provides a disincentive for carriers to offer policies with high limits. In the Example above, Carrier C could have reduced its liability from $10 million to $3 million if it chose to issue twenty $1 million policies, rather than one $20 million policy.

39.13[6] Equal Shares.

39.13[6][a] Understanding Equal Shares Approach. Under the equal shares or per capita approach, loss is allocated equally among all carriers whose policies are triggered (subject to policy limits) [St. Paul Fire & Marine Ins. Co. v. Vigilant Ins. Co., 919 F.2d 235, 242-43 (4th Cir. 1990)].

39.13[6][b] Supporting Rationale for Equal Shares Approach. It provides a simplistic method of dividing loss.

39.13[6][c] Key Criticism of Equal Shares Approach. It is overly simplistic and does not accurately reflect the varying degrees of risk assumed by each insurer. This approach will therefore disproportionately assign part of the loss to certain carriers.

Consider:

This method is more commonly used where courts apportion loss among concurrent insurers by application of "other insurance" clauses [*see* § 39.08 above].

The equal shares approach, however, has a logical basis when allocating defense costs when multiple carriers each have

an independent duty to defend [*see* § 39.15[7] below].

39.13[7] Bathtub Approach.

39.13[7][a] Understanding Bathtub Approach. Under the bathtub method, or maximum loss rule, liability is first apportioned horizontally along the triggered period, and then apportioned vertically in a bottom-up fashion, similar to the way water fills up a bathtub. Thus, apportionment is made equally among all policies until the policy with the lowest limit is exhausted. Apportionment then continues in a similar fashion to all remaining policies until the loss has been apportioned in full or coverage is exhausted [Mission Ins. Co. v. Allendale Mut. Ins. Co., 95 Wash. 2d 464 (1981) ; Employers Mut. Cas. Co. v. MFA Mut. Ins. Co., 384 F.2d 111, 115 (10th Cir. 1967)].

Consider:

A primary insurer will be required to exhaust its liability limit before any excess insurers directly above it, but not necessarily before excess insurers in other years.

Example:

Assume that, in year one, a policyholder has $1 million in primary coverage and $5 million in excess coverage. In year two, the policyholder has $2 million in primary coverage and $5 million in excess coverage. The excess policy in year one will be reached before the primary policy in year two is exhausted.

39.13[7][b] Supporting Rationale for Bathtub Approach. This method combines the fairness of horizontal allocation (spreading the loss over time) with a respect for the layering of coverage in a given policy period.

39.13[7][c] Key Criticism of Bathtub Approach. This approach does not adequately deal with periods where the policyholder chose not to obtain insurance or purchased too little insurance.

Consider:

Pro rata by time with vertical exhaustion provides a similar approach, but because an equal share of the loss is assigned to each triggered year, periods of no insurance or inadequate insurance can readily be apportioned to the insured.

Legal Topics:

For related research and practice materials, see the following legal topics:
Insurance LawBusiness InsuranceSelf-InsuranceGeneral OverviewInsurance LawClaims & ContractsCoinsuranceGeneral OverviewInsurance LawClaims & ContractsCoinsuranceContributionInsurance LawExcess InsuranceApportionment of LiabilityInsurance LawGeneral Liability InsuranceCoverageTriggersGeneral OverviewInsurance LawGeneral Liability InsuranceCoverageTriggersContinuous TriggersInsurance LawGeneral Liability InsuranceCoverageTriggersInjury in FactInsurance LawGeneral Liability InsuranceMultiple Insurers

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39.14 ''All Sums'' Approach (Joint and Several Liability).

39.14[1] Understanding ''All Sums'' Approach. Under the "all sums" approach, also known as joint and several liability, each insurer is deemed liable in full for the policyholder's damages, up to the limits of its policy. The insured is entitled to choose a tower of coverage issued for a single year from which to seek indemnity and defense costs. Coverage proceeds from the bottom upward until the insured's loss is fully indemnified or coverage is exhausted. The selected carrier or carriers may then proceed by way of contribution against other carriers whose policies are also triggered by the injury.

Courts applying "all sums" differ as to whether they allow a policyholder to look to other policy periods where the coverage in the selected year is insufficient to fully indemnify the policyholder for the loss, *i.e.*, "stacking." Under Keene Corp. v. Ins. Co. of N. Am. [667 F.2d 1034 (D.C. Cir. 1981)] , the seminal decision on the "all sums" approach, the court held that a policyholder is limited to a single year of coverage and that any loss exceeding the total available limits for that year must be borne by the insured. Other jurisdictions, such as Pennsylvania, allow an insured to look to other policy periods to fully satisfy its claim where there is insufficient coverage in any single year [J.H. France Refractories Co. v. Allstate Ins. Co., 534 Pa. 29, 42 (1993)]. Courts adopt this latter approach to guarantee that insureds will be fully indemnified for their covered losses.

Example:

Assume an insured suffers a $20 million loss that triggers 10 successive policies. In the first five years, the insured did not purchase insurance that would cover the loss. In years six through nine, it purchased primary coverage with limits of $1 million and excess coverage in the amount of $2 million. In year 10, it purchased a $5 million primary policy and a $10 million excess policy. Under the "all sums" method, the insured will pursue coverage under year 10, as it has the most coverage in that year. In a jurisdiction that prohibits stacking, the insured will recover $15 million and bear the remaining $5 million. In a jurisdiction that permits stacking, the insured can recover the remaining $5 million by "spiking" policies in years six through nine until it has fully satisfied its loss. The insurers who paid a disproportionate amount of the loss can then pursue coverage from other carriers that have not paid their proportionate share.

Consider:

The results in the above example would vary considerably under a pro rata method. For instance, under a time-on-the-risk allocation, rather than collapsing the loss into one policy year, $2 million would be assigned to each year. The insured would therefore be left to pay $10 million out of its own pocket, as it chose not to purchase insurance for five of the 10 years.

39.14[2] Supporting Rationale for ''All Sums'' Approach. Joint and several allocation maximizes a policyholder's coverage and attempts to treat progressive injury claims in the same manner as traditional injuries. In doing so, it avoids apportionment to self-insured or impaired years. Courts applying this theory rely on the language in a liability policy that requires the insurer to indemnify the policyholder for "all sums" the insured shall become legally obligated to pay as damages because of bodily injury or property damage, not simply some pro rata portion thereof. These courts note that there is no express language in the policy that authorizes pro rata allocation of damages. Rather, once triggered, the insurer's obligation is to cover the policyholder's liability in full. The seminal decision applying joint and several liability is Keene Corp. v. Ins. Co. of N. Am. [667 F.2d 1034 (D.C. Cir. 1981)].

39.14[3] Key Criticisms of ''All Sums'' Approach. The "all sums" approach has been criticized on numerous grounds:

(1) *It ignores contractual limitations and requires insurers to provide coverage periods in which it received no premiums.* While certain liability policies require that the insurer indemnify the policyholder for "all sums," these policies qualify that obligation to only those damages that took place during the policy period. In failing to recognize this limitation on recoverable damages, the "all sums" approach fails to interpret the policy as a whole. As one judge commented, it "requires the insurer ... to provide insurance coverage it neither contracted to provide, nor received insurance premiums for" [Am. Nat'l Fire Ins. Co. v. B&L Trucking and Constr. Co., 951 P.2d 250, 258 (Wash. 1998) (Madsen, J., dissenting)]. Other courts have suggested that the "all sums" language "was never intended to cover apportionment when continuous injury occurs over multiple years" [Owens Ill., Inc. v. United Ins. Co., 650 A.2d 974, 989 (N.J. 1994)].

Consider:

Some excess policies indemnify the insured for "ultimate net loss" and do not contain the "all sums" language. Furthermore, many liability policies today, including the ISO CGL forms, do not contain the "all sums" language, but rather indemnify "*those* sums the insured becomes legally obligated to pay as damages to which this insurance applies."

(2) *It is inequitable.* The joint and several approach saddles those insurers in the "spike" year with the entirety of the loss, even though only a portion of the damages occurred during the "spike" year. Insureds who failed to procure insurance for long periods of time or purchased insufficient amounts are afforded a windfall at the expense of the selected insurers, who must bear the loss for all impaired periods. An extreme example drives home the point: a policyholder that purchased insurance in only one year out of 20 can be fully indemnified for a large property damage loss that continued over that same 20-year period, even where the property damage extended only one day into the period of coverage. Several courts have noted that it would be illogical to permit a policyholder that purchased coverage for only one year to be entitled to the same amount of coverage as one that purchased insurance for 20 out of 20 years [Ins. Co. of N. Am. v. Forty-Eight Insulations, 633 F.2d 1212, 1225 (6th Cir. 1980)].

(3) *Allowing the insured to choose one year is inconsistent with the premise that multiple years are involved.* Insofar as the joint and several approach collapses the loss into a single policy period, it is inconsistent with the assumption that injury occurred over multiple periods. Once we assume that multiple years are involved, damages for injury should logically be apportioned across all years as well.

(4) *It is uneconomical*. The joint and several approach results in additional, and potentially costly, litigation. The insurer or insurers that are selected to shoulder the entire loss are left with little recourse but to pursue contribution from other

insurers whose policies were triggered by the claim. This approach runs counter to goals of promoting judicial economy and efficiency because it often necessitates the commencement of a second proceeding. This criticism, however, may be mitigated where all carriers from whom contribution is sought are impleaded into the coverage action between the insured and targeted insurer.

(5) *It shifts the insured's burden of proof onto the "spiked" insurers*. Burdens typically borne by the policyholder now become the burden of those insurers unfortunate enough to be selected to satisfy the insured's loss. To obtain contribution from other insurers potentially responsible for the loss, these insurers must not only prove that the loss is covered under each policy, but are often cast in the unenviable position of having to prove the existence and terms of coverage where policies are missing or incomplete. The insurer is often at a disadvantage because it has less access to information and witnesses than would the insured, who purchased the policies.

(6) *The policyholder's problems now become the insurer's problems*. Progressive or long-tail losses often span decades. During that time, an insured is required to make a number of decisions about its insurance program. Some of those decisions may later turn out to be problematic. For example, it may have purchased no insurance in certain years or insurance that excluded the particular damage at issue. It may have purchased insurance from carriers that are now insolvent. It may have purchased too little insurance or failed to institute proper record keeping or document retention policies that would enable it to locate earlier insurance policies. The joint and several approach permits a policyholder to wipe its hands clean of these problems and transfer them to an insurer of its choice. That insurer now inherits a series of problems for which it played no part in creating.

A related point is the reality that many decisions made by the policyholder inured to its economic benefit at the time the decision was made, whether it be to purchase lower liability limits, to forego supplemental insurance or specific endorsements or to retain greater portions of the risk through higher self-insured retentions or deductibles. While these decisions afforded the insured an economic benefit by way of lower premiums, the consequences of those decisions is the assumption of a greater share of the loss should it face liabilities in the future. The joint and several approach allows the insured to reap the benefit of its risk-related decision making without ever having to pay the consequences. Those negative consequences do not disappear; rather, they are shifted to the insurer in the "spike" year, even though the insurer never gained any economic benefit from the risk-related decisions that led to those consequences.

Example:

Assume that during all but one year of a 30-year period, the policyholder opted to save premiums by self-insuring the first $100,000 of any loss. In one of those 30 years, it chose to purchase primary coverage with no self-insured retention. By selecting the year in which it purchased the primary coverage to satisfy its loss, the insured avoids having to pay any share of the loss, while still enjoying the cost savings of self-insuring. The primary carrier, on the other hand, never enjoyed any benefit from the insured's decision to self-insure but is negatively affected by it because it reduces the amount available through contribution. The primary carrier in essence must pay the $100,000 retained by the insured in each of 29 years before it is able to recoup any sums from the other insurers whose policies were triggered by the loss.

Cross Reference:

For a discussion of treatment of self-insured retentions and deductibles in allocation schemes, *see* § 39.15[5] below.

(7) *It provides disincentives concerning the purchase of adequate insurance.* A policyholder that is allowed to escape many of the consequences of its risk-related decisions will have less incentive to purchase insurance adequate to cover its risks. Likewise, insurers may be reluctant to underwrite policies with higher limits in "joint and several" jurisdictions for fear of later being the insured's primary target in a progressive injury claim.

(8) *It mixes principles of tort law into contracts.* The principle of joint and several liability is a tort concept. Obligations of an insurer to its insured are not derived from tort principles but from contract. Thus, determining contractual obligations based on tort theories seems out-of-place.

Legal Topics:

For related research and practice materials, see the following legal topics:
Insurance LawClaims & ContractsCoinsuranceGeneral OverviewInsurance LawClaims & ContractsCoinsuranceContributionInsurance LawExcess InsuranceApportionment of LiabilityInsurance LawGeneral Liability InsuranceCoverageTriggersContinuous TriggersInsurance LawGeneral Liability InsuranceMultiple Insurers

New Appleman Insurance Law Practice Guide

Volume 3: Separate Insurance Lines
Chapter 39 UNDERSTANDING MULTIPLE INSURER SITUATIONS
IV. UNDERSTANDING HOW COURTS ALLOCATE LIABILITY AMONG CONSECUTIVE INSURERS.

3-39 New Appleman Insurance Law Practice Guide 39.15

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39.15 Identifying Issues That Arise When Calculating Allocated Shares.

39.15[1] Determine Which Policies Share in Loss: Trigger. Toxic tort or gradual pollution claims will often involve causes and injuries that span a number of years. Damage or injury may not become known for years after exposure starts, or even ends. When a policyholder has been covered by several policies over a period of time, identifying when the injury takes place is necessary to determine which policies must respond, i.e., are triggered.

Consider:

The term "trigger" does not appear in the language of the insurance policy. Rather, it is a term commonly used by courts and commentators to describe when a policy responds to a given loss. Trigger, however, should not be confused with coverage. Just because a policy is triggered does not necessarily mean that it covers a given loss. A given policy may be within the "trigger period" but may have, for example, an exclusion that applies to the particular claim.

Most liability policies cover injury that takes place during the effective dates of the policy. Some policies, however, require that the injury causing event, *i.e.*, the "occurrence" or "accident," take place during the policy period. Others provide coverage for claims made during the policy period. Consequently, the particular language of each policy must be considered to determine if it responds to a progressive loss.

Warning:

Although a liability policy may provide that it covers damage resulting only from "occurrences" or "accidents" that take place during the policy period, many such policies define these terms to include injurious exposure to conditions that result in bodily injury or property damage during the policy period.

The injury that triggers liability in long-tail claims often cannot be linked to a single event. Rather, the injury or damage is typically caused by events that develop or intensify over time. As it is difficult, if not impossible, to pinpoint when the injury occurred, courts apply various theories to determine which policy or policies are triggered. The four leading trigger theories are: (1) exposure; (2) manifestation; (3) continuous trigger; and (4) injury-in-fact.

(1) Under the exposure theory, the injury is deemed to take place on the date of exposure to the

injury-producing agent [Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc. 633 F.2d 1212 (6th Cir. 1980)]. Those policies in effect on the exposure dates are triggered.

(2) Under the manifestation trigger, injury is deemed to take place when the injury became reasonably apparent or known to the claimant [Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co., 682 F.2d 12 (1st Cir. 1982)]. Those policies in effect when injury becomes manifest are triggered. Very few jurisdictions follow this approach.

(3) Under the continuous trigger, injury is deemed to take place from exposure through manifestation. All policies in effect during this continuous period are triggered [Keene v. Ins. Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981) ; Montrose Chem. Corp. v. Admiral Ins. Co., 10 Cal. 4th 645, 687 (1995)]. Thus, for example, in the context of asbestos, the Illinois Supreme Court held that if either exposure, sickness or diagnosis happens during the policy period, the policy is triggered [Zurich v. Raymark, 118 Ill. 2d 23, 47-48 (1987)]. The continuous trigger is the most widely adopted trigger theory.

Strategic Point--Policyholder:

Policyholders will almost always advocate a continuous trigger theory, as this theory usually maximizes a policyholder's recovery.

(4) Finally, under the injury-in-fact theory, a policy is triggered only if actual injury takes place during the policy period. [Am. Home Prods. Corp. v. Liberty Mut. Ins. Co., 565 F. Supp. 1485 (S.D.N.Y. 1983) , *aff'd*, 748 F.2d 760 (2d Cir. 1984)].

Consider:

Injury-in-fact is not really a trigger theory but is the analysis used to determine whether a liability policy must respond. As one author observes, "the injury-in-fact theory merely restates the issue to be analyzed, mainly, 'When did the injury (in fact) happen?' " In contrast, the exposure, manifestation and continuous trigger theories "describe judicially created shortcuts to answer that question." [Vance A. Woodward, *Is "Injury-in-Fact" Really a Trigger in Insurance Coverage*?, 21-24 Mealey's Litig. Rep. Ins. 10 (April 24, 2007)].

Consider:

Because it is usually difficult to determine when injury actually occurred, the continuous injury trigger and injury-in-fact theory will often produce the same results. As courts and commentators have recognized, where the property damage or bodily injury is deemed to have occurred at the first exposure to a hazardous substance, it is difficult to distinguish the two theories [Pub. Serv. Co. of Colo. v. Wallis & Cos., 986 P.2d 924, 939 n. 24 (Colo. 1999)]. But where sufficient evidence exists, the injury-in-fact rule may very well produce a different result and afford insurers, whose policies would otherwise be triggered under a continuous trigger, the opportunity to demonstrate that injury did not in fact take place during its policy period. The burden, however, remains in the first instance with the insured to demonstrate that actual injury took place within a given insurer's policy in order to trigger that policy.

Jurisdictions that subscribe to the continuous trigger theory or injury-in-fact rule sometimes differ in defining when the injurious process begins and ends. Some jurisdictions presume that injury occurs contemporaneously with a given event, while others require proof of actual injury. For example, in the context of environmental contamination, some jurisdictions hold that the trigger period commences upon disposal of wastes at the contaminated site [Quincy Mut. Fire Ins. Co. v. Borough of Bellmawr, 172 N.J. 409, 433 (2002)]. This approach presumes that injury occurs upon disposal and dispenses with the need to conduct a factual finding. Other courts focus on when the contaminants first escaped or were discharged into the environment [Spartan Petroleum Co. v. Federated Mut. Ins. Co., 162 F.3d 805,

811 (4th Cir. 1998) ; Harleysville Mut. Ins. Co. v. Sussex County, 831 F. Supp. 1111, 1124-25 (D. Del. 1993)]. This may require expert testimony.

In terms of when the injury ceases, some courts hold that the trigger period ends when the injury becomes known [Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1047 (D.C. Cir. 1981)]. Others hold that it continues until the condition is remediated [Soc'y Ins. v. Town of Franklin, 607 N.W.2d 342, 346 (Wis. Ct. App. 2000)]. In the case of property damage claims involving asbestos, some courts find that injury occurs--and is complete--upon installation of asbestos in buildings [Md. Cas. Co. v. W.R. Grace & Co., 23 F.3d 617, 627 (2d Cir. 1994)].

The Second Circuit, which adheres to an actual injury theory, recently held in the context of an environmental claim that "property damage occurs as long as contamination continues to increase or spread, whether or not the contamination is based on active pollution or the passive migration of contamination into the soil and groundwater" [Olin Corp. v. Certain Underwriters of Lloyd's London, 468 F.3d 120, 131, (2d Cir. 2006)]. The Second Circuit previously observed in the asbestos context that injury continues as long as there is asbestos in the lung [Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1198 (2d Cir. 1995)]. It triggered policies from the date of first exposure to the date of death or claim, whichever occurred first [*id.* at 1199].

Strategic Point--Insurer:

Insurers on the risk after injury manifests, or at least after damages and liability become certain, may be able to assert a "known loss" defense.

Cross Reference:

For an understanding of the known loss doctrine, *see* Appleman, Insurance Law and Practice § 4528 (J. Appleman ed.).

39.15[2] Determine Start and End Dates for Allocation. For the most part, this issue goes hand-in-hand with the issue of trigger. The timeframe over which the loss is apportioned will be determined by the trigger theory adopted in the particular jurisdiction.

Courts employing an exposure trigger or manifestation trigger will typically spread the loss over a shorter period (sometimes a single year) than courts adopting a continuous trigger. Where a continuous trigger is used, the start date for allocation purposes will begin from the date of first exposure and continue through manifestation and sometime beyond. In jurisdictions that apply pro rata contribution, each triggered carrier (subject to any available coverage defenses) will be apportioned its proportionate share of the damage. The insured will also be assigned a share for periods of no insurance, self-insurance, too little insurance or other impairment. In jurisdictions employing the "all sums" method, the damages will not initially be spread across the entire trigger period but will instead be collapsed into a single year of the insured's choosing. Nonetheless, defining the allocation period under an "all sums" approach is important for reallocation among insurers.

There are circumstances, however, where the stop and start dates for allocation depart from the trigger period. For example, exposure may have taken place several years before the insured purchased insurance, or before coverage for the type of loss was ever available. Similarly, if the injury ceases during a time period where the policyholder opted not to purchase insurance, or did not purchase the proper type of insurance, the end date for allocation purposes may very well extend beyond the last triggered insurance policy. Under these circumstances, policyholders will often argue that these periods should not be included in the allocation because the share apportioned to such periods is not recoverable from an insurer and must be borne by the insured.

Example:

Many insurers began including an absolute pollution exclusion in their policies beginning in 1986. Whether the allocation period will continue beyond 1986, for which the policyholder will be responsible under the theory that it opted not to purchase adequate insurance, will often hinge on whether and when supplemental coverage, such as an environmental impairment liability policy, was available.

Cross Reference:

See § 39.15[6][a] below for a discussion of self-insured years.

Another issue that arises is whether to allocate fully to the first triggered policy where the injury commences after the policy's inception date (which will almost always be the case) or whether to prorate that carrier's share. This same issue also arises with respect to end dates, i.e., whether to allocate fully to the last triggered policy where the injury ceases prior to the policy termination date. Some courts allocate to the entire policy as long as the damage takes place at some point during the policy's effective dates [Wooddale Builders, Inc. v. Md. Cas. Co., 722 N.W.2d 283, 294 (Minn. 2006)]. Other courts apportion the loss based on the number of days on the risk, rather than years [Quincy Mut. Fire Ins. Co. v. Borough of Bellmawr, 172 N.J. 409, 436-37 (2002)]. The New Jersey Supreme Court reasoned that principles of simple justice dictate that the first carrier on the risk should not be responsible for an entire year within the continuous trigger period merely because it was on the risk for a portion of that year [*id.*]

An issue exists in the property damage context as to whether the allocation period should cease on the date that the insured became aware of the contamination, or continue until the remediation is completed. The prevailing view appears to be that the allocation period ends when the condition manifests [Wooddale Builders, Inc. v. Md. Cas. Co., 722 N.W.2d 283, 299 (Minn. 2006)]. Allocating until remediation is complete is often difficult to achieve in the context of most environmental claims, since site cleanup will often continue for several years after the insurance claim arises. In the bodily injury context, such as asbestos or other toxic tort claims, the date of diagnosis or manifestation of disease typically represents the end date [J.H. France Refractories Co. v. Allstate Ins. Co., 534 Pa. 29, 37 (1993)], although some courts have held that injury continues as long as the disease progresses [*Stonewall*, 73 F.2d at 1199]. In such case, the end date may be defined by when the claim was commenced.

39.15[3] Consider Policy Limits in Multi-Year and Stub Policies. When allocating losses, an issue often arises as to the treatment of policies in effect for more than one annual period (multi-year policies) and policies in effect for less than one year (stub policies). The questions that arise are similar for both types of policies. Should a multi-year policy be assigned a single per occurrence limit for the duration of the policy, or should it be assigned a separate per occurrence limit for each year that it is in effect? Similarly, should a stub policy be treated as if it contains a full liability limit, or should it be assigned a prorated limit?

39.15[3][a] Multi-Year Policies. Of course, when addressing this issue, the first place to start is the policy itself. Some multi-year policies contain what has been called an "annualization" clause, i.e., a provision that states the liability limit shall apply separately for each consecutive annual period, but many multi-year policies contain no express provision. Where the policy is silent, the majority of courts have held that only a single liability limit applies for the duration of the policy [*see, e.g.,* CSX Transp., Inc. v. Commercial Union Ins. Co., 82 F.3d 478 (D.C. Cir. 1996) ; Soc'y of Roman Catholic Church of Dioceses of Lafayette Lake Charles, Inc. v. Interstate Fire & Cas. Co., 26 F.3d 1359 (5th Cir. 1994)]. Courts have similarly found that a policyholder must satisfy only one deductible of a multi-year policy and not a separate deductible for each year [Uniroyal, Inc. v. Home Ins. Co., 707 F. Supp. 1368 (E.D.N.Y. 1988)].

Courts in New Jersey, however, have taken the opposite approach and have applied annual limits to multi-year policies [Chemical Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co., 978 F. Supp. 589, 606-09 (N.J. 1997) , *rev'd on other grounds*, 177 F.3d 210 (3d Cir. 1999) ; U.S. Mineral Prods. Co. v. Am. Ins. Co., 348 N.J. Super. 526, 529 (App. Div. 2002)]. These cases follow the New Jersey Supreme Court's ruling in Owens Illinois, Inc. v. United Ins. Co. [138 N.J. 437, 478-79 (1994)], which declared for allocation purposes that long-tail environmental damage would be treated as one occurrence per year, as opposed to one continuous occurrence.

Cross Reference:

For a discussion of policies written on a three-year basis and the treatment courts have accorded the issue of annualization of per occurrence limits, *see* Jeannine W. Chanes, *Once is Never Enough: Annualization of Per Occurrence Limits in Three-Year Policies*. 14-27 Mealey's Litig. Rep. Ins. 10 (2000) .

39.15[3][b] Stub Policies. A stub policy, or fractional period issue, may arise for different reasons. For example, it may be due to cancellation of the policy before its expiration date, or a stub policy may take the form of an endorsement, extending the policy for a few months in exchange for an additional (prorated) premium. A policyholder may seek such an endorsement, for example, when it is in the process of restructuring its current insurance program. Sometimes a stub issue may arise when the policy is written for more than a year but less than two years.

As is the case with multi-year policies, the actual language of the insurance policy will determine the outcome. As a general principle, however, absent policy language to the contrary, stub policies will carry full limits for the fractional period [*see, e.g.,* U.S. Mineral Prods. Co. v. Am. Ins. Co., 348 N.J. Super. 526 (App. Div. 2002) (concluding that two-week extension created a new annual limit); Stonewall Ins. Co. v. Cont'l Ins. Co., 73 F.3d 1178, 1216 (2d Cir. 1995) (holding that policy cancelled before expiration had full annual limit for nine-month period)]. In so holding, courts typically reason that: (1) nothing in the policy language permits prorating limits for periods shorter than one year; and (2) the proration of the premium reflects the shortened length of time for which the insurer is exposed to the risk of loss, not a reduced quantum of protection available if the risk materializes in the stub period [*see* Cadet Mfg. Co. v. Am. Ins. Co., 391 F. Supp. 2d 884, 890 (W.D. Wash. 2005)].

Example:

The policyholder procured a policy from Carrier A effective January 1, 1967, with a per occurrence and aggregate limit of $10 million. Effective April 1, 1967, the policyholder cancelled the policy and replaced it with a policy from Carrier B. Carrier A issued a cancellation endorsement that shortened the policy period and refunded a portion of the premium. Decades later, the policyholder presented Carrier A with $10 million of asbestos product-liability losses. Carrier A argued that its liability was capped at $2.5 million, since the policy was only in effect for one-quarter of the year. The court disagreed and held that where a policy is cancelled before the end of its stated period, there is no proration of the policy limits and the insured is entitled to recover up to the full policy limits for the shortened period [OneBeacon Ins. Co. v. Georgia-Pacific Corp., 474 F.3d 6, 8 (1st Cir. 2007)].

Exception:

Where a policy is upgraded, as opposed to replaced or extended, proration may be allowed. For example, where a $2 million policy was replaced part way through the policy term with a $5 million policy from the same insurer covering the remainder of the original policy's term, the court prorated the limits to avoid a windfall to the insured. The court recognized that the aim of the transaction was to upgrade the policy limits from $2 million to $5 million and that a payout of $7 million would be unreasonable [Stonewall Ins. Co. v. Cont'l Ins. Co., 73 F.3d 1178, 1217 (2d Cir. 1995)].

Warning:

A second line of cases holds that the stub period is subject to the limit of the original policy and does not create a new annual limit [*ee, e.g.,* Diamond Shamrock Chems. Co. v. Aetna Cas. & Sur. Co., 258 N.J. Super. 167, 225-26 (App. Div. 1992) ; Gen. Refractories Co. v. Ins. Co. of N. Am., 2006 Pa. Super. 224 (2006)].

Strategic Point:

Consideration should be given as to whether the stub period is to be allocated an annual share of the loss

or a share based on the number of months or days of the fractional period. Some courts have departed from the annual approach when allocating. The Connecticut Supreme Court has endorsed an allocation approach based on the number of months, not years on the risk, while the New Jersey Supreme Court has used days. [Sec. Ins. Co. v. Lumbermens Mut. Cas. Co., 264 Conn. 688, 698 (2003) ; Quincy Mut. Fire Ins. Co. v. Borough of Bellmawr, 172 N.J. 409, 436 (2002)].

39.15[4] Consider Whether Non-Cumulation and Deemer Clauses Reduce Liability Limits. A policyholder's insurance program that spans decades will typically be made up of a number of different carriers at differing layers of coverage. It is not unusual, however, for a policyholder to renew its primary or first-layer excess coverage with a single carrier for several years in a row. These policies may sometimes contain non-cumulation clauses, which typically reduce the limit of liability in a given policy by amounts paid under prior policies with respect to the same occurrence, or otherwise cap liability at the highest limit of any policy issued by that carrier. Also, such policies may contain a "deemer" clause, which is a mechanism to determine which single policy responds where an occurrence potentially triggers more than one policy. Because the intent of these clauses is to limit the insurer's liability where loss spreads over more than one policy period, these clauses must be considered when allocating a long-tail loss.

39.15[4][a] Non-Cumulation Clauses. The following are two examples of non-cumulation clauses:

Example 1:

Regardless of the number of insured persons, injured persons, claims, claimants or policies involved, our total liability for damages resulting from one loss will not exceed the limit of liability for coverage X shown on the declarations page. All bodily injury, personal injury and property damage resulting from one accident or from continuous or repeated exposure to the same general conditions is considered the result of one loss.

Example 2:

If the same occurrence gives rise to personal injury, property damage or advertising injury or damage which occurs partly before and partly within any annual period of this policy, each occurrence limit and the applicable aggregate limit or limits of the policy shall be reduced by the amount of each payment made by the company with respect to each occurrence, either under a previous policy or policies of which this policy is a replacement, or under this policy with respect to previous annual periods thereof.

It should come as no surprise that these provisions have received varying treatment by courts. Courts that have analyzed the issue based on a strict reading of the policy enforce such non-cumulation clauses. For example, the New York Court of Appeals enforced a non-cumulation clause identical to the provision in Example 1, where an infant plaintiff was allegedly exposed to lead paint continuously over three consecutive policy periods issued by the same carrier. Each policy contained limits of $300,000, and the issue was whether the available insurance coverage was $300,000 or $900,000. The court was mindful that if each successive policy had been written by a different carrier, each carrier would be liable up to the limits of its policy, and inquired "[w]hy should plaintiffs recover less money because the same insurer wrote them all?" In answering this question, the court held that plaintiffs were entitled to only one limit because the policy clearly said so [Hiraldo v. Allstate Ins. Co., 5 N.Y.3d 508, 513 (2005)].

In another case, the insurer issued 10 consecutive policies that contained the non-cumulation clause in Example 2. The insured sought to avoid application of the clause to a latent injury asbestos claim by suggesting that if it selects the last issued policy in which to recover payment, the non-cumulation clause becomes inoperable, and it may therefore recover under each policy in reverse chronological order. The Third Circuit rejected these efforts, finding that such an interpretation violates the provision's very purpose and effectively allows it to be read entirely out of the policy [Liberty Mut. Ins. Co. v. Treesdale, Inc., 418 F.3d 330, 342 (3d Cir. 2005)].

In contrast, the New Jersey Supreme Court found the same non-cumulation clause to be unenforceable. Its holding was particular to how New Jersey treats progressive indivisible property damage for purposes of trigger and allocation. It

reasoned that at the heart of a non-cumulation clause is the notion of a single occurrence with multiple-year effects. New Jersey law, however, rejects the idea that in an environmental exposure case successive policies are triggered by a single occurrence [Spaulding Composites Co. v. Aetna Cas. & Sur. Co., 176 N.J. 25, 44 (2003) ; *see also* Outboard Marine Corp. v. Liberty Mut. Ins. Co., 283 Ill. App. 3d 630, 644-45 (1996) (finding enforcement of non-cumulation clause to be at odds with application of pro rata allocation)].

Cross Reference:

Some courts refuse to enforce non-cumulation clauses on the basis that they are analogous to escape clauses. *See* § 39.09[2] above, which discusses this issue in the context of "other insurance" clauses.

39.15[4][b] Deemer Clauses. Deemer clauses have also been given disparate treatment by courts, although they appear to be generally more disfavored than non-cumulation clauses. Deemer clauses have invoked the ire of courts when they contain language that, if enforced, would allow an insurer to escape liability by placing the loss in a policy issued by a subsequent carrier. For example, some deemer clauses have language to the effect that bodily injury or property damage caused by the continuous or repeated exposure to conditions shall be deemed to occur only on the last day of the last exposure to such conditions. Some courts have found deemer clauses of this sort to be illusory in the context of environmental pollution claims because the day of last exposure may never be known, and therefore, coverage might never be triggered [United Techs. Corp. v. Liberty Mut. Ins. Co., 1993 Mass. Super. LEXIS 281, *65, 1 Mass. L. Rptr. 91 (Mass. Super. Ct. 1993)].

Others find this clause to be ambiguous because the last day of exposure could refer to several possibilities, such as the last day of dumping or the last day that waste was remediated [Endicott Johnson Corp. v. Liberty Mut. Ins. Co., 928 F. Supp. 176, 182 (N.D.N.Y. 1996)].

Some courts have refused to enforce this type of clause on the basis that the purpose of the deemer clause is to prevent the stacking of claims by assigning the loss to one policy, not by completely excluding coverage [Liberty Mut. Ins. Co. v. Black & Decker Corp., 383 F. Supp. 2d 200, 212 (D. Mass. 2004)].

Nonetheless, other courts have enforced deemer provisions of this nature even where the injury last occurs in a subsequent policy issued by another carrier [Monsanto Co. v. Aetna Cas. & Sur. Co., 1993 Del. Super. LEXIS 464, at *15 (Del. Super. Ct. Dec. 21, 1993)].

As a whole, it appears that a deemer clause has a better chance of being enforced when it seeks to limit exposure to only one policy issued by the same carrier, as opposed to escaping liability by shifting the loss to a period insured by another carrier.

39.15[4][c] Effect of Non-Cumulation and Deemer Clauses on Allocation. In cases where courts enforce non-cumulation or deemer clauses, an issue that arises upon allocation is whether the insured is left to bear that portion of the loss assigned to years impaired by such clauses, or whether those impaired years should be removed from the allocation altogether, thereby effectively shortening the trigger period. The same concerns arise when successive claims-made policies have been written by the same carrier. Although only one policy will be triggered, how are the remaining years treated for allocation purposes? Courts have not yet specifically addressed this issue, but they may very likely treat such years the same as any other impaired year.

39.15[5] Consider How to Apportion Deductibles and Self-Insured Retentions. As a means of reducing insurance premiums, many companies have opted to assume a portion of their liability risk through deductibles and self-insured retentions ("SIRs"). When allocating liability under one of the pro rata methods for an occurrence that spans over multiple policy periods, questions often arise as to how many deductibles or SIRs must be satisfied.

Insurer's Perspective:

Insurers argue that a full deductible or SIR must be satisfied for each triggered period before excess coverage becomes available.

Insurer's Perspective:

Insureds, on the other hand, often argue that they should not be required to satisfy multiple deductibles or SIRs for a single occurrence. Instead, they contend that it is more appropriate to satisfy only one, weighted average deductible or SIR. Alternatively, insureds argue that insofar as the insurer's obligations are prorated, it is only fair to also prorate the insured's deductibles and SIRs. Prorating the deductible or SIR has the practical effect of lowering the attachment point of the excess policies.

Most courts side with insurers on this issue and require the policyholder to satisfy a full deductible or SIR for each policy period in which it seeks coverage [Pub. Serv. Co. v. Wallis & Cos., 986 P.2d 924, 941 (Colo. 1999) ; N. States Power Co. v. Fid. & Cas. Co. of N.Y., 523 N.W.2d 657, 664 (Minn. 1994) ; Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co., 275 Kan. 698, 750 (2003)]. Courts base this result on the clear language of the excess policies and the recognition that any other approach would upset the balance of risk between insured and insurer [Olin Corp. v. Ins. Co. of N. Am., 221 F.3d 307, 327-28 (2d Cir. 2000)]. Indeed, pro rata allocation, while spreading the damages across multiple policy periods, leaves in tact the full liability limits of each policy. To prorate a deductible or SIR without prorating liability limits would result in a windfall to the policyholder [Benjamin Moore & Co. v. Aetna Cas. & Sur. Co., 179 N.J.87, 105-110 (2004)].

Nonetheless, a few courts have prorated deductibles and SIRs on the basis of fairness or ambiguity [*see, e.g.*, Lafarge Corp. v. Hartford Cas. Ins. Co., 61 F.3d 389 (5th Cir. 1995) ; Nationwide Mut. Ins. Co. v. Lafarge Corp., 910 F. Supp. 1104, 1108 (D. Md. 1996) , *aff'd*, 121 F.3d 699 (4th Cir. 1997)].

Distinguish:

Deductibles differ from SIRs in a few respects. For allocation purposes, it should be kept in mind that policies with a deductible attach differently than policies above an SIR. A deductible is subtracted from policy limits, thereby reducing the amount of insurance available. A policy with a deductible, however, offers "first dollar" coverage. In contrast, the full limits of a policy subject to an SIR are available once the retained limit has been exhausted. Thus, for example, assume the insured purchased a $1 million policy subject to a $100,000 SIR. After the insured pays $100,000, it stills has $1 million in coverage available. In contrast, if the insured purchased a $1 million policy with a $100,000 deductible, the insured would have only $900,000 available after the deductible is applied.

Under a joint and several approach, only one deductible or SIR need be satisfied by the insured, since the loss is collapsed into one policy period. In this situation, the carrier or carriers selected by the insured to pay the claim will seek to recoup sums paid in excess of their pro rata share from other carriers whose policies were triggered. The issue of how to treat deductibles or SIRs in the context of a contribution action is somewhat more complicated. On the one hand, it seems fair that each insurer should enjoy the benefit of a deductible or SIR since the insurer presumably received a lower premium for this benefit. On the other hand, it is unfair that the targeted insurer should bear the costs of all deductibles and SIRs, thereby reducing the amount available by way of contribution, simply because it was unfortunate enough to have been selected by the insured to satisfy the entirety of the loss. Indeed, the insurer in a spike year obtained no benefit from reduced premiums enjoyed by the insured when the insured decided to retain part of the risk in other years. Hence, a question remains concerning how to apportion deductibles or SIRs among carriers that otherwise would have been the responsibility of the insured.

If the spiked insurer must satisfy one SIR in each policy period, it will be required to pay an amount possibly far in excess of its proportionate share (bearing in mind that it benefited from one actual deductible or SIR in its policy period). If the amount assigned to deductibles and SIRs is to be shared by all insurers, then none will enjoy the full benefit of its bargain, and each policy will attach at a level lower than contemplated. Thus, the dilemma for courts is

whether each insurer should pay a little more than it otherwise would so as to avoid one carrier being saddled with the entirety of the excess, or if the targeted insurer should stand in the shoes of the insured and recover no more than what the insured could have received.

39.15[6] Consider Apportionment to Gap Periods. When allocating a progressive loss that spans several years, it is not unusual that there will be certain gaps in the insured's coverage program. Coverage gaps may arise for a number of reasons:

1. The insured did not purchase insurance;

2. The insured purchased too little insurance;

3. An exclusion applies;

4. The insurer is insolvent;

5. The policy is lost or missing;

6. The policy limits are impaired or exhausted; or

7. The policy is the subject of buy-back agreement.

Policyholders will typically argue that periods in which there are gaps in coverage should be removed from the "allocation block," whereas insurers will argue that gap periods should be included in the allocation and assigned to the policyholder. Courts applying a pro rata allocation method hold that the insured must generally bear that portion of the loss assigned to gap periods [Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1224 (6th Cir. 1980) ; Owens-Illinois, Inc. v. U.S. Ins. Co., 138 N.J. 437, 439 (1994)]. In contrast, gap periods become the responsibility of the insurers under a joint and several approach (except to the extent that the insured did not purchase adequate insurance in the spike year to fully cover the loss) [Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1049 (D.C. Cir. 1981)]. Thus, the treatment of gap periods presents the major difference between pro rata and joint and several allocation.

39.15[6][a] Self-Insured Years. Several courts have held that the policyholder is responsible for its pro rata share of the loss during periods when it was self-insured or otherwise without coverage due to a policy exclusion [Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1203-04 (2d Cir. 1995) ; Owens-Illinois, Inc. v. U.S. Ins. Co., 138 N.J. 437, 479 (1984)]. But courts generally do not assign a pro rata share to the insured for time periods in which insurance was not available [Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1203-04 (2d Cir. 1995)].

Example:

In *Stonewall*, the Second Circuit held that the proration-to-the-insured approach should not be applied to years after asbestos liability insurance was no longer available [73 F.3d at 1203-04].

Consider:

In *Olin*, a number of the insured's commercial general liability ("CGL") policies contained pollution exclusions. The Second Circuit considered whether coverage was available for pollution liability under environmental impairment liability ("EIL") policies. The court found that EIL coverage was available to large U.S. companies several years before the pollution was discovered. Because the insured had failed to obtain an EIL policy, it was held responsible for injury during periods that it went uninsured [Olin Corp. v. Ins. of N. Am., 221 F.3d 307, 325-26 (2d Cir. 2000)].

Cross Reference:

For a further discussion of EIL insurance and its availability, *see* Environmental Law Practice Guide §§ 8.01[2][a] and 8.03[10][c].

39.15[6][b] Insufficient Insurance. An insured assumes a share of the risk "either by declining to purchase available insurance or by purchasing what turns out to be an insufficient amount of insurance" [Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1204 (2d Cir. 1995)].

Where a progressive loss spans decades, the policy limits in the earlier years may sometimes be insufficient to cover the pro rata share assigned to that year. In such case, the insured must assume the loss for any excess amounts. The same considerations apply where the policy's aggregate limits were exhausted by prior claims or otherwise subject to a policy buy-back agreement.

A joint and several allocation approach enables a policyholder to avoid the risk associated with long periods of underinsuring as long as it had adequate limits in at least one triggered policy year. A joint and several approach, however, does not necessarily maximize coverage in all situations. Where the insured's loss exceeds the total limit of coverage in a given year, the insured will be unable to recover the excess unless the jurisdiction allows for "stacking."

39.15[6][c] Insolvency. When an allocated share of the loss is assigned to an insolvent carrier, the question that arises is whether the umbrella or excess carrier should be required to "drop-down" in place of the insolvent carrier. The particular policy language must be consulted, but as a general rule, many courts have refused to require umbrella or excess carriers to "drop-down" to cover losses that should have been covered by policies issued by insolvent carriers [*see, e.g.,* Werner Indus., Inc. v. First State Ins. Co., 112 N.J. 30 (1988) ; Ambassador Assoc. v. Corcoran, 79 N.Y.2d 871 (1992)].

Cross Reference:

For a discussion of insurer insolvency and drop-down law, *see* Eric Mills Holmes, Appleman on Insurance 2d § 163.3; Insolvency: Effects of Insurer's Insolvency; Daniel A. Austin, *Drop-Down? Drop Dead! Excess Insurer Is Not Required to Provide Primary Coverage in Lieu of an Insolvent Insurer*, 24-9 ABIG 24 (Nov. 2005).

Consequently, the insured is responsible in pro rata jurisdictions for years in which its insurer is bankrupt [Benjamin Moore & Co. v. Aetna Cas. & Sur. Co., 179 N.J.87, 99-101 (2004)]. In jurisdictions that follow the "all sums" approach, the insured can transfer this responsibility to one or more of its carriers.

Lexis.com Search:

To determine whether an insurer is insolvent, search:

Legal > Legal News > Mealey's Legal NewsBriefs > Insurance Insolvency NewsBrief: Mealey's Litigation Report (abstracts)

Legal > Area of Law - By Topic > Insurance > Search News > Legal News > Insurance Insolvency: Mealey's Litigation Report (full text)

Legal > Area of Law - By Topic > Insurance > Best's Company Reports

39.15[6][d] Lost or Missing Policies. Courts in pro rata jurisdictions have likewise apportioned to insureds periods when the insured is unable to prove the existence or terms of insurance policies that have become lost or missing [Sec. Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co., 826 A.2d 107 (Conn. 2003)].

Cross References:

For a discussion of lost policy law and the proof required to establish the existence and terms of lost policies, *see*:

California Law: Ryan L. Werner, Implied Duty of Good Faith and Fair Dealing: Proof of Lost Policy Provisions, California Insurance Law & Practice § 13.03; and

New York Law: Judith S. Roth, Insurance Coverage of Environmental Risks: Disputing the Existence and Terms of Policies, New York Insurance Law § 43.05 (Walcott B. Dunham, Jr., ed.).

The burden to prove the contents of a policy rests with the insured [Dart Indus. Inc. v. Commercial Union Ins. Co., 28 Cal. 4th 1059, 1071 (2002)]. In "all sums" jurisdictions, the burden to prove the existence and terms of lost policies is essentially shifted to the insurers that issued policies in the spike year when they seek to recover in contribution from other carriers. In "all sums" jurisdictions, consideration should be given to whether a policyholder, by failing to properly maintain its insurance policies or otherwise failing to maintain adequate records to prove their existence and terms, should be responsible for the allocated share assigned to lost policies in a contribution action. Indeed, a careless policyholder can severely impair the contribution rights of carriers in the spike year if the policyholder fails to keep records of its prior insurance. Since such bookkeeping is solely within the policyholder's control, it would seem reasonable that the policyholder should bear some responsibility for its actions.

39.15[7] Consider How to Apportion Defense Costs. Many of the same issues that arise when allocating indemnity costs also arise when allocating defense costs. Accordingly, most courts apportion defense costs in the same manner as they apportion indemnity costs [Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1224-25 (6th Cir. 1980) ; Owens-Illinois, Inc. v. United Ins. Co., 138 N.J. 437 (1994)].

Policyholders have sought to draw a distinction between defense and indemnity in jurisdictions that have adopted pro rata allocation. Their argument is predicated on the concept that the duty to defend is broader than the duty to indemnify. Whereas the duty to indemnify is based on actual facts as adjudicated in the underlying action, the duty to defend is based on allegations in the complaint, even if those allegations are groundless, false or fraudulent.

Cross Reference:

For a discussion of the duty to defend, *see* § 1.19[2][b] above.

Thus, where a claim potentially falls within the coverage of successive insurance policies, each insurer has an independent obligation to defend. Policyholders have therefore argued for a joint and several liability approach to apportionment of defense costs, even where the jurisdiction allocates indemnity on a pro rata basis.

These efforts have generally been rejected. Most courts allocate defense costs on a pro rata basis in long tail claims that implicate multiple insurance policies on the grounds that the insurer did not contract to pay defense costs for losses that took place outside the policy period [Sec. Ins. Co. v. Lumbermens Mut. Cas. Co., 264 Conn. 688, 710 (2003) ; Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1224-25 (6th Cir. 1980)]. Consequently, policyholders are apportioned a share of defense costs during periods where, for example, they entered into buy-back agreements, are unable to prove the existence or terms of policies or are otherwise self-insured [*id.*].

Consider:

The Connecticut Supreme Court held in *Security Insurance Company* that the insured must be allocated its pro rata share of defense costs for periods in which it was uninsured or had lost or destroyed policies. The court left open, however, the issue of apportionment of defense costs among successive insurers where there is uninterrupted coverage [264 Conn. 688, 720 n.8 (2003)].

Distinguish:

Allocation of Defense Costs Between Covered and Non-Covered Claims: Where a complaint asserts multiple claims, some of which are potentially covered and some of which are not, some courts will require the policyholder to reimburse the insurer for costs incurred in the defense of non-covered claims [Buss v. Superior Court, 16 Cal. 4th 35 (1997) ; QSP, Inc. v. Aetna Cas. & Sur. Co., 256 Conn. 343, 354 (2001)]. While this presents another situation where courts will allocate a portion of defense costs to insureds, it is a concept separate and distinct from the apportionment of defense costs over successive years and concerns apportionment between insured and insurer, as opposed to multiple insurers.

Other courts applying pro rata apportionment to indemnity costs have made a distinction when it comes to defense costs, and allocated on an equal shares basis among all primary insurers [Wooddale Builders, Inc. v. Md. Cas. Co., 722 N.W.2d 283, 302 (Minn. 2006)]. The Minnesota Supreme Court reasoned that:

> The duty to defend is broader than the duty to indemnify in three ways: (1) the duty to defend extends to every claim that "arguably" falls within the scope of coverage; (2) the duty to defend one claim creates a duty to defend all claims; and (3) the duty to defend exists regardless of the merits of the underlying claims [*id.*].

Thus, it appears that Minnesota courts will not apportion defense costs to the policyholder for self-insured years where at least one triggered policy contains a duty to defend. Bear in mind, however, that excess insurers generally have no obligation to pay defense costs if the primary insurers have a duty to defend [Liberty Surplus Ins. Corp. v. Segal Co., 420 F.3d 65 (2d Cir. 2005)]. Hence, defense costs will not be allocated to excess policies where primary coverage exists.

It is also important to distinguish between policies that reimburse defense costs from policies that contain a duty to defend. Many excess policies are written on an "ultimate net loss" basis and include payment of defense costs within "ultimate net loss." Courts recognize that the duty to pay defense costs under an ultimate net loss policy is co-extensive with the duty to indemnify [Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1219 (2d Cir. 1995)]. Thus, unlike under a primary policy, where the duty to defend extends to every claim that potentially falls within the scope of coverage, the duty to reimburse defense costs under an excess policy extends only to claims established to be covered [*id.*]. Therefore, in the absence of primary coverage, defense costs under excess policies should be apportioned the same way as indemnity costs, even in jurisdictions, such as Minnesota, that apportion defense costs equally among primary insurers.

Legal Topics:

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