



# 50 INSURANCE CASES EVERY SELF-RESPECTING ATTORNEY OR RISK PROFESSIONAL SHOULD KNOW

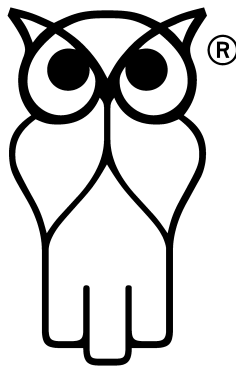
AN ANALYSIS OF THE TOP 50 PROPERTY-CASUALTY COVERAGE CASES  
AND THEIR IMPLICATIONS

**International Risk Management Institute, Inc.**

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## FOREWORD

For more than 30 years, International Risk Management Institute, Inc. (IRMI), has been a premier provider of risk management and insurance information to corporations, law firms, government, and the insurance industry. This information is developed by the most experienced research and editorial team in insurance reference publishing in partnership with a host of industry practitioners who work with us.

IRMI has been pleased to work with Jill B. Berkeley as author and editor of *[CGL Reporter, The Insurance Coverage Litigation Handbook](#)* for more than 25 years. In 1997, the Insurance Coverage Litigation Committee (ICLC) of the Tort Trial and Insurance Practice Section (TIPS) of the American Bar Association became involved, forming an editorial board led by Jill to write the case summaries to be published in *CGL Reporter*. In return, a portion of the revenues from *CGL Reporter* subscriptions are donated by IRMI to fund scholarships for participation in TIPS continuing legal education programs with the goal of increasing diversity amount participants in TIPS programs.

Recently, TIPS members and *CGL Reporter* editorial board members came to IRMI with an idea for a white paper on the top insurance coverage cases of all time. It seemed like a rather grandiose proposition, but an interesting one as well. What follows is the product of that discussion—summaries of 50 U.S. insurance coverage cases that are arguably the most influential of all time, along with insightful analysis on the implications of those decisions. (Please read the Introduction on page 1 to see how the authors went about compiling the list.)

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please [contact us](#) using the form on our website. We sincerely hope you find this publication to be interesting and educational.

All the best,

Jack P. Gibson, CPCU, CRIS, ARM

President and CEO

International Risk Management Institute, Inc.

## TOP 50 CASES

Below is a list of the 50 most interesting, influential, and vital property-casualty insurance coverage cases, in our opinion, with links to the case summaries. The implications of these cases are discussed in the pages that follow. An alphabetical listing of all the cases mentioned in this book can be found in the Cumulative Case Index.

### Insuring Agreement

#### What Is “Property Damage”?

1. [Eljer Mfg., Inc. v. Liberty Mut. Ins. Co.](#), 972 F.2d 805 (7th Cir. 1992)
2. [Travelers Ins. Co. v. Eljer Mfg., Inc.](#), 757 N.E.2d 481 (Ill. 2000)
3. [U.S. Fid. & Guar. v. Wilkin Insulation Co.](#), 578 N.E.2d 926 (Ill. 1991)
4. [Vandenberg v. Superior Ct.](#), 88 Cal. Rptr. 2d 366, 982 P.2d 229 (1999)

#### What Is a “Suit”?

5. [Central Ill. Light Co. v. Home Ins. Co.](#), 213 Ill. 2d 141, 821 N.E.2d 206 (2004)
6. [Powerine Oil Co., Inc. v. Superior Ct. of Los Angeles \(Central Nat’l Ins. Co., Real Party in Interest\)](#), 37 Cal. 4th 377, 33 Cal. Rptr. 3d 562, 118 P.3d 589 (2005)

#### What Are “Damages”?

7. [Aerojet-General Corp. v. Superior Ct.](#), 211 Cal. App. 3d 319, 257 Cal. Rptr. 621 (1989)
8. [AIU Ins. Co. v. Superior Ct.](#), 51 Cal. 3d 807, 274 Cal. Rptr. 820, 799 P.2d 1253 (1990)

#### What Are “Intentional Acts”?

9. [J.C. Penney Cas. Ins. Co. v. M.K.](#), 52 Cal. 3d 1009, 278 Cal. Rptr. 64, 804 P.2d 689 (1991)
10. [Shell Oil Co. v. Winterthur Swiss Ins. Co.](#), 12 Cal. App. 4th 715, 15 Cal. Rptr. 2d 815 (1993)

#### What Is the “Duty To Defend”?

11. [Buss v. Superior Ct.](#), 16 Cal. 4th 35, 65 Cal. Rptr. 2d 346, 939 P.2d 766 (1997)
12. [Employers Ins. of Wausau v. Ehlco Liquidating Trust](#), 186 Ill. 2d 127, 708 N.E.2d 1122 (1999)
13. [General Agents Ins. Co. v. Midwest Sporting Goods Co.](#), 215 Ill. 2d 146, 828 N.E.2d 1092 (2005)
14. [Gray v. Zurich Ins. Co.](#), 65 Cal. 2d 263 (1966)
15. [Horace Mann Ins. Co. v. Barbara B.](#), 4 Cal. 4th 1076, 17 Cal. Rptr. 2d 210 (1993)
16. [Lee v. Aetna Cas. & Sur. Co.](#), 178 F.2d 750 (2d Cir. 1949)
17. [Maryland Cas. Co. v. Peppers](#), 64 Ill. 2d 187, 355 N.E.2d 24 (1976)
18. [San Diego Navy Federal Credit Union v. Cumis Ins. Co.](#), 162 Cal. App. 3d 358 (1984)

### Exclusions

#### What Is “Concurrent Causation”?

19. [Garvey v. State Farm Fire & Cas. Co.](#), 48 Cal. 3d 395 (1989)
20. [State Farm Mut. Auto. Ins. Co. v. Partridge](#), 10 Cal. 3d 94 (1973)

### Conditions

#### What Is “Notice”?

21. [Campbell v. Allstate Ins. Co.](#), 60 Cal. 2d 303, 32 Cal. Rptr. 827, 384 P.2d 155 (1963)
22. [Country Mut. Ins. Co. v. Livorsi Marine, Inc.](#), 222 Ill. 2d 303, 856 N.E.2d 338, 305 Ill. Dec. 533 (2006)

**What Is the “Duty To Cooperate”?**

**23. *Waste Mgmt., Inc. v. International Surplus Lines Ins. Co.***, 144 Ill. 2d 178, 579 N.E.2d 322 (1991)

**What Is “Consent To Settle”?**

**24. *Aerojet-General Corp. v. Commercial Union Ins. Co.***, 155 Cal. App. 4th 132, 65 Cal. Rptr. 3d 803 (2007)

**25. *Miller v. Shugart***, 316 N.W.2d 729 (Minn. 1982)

**26. *Qualcomm, Inc. v. Certain Underwriters at Lloyd’s of London***, 161 Cal. App. 4th 184 (2008)

**Are “Successors” Covered?**

**27. *Henkel Corp. v. Hartford Acc. & Indem. Co.***, 62 P.3d 69 (Cal. 2003)

**Limits of Liability****What Are “SIRS/Deductibles”?**

**28. *Missouri Pac. R.R. Co. v. International Ins. Co.***, 288 Ill. App. 3d 69, 679 N.E.2d 801 (1997)

**29. *Montgomery Ward & Co., Inc. v. Imperial Cas. & Indem. Co.***, 81 Cal. App. 4th 356, 97 Cal. Rptr. 2d 44 (2000)

**Long-Tail Liability Issues****Allocation**

**30. *Aerojet-General Corp. v. Transport Indem. Co.***, 17 Cal. 4th 38, 70 Cal. Rptr. 2d 118, 948 P.2d 909 (1997)

**31. *J.H. France Refractories Co. v. Allstate Ins. Co.***, 626 A.2d 502 (Pa. 1993)

**32. *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.***, 652 A.2d 30 (Del. 1994)

**33. *Owens-Illinois, Inc. v. United Ins. Co.***, 650 A.2d 974 (N.J. 1994)

**34. *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.***, 73 F.3d 1178 (2d Cir. 1995)

**When Is Coverage Triggered?**

**35. *Eagle-Picher Ind., Inc. v. Liberty Mut. Ins. Co.***, 682 F.2d 12 (1st Cir. 1982)

**36. *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.***, 633 F.2d 1212 (6th Cir. 1980)

**37. *Keene Corp. v. Insurance Co. of N. Am.***, 667 F.2d 1034 (D.C. Cir. 1981)

**38. *Koppers Co., Inc. v. Aetna Cas. & Sur. Co.***, 98 F.3d 1440 (3d Cir. 1996)

**39. *Outboard Marine Corp. v. Liberty Mut. Ins. Co.***, 283 Ill. App. 3d 630, 670 N.E.2d 740 (2d Dist. 1996)

**40. *U.S. Gypsum Co. v. Admiral Ins. Co.***, 268 Ill. App. 3d 598, 643 N.E.2d 1226 (1st Dist. 1994)

**41. *Zurich Ins. Co. v. Raymark Ind. Inc.***, 514 N.E.2d 150 (Ill. 1987)

**How Many “Occurrences”?**

**42. *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.***, 676 F.2d 56 (3d Cir. 1982)

**43. *Lee v. Interstate Fire & Cas. Co.***, 86 F.3d 101 (7th Cir. 1996)

**44. *Nicor, Inc. v. Associated Electric & Gas Ins. Servs. Ltd.***, 223 Ill. 2d 407, 860 N.E.2d 280 (2006)

**Bad Faith****What Constitutes “Bad Faith”?**

**45. *Crisci v. Security Ins. Co. of New Haven, Conn.***, 66 Cal. 2d 425, 58 Cal. Rptr. 13, 426 P.2d 173 (1967)

**46. *Egan v. Mutual of Omaha Ins. Co.***, 24 Cal. 3d 809, 157 Cal. Rptr. 482, 598 P.2d 452 (1979)

**47. *Gruenberg v. Aetna Ins. Co., et al.***, 9 Cal. 3d 566, 108 Cal. Rptr. 480 (1973)

**48. *Stowers Furniture Co. v. American Indem. Co.***, 15 S.W.2d 544 (Tex. Comm’n App. 1929)

**49. *Waller v. Truck Ins. Exch., Inc.***, 11 Cal. 4th 1, 44 Cal. Rptr. 2d 370, 900 P.2d 619 (1995)

**50. *White v. Western Title Ins. Co.***, 40 Cal. 3d 870, 221 Cal. Rptr. 509 (1985)



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## INTRODUCTION

In today's world, the amount of information available is limitless and often overwhelming. We crave analysis and evaluation to identify what information really matters and to process the implications of what is significant. Information overload prevails in our professional world as much as in personal life. How do we really know what is important, let alone credible, reliable, or worth knowing?

It is in the spirit of providing perspective that we have sought to identify and analyze the top 50 U.S. insurance coverage decisions. We have focused primarily on the commercial general liability (CGL) policy and its basic concepts. We have culled cases from all over the United States and chosen those cases that establish the "building blocks" for determining whether the policy provides coverage. This was by no means a small task.

Our primary disclaimer is that many other cases easily qualify for a spot in the top 50. We did not undertake the project from a scientific or statistically analytic perspective. Based on our many years of insurance coverage practice, the process instead involved identification of cases that have been pivotal in developing the most essential principles governing interpretation of key CGL policy provisions. It should not surprise anyone that the first list generated by the authors totaled more than 200 cases. Through the discussion process, we discovered that there were approximately 15 issues reflected by the majority of cases. By pinpointing these issues, we finally were able to cut the list to 50.

What follows, then, are 15 separate essays on the major insurance coverage concepts with discussion of the "lessons learned" from the most important cases. Detailed summaries of each case follow. Our sincere wish is that each essay individually—and the entire collection collectively—will provide the reader with a thought-provoking, meaningful, and interesting journey through the world of insurance coverage issues and disputes. We hope you will enjoy reading the collection as much as we did creating it.

## INSURING AGREEMENT



**JILL B. BERKELEY**  
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### WHAT IS PROPERTY DAMAGE?—JILL B. BERKELEY

- *Eljer Mfg., Inc. v. Liberty Mut. Ins. Co.*, 972 F.2d 805 (7th Cir. 1992)
- *Travelers Ins. Co. v. Eljer Mfg., Inc.*, 757 N.E.2d 481 (Ill. 2000)
- *U.S. Fid. & Guar. v. Wilkin Insulation Co.*, 578 N.E.2d 926 (Ill. 1991)
- *Vandenberg v. Superior Ct.*, 21 Cal. 4th 815, 88 Cal. Rptr. 2d 366, 982 P.2d 229 (1999)

The engine that powers the coverage provided by the commercial liability policy starts with the insuring agreement. The insurer will pay all sums that the insured is legally obligated to pay as damages because of property damage and bodily injury resulting from an occurrence. The cases that have addressed what constitutes property damage arise in every type of dispute—from products liability and commercial contracts to environmental contamination and construction. For the most important cases, we recognize two that are useful as building blocks to understand what does and does not constitute “property damage.”

The analysis begins with the policy definition of “property damage,” consisting of two separate prongs: (1) physical injury to tangible property and (2) loss of use of tangible property without physical injury. Whether the claim is covered depends on an interpretation of the policy definition, as opposed to what and how the legal cause of action is alleged. The existence of property damage is also an important element of the economic loss doctrine encountered in the underlying liability dispute and serves an interesting analytic tool in determining whether there is coverage under the CGL policy.

For the most important cases, we recognize two that are useful as building blocks to understand what does and does not constitute “property damage.”

In Illinois, a pair of cases tests application of the “property damage” definition under the same factual circumstances. In the Seventh Circuit’s version of *Eljer Mfg., Inc. v. Liberty Mut. Ins. Co.*, 972 F.2d 805 (7th Cir. 1992), the court held that the incorporation of a defective product into another product



constituted property damage, as physical injury to tangible property, at the moment of incorporation.

Eljer manufactured and sold defective plumbing systems that were installed in numerous buildings. A large number of the systems developed leaks after installation, resulting in property damage claims against Eljer. Liberty Mutual, Eljer's CGL insurer, contended that property damage did not occur until a system actually leaked, resulting in physical injury to the surrounding walls, floors, or ceilings. Eljer claimed that the physical injury occurred when the system was installed.

The Seventh Circuit agreed with Eljer. The court based its decision on Illinois cases that it read as holding that the absence of physical injury in the ordinary sense was immaterial, as long as the insured's defective product reduced the value of the finished product.

When the same facts came before the Illinois Supreme Court, it soundly rejected the Seventh Circuit's ruling. In *Travelers Ins. Co. v. Eljer Mfg., Inc.*, 757 N.E.2d 481 (Ill. 2000), the court disagreed with the policyholders' argument, holding that the home owners whose systems did not leak suffered no "physical injury to tangible property." The court also held that the post-1986 edition CGL insurance policies are not triggered if a home is physically damaged by a home owner replacing a nonleaking system; this does not constitute physical injury to tangible property arising from a covered occurrence under the policies.

On a related issue to whether property damage has occurred or only economic loss is sought, in *Vandenberg v. Superior Ct.*, 21 Cal. 4th 815, 88 Cal. Rptr. 2d 366, 982 P.2d 229 (1999), the California Supreme Court rejected the "*ex contractu/ex delicto*" distinction that had plagued the appellate courts' analysis of whether insurance coverage was dependent on the "cause of action" pleaded by the underlying plaintiff.

A former landowner was sued by the buyer of its property for soil contamination. The causes of action included breach of contract, nuisance, negligence, waste, trespass, strict liability, and injunctive relief. The defendant's liability insurers denied coverage based on the fact the cause of action was for breach of contract.

Consistent with *Vandenberg* are two recent state supreme court opinions: *Lamar Homes v. Mid-Continent Cas. Co.*, 242 S.W.3d 1 (Tex. 2007), and *American Family Mut. Ins. Co. v. American Girl, Inc.*, 268 Wis. 2d 16, 673 N.W.2d 65 (2003). To the contrary, see *Burlington Ins. Co. v. Oceanic Design*

*& Constr., Inc.*, 383 F.3d 940 (9th Cir. 2004), and *VBF, Inc. v. Chubb Grp. of Cos.*, 263 F.3d 1226 (10th Cir. 2001).

The definition of “property damage” in an insurance policy was interpreted consistently with the economic loss doctrine in a pair of Illinois cases in the context of asbestos removal. In *U.S. Fid. & Guar. v. Wilkin Insulation Co.*, 578 N.E.2d 926 (Ill. 1991), the Illinois Supreme Court determined that what may have looked solely like economic loss actually did constitute property damage. The presence of health-threatening, asbestos-containing products released over time was found to have contaminated buildings, constituting physical injury to tangible property.

The damage was not the result of the failure of the asbestos to perform its contractual function as an insulator. Rather, its detrimental impact was caused by a “wholly ancillary and coincidental phenomenon,” namely the diffusion of harmful fibers. Asbestos-related cost of repair and replacement was held to be more than merely economic damage.

This symmetry between the insurance concept of physical injury to property and the tort concept of damage to property beyond merely contract claims is noted in the companion case to *Board of Educ. v. AC&S, Inc.*, 131 Ill. 2d 428, 546 N.E.2d 580 (1989). Although this case preceded the *U.S. Fid. & Guar. v. Wilkin* analysis, the Illinois Supreme Court determined that a tort claim sounding in negligence and strict product liability against asbestos installers pleaded property damage for purposes of passing the costs of asbestos abatement onto those parties that manufactured, sold, and installed the asbestos.

The court rejected the claim that the parties suffered a claim for breach of contract only. The court concluded that the installation of asbestos sufficiently contaminated the building so that damage to property other than the defective product occurred. The claim was not that the asbestos failed to perform its function, i.e., insulate effectively, but that it deteriorated in a dangerous manner and was defective, toxic, and harmful.



**AMY FINK**  
Jones Day

## WHAT IS A “SUIT”?—AMY FINK

- *Central Ill. Light Co. v. Home Ins. Co.*, 213 Ill. 2d 141, 821 N.E.2d 206 (2004)
- *Powerine Oil Co., Inc. v. Superior Ct.*, 37 Cal. 4th 377, 33 Cal. Rptr. 3d 562, 118 P.3d 589 (2005)

Whether or not an insurer has a duty to provide coverage to a policyholder in the absence of the existence of a formal “lawsuit” is the subject of many disputes between the insurers and insureds. Typically, CGL insuring agreements provide that the insurer has the “right and duty to defend any suit against the insured” and further provide that the insurer “may make such investigation and settlement of any claim or suit as it deems expedient.” Pre-1986 CGL forms did not define “suit.” More recent forms define “suit” as a “civil proceeding” including “an arbitration proceeding” and “any other alternative dispute resolution proceeding.” See CG 00 01 12 04, Sec. V, ¶18.

Absent a formal “suit,” insurers will argue that the policyholder is not “legally obligated” to pay damages costs unless there is a lawsuit or even a judgment against the policyholder.

Some courts have held that the definition of “suit” requires a court proceeding. See *Foster-Gardner, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 18 Cal. 4th 857, 959 P.2d 265 (1998). Other courts have found that the duty to defend arises upon a threat of legal action (such as a potentially responsible party letter issued by the U.S. Environmental Protection Agency) or an increased exposure to liability from a failure to perform. See *e.g.*, *Carpentier v. Hanover Ins. Co.*, 248 A.D.2d 579, 670 N.Y.S.2d 540 (N.Y. App. Div. 2d Dept. 1998) (a letter whereby the government assumed a coercive, adversarial posture and threatened the insured with probable and imminent financial consequences was the functional equivalent of a suit within the meaning of the policy); *Outboard Marine Corp v. Liberty Mut. Ins. Co.*, 283 Ill. App. 3d 630, 670 N.E.2d 740 (2d Dist. 1996).

Absent a formal “suit,” insurers will argue that the policyholder is not “legally obligated” to pay damages costs unless there is a lawsuit or even a

judgment against the policyholder. The insuring agreement of the CGL policy typically states that:

**WE WILL PAY THOSE SUMS THAT THE INSURED BECOMES LEGALLY OBLIGATED TO PAY AS DAMAGES BECAUSE OF “BODILY INJURY” OR “PROPERTY DAMAGE” TO WHICH THIS INSURANCE APPLIES.**

Some insurers rely on this language to argue that, to be “legally obligated” for purposes of coverage under a CGL policy, there must be a legally binding judgment entered against the insured and thus, at a minimum, a lawsuit asserting liability against the insured.

This issue was addressed by the Illinois Appellate Court in *Central Ill. Light Co. (CILCO) v. Home Ins. Co.*, 213 Ill. 2d 141, 821 N.E.2d 206 (2004). In *CILCO*, the court held that neither a lawsuit nor an administrative complaint is necessary to trigger a duty to indemnify. The court determined that CILCO was operating under a legal obligation because the Illinois Environmental Protection Agency had made a tacit threat to file a complaint if CILCO did not voluntarily remediate the property.

Some courts have reached a contrary result. California courts have struggled with providing the policyholder with coverage in environmental liabilities. In 2001, the California Supreme Court held that Comprehensive Environmental Response Compensation and Liability Act (CERCLA) response costs are not covered because, since there is no duty to defend without a formal suit, and because the duty to defend is broader than the duty to indemnify, there can be no duty to defend if there is no duty to indemnify. See *Certain Underwriters at Lloyd’s of London v. Superior Ct.*, 24 Cal. 4th 945, 103 Cal. Rptr. 2d 672, 16 P.3d 94 (2001) (*Powerine I*).

In *Powerine Oil Co., Inc. v. Superior Ct.*, 37 Cal. 4th 377, 33 Cal. Rptr. 3d 562, 118 P.3d 589 (2005) (*Powerine II*), the California Supreme Court held that the duty to defend a “suit” seeking “damages” under the standard CGL policies is restricted to civil actions prosecuted in a court, initiated by the filing of a complaint, and does not include claims, which can denote proceedings conducted by administrative agencies under environmental statutes. However, it should be noted that even in jurisdictions that do not follow the *CILCO* analysis, whether or not coverage is provided in the absence of a suit turns on the specific policy language at issue rather than an automatic finding of no coverage.

*Powerine I* and *II* made the distinction between an administrative proceeding versus a court-ordered cleanup. *Powerine I* held that there was no duty to defend an administrative proceeding brought to enforce an agreed consent order. The court reasoned that the insurer's duty to indemnify is limited to "money ordered by a court" and does not extend to environmental cleanup costs ordered by an administrative agency pursuant to an environmental statute. *Powerine II*, however, did retreat from that position based on language in the excess insurers' policies that was broader and held to cover costs that the insured must expend in complying with an administrative agency's pollution cleanup and abatement orders.



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## WHAT ARE "DAMAGES"?—JILL B. BERKELEY

- *Aerojet-General Corp. v. Superior Ct.*, 211 Cal. App. 3d 219, 257 Cal. Rptr. 621 (1989)
- *AIU Ins. Co. v. Superior Ct.*, 51 Cal. 3d 807, 274 Cal. Rptr. 820, 799 P.2d 1253 (1990)

The issue of "what are damages" is illustrated in those cases in which the court must determine whether the payment of response costs in a Comprehensive Environmental Response Compensation and Liability Act (CERCLA) environmental cleanup action meets the policy's definition of "damages" because of property damage. The question was answered by the California court in its 1990 supreme court decision, *AIU Ins. Co. v. Superior Ct.*, 51 Cal. 3d 807, 274 Cal. Rptr. 820, 799 P.2d 1253 (1990), which followed the 1989 decision, *Aerojet General Corp. v. Superior Ct.*, 211 Cal. App. 3d 219, 257 Cal. Rptr. 621 (1989). Although this decision hardly settled the matter in other jurisdictions, it has come to be known as the definitive answer, making clear the distinction between restitution (i.e., the return of something wrongfully received), and response costs, whether incurred directly by the polluter or paid to reimburse the government.

Insurers argue that remediation costs pursuant to government actions seek injunctive or other equitable relief and therefore are not "money damages." Policyholders counter that the term "damages," under its common, ordinary meaning, covers such costs because they are required to expend money for third-party damage.

Although there is a split of authority over whether cleanup costs constitute “damages” under an insurance policy, the following are cited as following the majority position upholding coverage.

- ◆ *A.Y. McDonald Ind. v. Insurance Co. of N. Am.*, 475 S.W.2d 607 (Iowa 1991)
- ◆ *Aetna Cas. & Sur. Co. v. Nuclear Eng’g Co.*, 2002 Ky. App. LEXIS 451 (Ky. Ct. App. Mar. 8, 2002)
- ◆ *Alabama Plating Co. v. U.S. Fid. & Guar. Co.*, 690 So. 2d 331 (Ala. 1996)
- ◆ *Atlantic Wood Ind., Inc. v. Lumbermen’s Underwriting Alliance*, 396 S.E.2d 541 (Ga. App. 1990)
- ◆ *Bausch & Lomb Inc. v. Utica Mut. Ins. Co.*, 330 Md. 758, 625 A.2d 1021 (Md. 1993)
- ◆ *Boeing Co. v. Aetna Cas. & Sur. Co.*, 784 P.2d 507 (Wash. 1990)
- ◆ *C.D. Spangler Const. Co. v. Industrial Crankshaft & Eng’g Co., Inc.*, 388 S.E.2d 557 (N.C. 1990)
- ◆ *Coakley v. Maine Bonding & Cas. Co.*, 618 A.2d 777 (N.H. 1992)
- ◆ *Compass Ins. Co. v. City of Littleton*, 984 P.2d 606 (Colo. 1999)
- ◆ *Compass Ins. Co. v. Cravens, Dargan & Co.*, 748 P.2d 724 (Wyo. 1988)
- ◆ *Farmland Ind., Inc. v. Republic Ins. Co.*, 941 S.W.2d 505 (Mo. 1997)
- ◆ *Hartford Accident & Indem. Co. v. Dana Corp.*, 690 N.E.2d 285 (Ind. App. 1997)
- ◆ *Hazen Paper Co. v. U.S. Fid. & Guar. Co.*, 555 N.E.2d 576 (Mass. 1990)
- ◆ *Lane Elec. Coop., Inc. v. Federated Rural Elec. Ins. Corp.*, 834 P.2d 502 (Or. App. 1992)
- ◆ *Minnesota Mining & Mfg. v. Travelers Indem.*, 457 N.W.2d 175 (Minn. 1990)
- ◆ *Morton Int’l, Inc. v. General Accident Ins. Co. of Am.*, 629 A.2d 831 (N.J. 1993)
- ◆ *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 283 Ill. App. 3d 630, 670 N.E.2d 740 (2d Dist. 1996)
- ◆ *Sanborn Plastics Corp. v. St. Paul Fire & Marine Ins. Co.*, 616 N.E.2d 988 (Ohio App. 1993)
- ◆ *U.S. Aviex Co. v. Travelers Ins. Co.*, 336 N.W.2d 838 (Mich. App. 1983)

In addition to these state court decisions, numerous federal courts, applying state law, have also determined that CERCLA response costs are “damages” under liability insurance policies. *See*:

- ◆ *Aetna Cas. & Sur. Co., Inc. v. Pintlar Corp.*, 948 F.2d 1507 (9th Cir. 1991) (applying Idaho law)
- ◆ *Bituminous Cas. Corp. v. Vacuum Tank Inc.*, 75 F.3d 1048 (5th Cir. 1996) (under Texas law, CERCLA response costs are damages)
- ◆ *Chesapeake Utils. Corp. v. American Home Assur. Co.*, 704 F. Supp. 551 (D. Del. 1989)
- ◆ *Federal Ins. Co. v. Susquehanna Broad. Co.*, 727 F. Supp. 169 (M.D. Pa. 1989)
- ◆ *GAF Corp. v. Continental Cas. Co.*, 1989 U.S. Dist. LEXIS 192 (E.D. La. Jan. 11, 1989)
- ◆ *Gerrish Corp. v. Universal Underwriters Ins. Co.*, 947 F.2d 1023 (2d Cir. 1991) (applying Vermont law)
- ◆ *Lindsay Mfg. Co. v. Hartford Accident & Indem. Co.*, 118 F.3d 1263 (8th Cir. 1997) (applying Nebraska law)
- ◆ *MAPCO Alaska Petroleum, Inc. v. Central Nat’l Ins. Co. of Omaha*, 795 F. Supp. 941 (D. Alaska 1991)
- ◆ *Morrow Corp. v. Harleysville Mut. Ins. Co.*, 101 F. Supp. 2d 422 (E.D. Va. 2000)
- ◆ *National Indem. Co. v. U.S. Pollution Control, Inc.*, 717 F. Supp. 765 (W.D. Okla. 1989)
- ◆ *Potomac Elec. Power Co. v. California Union Ins. Co.*, 777 F. Supp. 968 (D.D.C. 1991)
- ◆ *Quaker State Minit-Lube, Inc. v. Fireman’s Fund Ins. Co.*, 868 F. Supp. 1278 (D. Utah 1994)
- ◆ *SnyderGeneral Corp. v. Century Indem. Co.*, 113 F.3d 536 (5th Cir. 1997) (applying Texas law)

Presently, only the Supreme Court of Maine holds that CERCLA response costs are not considered “damages” under commercial general liability (CGL) policies. *Patrons Oxford Mut. Ins. Co. v. Marois*, 573 A.2d 16 (Me. 1990). When Maine reached its conclusion that the phrase “as damages” in CGL policies did not include CERCLA response costs, it relied in part on that state’s prior legal conclusion that such language would not cover the costs of punitive damages.



What is most telling is that in three jurisdictions that previously held that such injunctive relief was not covered as damages, the courts reversed the previous decisions to follow the *Aerojet* precedent. See:

- ◆ *Bausch & Lomb v. Utica Mut. Ins.*, 330 Md. 758, 625 A.2d 1021 (Md. 1993), rejecting *Maryland Cas. Co. v. Armco, Inc.*, 822 F.2d 1348 (4th Cir. 1987), applying Maryland law
- ◆ *Farmland Indus. v. Republic Ins. Co.*, 941 S.W.2d 505 (Mo. 1997), rejecting the Eighth Circuit's interpretation of Missouri law in *Continental Ins. Co. v. Northeastern Pharm. & Chem. Co.*, 842 F.2d 977 (8th Cir. 1988)
- ◆ *Johnson Controls, Inc. v. Employers Ins. of Wausau*, 665 N.W.2d 257 (Wis. 2003), overturning *City of Edgerton v. General Cas. Co.*, 514 N.W.2d 463 (Wis. 1994)



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## WHAT ARE “INTENTIONAL ACTS”?—AMY FINK

- *J.C. Penney Cas. Ins. Co. v. M.K.*, 52 Cal. 3d 1009, 278 Cal. Rptr. 64, 804 P.2d 689 (1991)
- *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 15 Cal. Rptr. 2d 815 (1993)

Generally, as a matter of public policy, insurers are not liable for the loss caused by willful acts of their insureds. Indeed, many states have adopted statutes to this effect to prevent the “moral hazard” of allowing the willful tortfeasor to reap any benefit from insurers. See, e.g., California Insurance Code Section 533. Recognizing this general principle, insurance policies typically contain an exclusion precluding coverage for damages arising from intentional conduct.

For example, the pre-1986 edition CGL policy forms define “occurrence” as an “accident ..., including injurious exposure to conditions, which results, during the policy period, in bodily injury and property damage neither expected nor intended from the standpoint of the insured.” Later CGL policy forms contain a separate exclusion for losses “expected or intended from the standpoint of the insured.” Application of these provisions and exclusions has been the subject of numerous coverage battles.



As an initial matter, the application of the “intended and expected” exclusion relates specifically to “intent” and the concept of fortuity. In other words, does the act itself need to be unintentional, or is it the result of the act (the injury or damage) that needs to be unexpected? Policyholders usually argue that to preclude coverage, the resulting damage must be intentional; whether the act itself is intentional is not determinative. Insurers generally argue the contrary. The answer to the coverage question varies based on the nature of the act itself, as well as the law of the applicable jurisdiction.

Courts and state law will usually presume or infer that harm was intended from certain criminal acts (such as sexual assaults and molestation) regardless of the subjective intent of the insured. By way of example, in *J.C. Penney Cas. Ins. Co. v. M.K.*, 52 Cal. 3d 1009, 278 Cal. Rptr. 64, 804 P.2d 689 (1991), the California Supreme Court ruled that, as a matter of law, California Insurance Code Section 533 precludes liability insurance coverage for an insured’s sexual molestation of a child. The court considered the child molester’s subjective intent to be irrelevant to the question of coverage, stating as follows:

**THERE IS NO SUCH THING AS NEGLIGENT OR EVEN RECKLESS SEXUAL MOLESTATION.... THE ACT IS THE HARM. THERE CANNOT BE ONE WITHOUT THE OTHER. THUS, THE INTENT TO MOLEST IS, BY ITSELF, THE SAME AS THE INTENT TO HARM.**

Other fact patterns for which intent to harm is inferred include beating someone on the head [see *Calvert Ins. v. Western Ins.*, 874 F.2d 396 (7th Cir. 1989)], and multiple stab wounds and violent injuries [see *Allstate Ins. Co. v. Carioto*, 194 Ill. App. 3d 767, 551 N.E.2d 382 (1st Dist. 2nd Div. 1990)].

The meaning of the phrase “expected or intended” has given rise to a plethora of coverage litigation. Some courts, such as *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 52 Cal. Rptr. 2d 580 (1993), have determined that the appropriate test for “expected” damages is whether the policyholder knew or believed its conduct was substantially certain or highly likely to result in that kind of damage. The basis for employing this test is that the ordinary and popular meaning of “expect” connotes subjective knowledge of or belief in an event’s probability. Under this rationale, employing an objective (“should have known”) standard would defeat the purpose of insurance because coverage cannot be denied on the basis that a

reasonable person would have foreseen the risk of harm to another if the insured in fact did not.

Other courts have adopted an objective standard, holding that if the insured knew or should have known that there was a substantial probability that certain results would follow his acts or omissions, then there has not been an occurrence or accident as defined in a CGL policy. See *City of Carter Lake v. Aetna Cas. & Sur. Co.*, 604 F.2d 1052 (8th Cir. Neb. 1979). Where courts have explained their rationale for adopting an objective view of “expected,” it is based largely on the belief that a subjective test gives policyholders too much of an advantage in coverage disputes. See e.g., *Truck Ins. Exch. v. Pickering*, 642 S.W.2d 113 (Mo. Ct. App. 1982) (“Supplanting an objective standard with a subjective standard for determining whether the act or conduct of an insured is ‘intentional’ or ‘expected or intended’ for purposes of assessing coverage would emasculate apposite policy provisions by making it impossible to preclude coverage for intentional acts or conduct absent admissions by insureds of a specific intent to harm or injure. Human nature augers against any viable expectation of such admissions.”)

Courts are also split on the issue of which party bears the burden of proof regarding the issue of whether injury is “expected or intended.” The answer to this question turns on whether the phrase “neither expected nor intended” is viewed as part of the insuring clause. According to some courts, because the phrase “neither expected nor intended” is part of the insuring clause (i.e., part of the definition of “occurrence”), the burden is on the insured to prove damages were not expected or intended. See *FMC Corp. v. Plaisted & Cos.*, 61 Cal. App. 4th 1132, 72 Cal. Rptr. 2d 467 (1998).

The 1986 and later CGL forms contain a separate exclusion for losses “expected or intended from the standpoint of the insured.” Placing this provision in an exclusion resolves the split in authority.

In comparison, other courts have taken a “functional view” of the phrase and construed it as an exclusion or limitation on coverage. See *Carter-Wallace, Inc. v. Admiral Ins. Co.*, 154 N.J. 312, 712 A.2d 1116 (1998). Under this rationale, because the phrase “neither expected nor intended” immediately follows the word “damages” in the definition of “occurrence,” its effect is to exclude those

harmful consequences that were expected and intended by the insured. Thus, the insurer bears the burden of proving the damages were “expected or intended.” See *Armstrong World Ind., Inc. v. Aetna Cas. & Sur. Co.*, 45 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690 (1996), *rev. denied* (Cal. Aug. 21, 1996).

As stated above, the 1986 and later CGL forms contain a separate exclusion for losses “expected or intended from the standpoint of the insured.” Placing this provision in an exclusion resolves the split in authority. Under these forms, as with exclusions in general, the insurer bears the burden of proving that a loss was “expected or intended.” Insurers, however, still raise the issue of fortuity as part of the insured’s burden of proof if there is evidence that the insured knew the damage would result.



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## WHAT IS THE “DUTY TO DEFEND”?— DOUGLAS M. DEWITT

- *Buss v. Superior Ct.*, 16 Cal. 4th 35, 65 Cal. Rptr. 2d 346, 939 P.2d 766 (1997)
- *Employers Ins. of Wausau v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 708 N.E.2d 1122 (1999)
- *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 215 Ill. 2d 146, 828 N.E.2d 1092 (2005)
- *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 54 Cal. Rptr. 104 (1966)
- *Horace Mann Ins. Co. v. Barbara B.*, 4 Cal. 4th 1076, 17 Cal. Rptr. 2d 210, 846 P.2d 792 (1993)
- *Lee v. Aetna Cas. & Sur. Co.*, 178 F.2d 750 (2d Cir. 1949)
- *Maryland Cas. Co. v. Peppers*, 64 Ill. 2d 187, 355 N.E.2d 24 (1976)
- *San Diego Navy Fed. Credit Union v. Cumis Ins. Co.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984)

The duty to defend is the linchpin of the liability insurance policy. The major benefit to the policyholder is that the insurer must provide the insured with a defense against any potentially covered claims. When the insurer acknowledges its duty to defend without reservation, the insured’s interests are protected. When the insurer questions its obligation to defend, either by reservation of rights or denying the duty to defend, the insured is no longer guaranteed it will receive the benefit of the bargain.

Generally, an insurer has the duty to defend if the claim or suit falls potentially within the policy's coverage, based on the allegations of the complaint, and, in some instances, other allowable facts or pleadings. See *Horace Mann v. Barbara B.*, 4 Cal. 4th 1076, 17 Cal. Rptr. 2d 210, 846 P.2d 792 (1993); *Gray v. Zurich*, 65 Cal. 2d 263, 54 Cal. Rptr. 104 (1966); and *Lee v. Aetna Cas. & Sur. Co.*, 178 F.2d 750 (2d Cir. 1949).

In ascertaining potentiality, the court must compare the allegations of the complaint to the terms of the policy. If the allegations establish the existence of any potentially covered claims under the policy, the insurer has a duty to defend the insured against the claims. Indeed, as recognized by Judge Learned Hand in *Lee v. Aetna Cas.*, an insurer ought to defend its insured in any action unless it is clear that the claim is not covered under the policy.

Often, controversies arise regarding the clarity and specificity of the allegations needed to give rise to the insurer's duty to defend; however, under the law of the majority of the jurisdictions, any ambiguities or vagueness in the allegations must be interpreted or construed in favor of the insured rather than in favor of the insurer.

While the determination of whether an insurer owes a duty to defend is typically limited to the allegations in the underlying complaint and the terms of the policy, extrinsic evidence sometimes plays a role in that determination. For instance, the majority of jurisdictions require an insurer to consider true but unpleaded facts when it is determining its duty to defend an insured against a claim. In other words, an insurer must look at not only the allegations of the complaint but also consider any extrinsic facts of which it is aware when determining whether it owes a duty to defend. If these true but unpleaded facts establish that the claim against the insured potentially falls within the scope of coverage under the policy, the insurer owes a duty to defend.

Additionally, in situations where the coverage issue is not dependent on an ultimate fact or crucial issue to the insured's liability in the underlying action [see *Murphy v. Urso*, 88 Ill. 2d 444 (1981); and *Lee v. Aetna Cas. & Sur. Co.*], or if the allegations of the complaint are ambiguous or inadequate to evaluate the insurer's duty to defend, several jurisdictions allow introduction of extrinsic evidence to determine if the duty to defend can be terminated before conclusion of the underlying action. A recent pair of cases in Illinois demonstrates that allegations in third-party pleadings may be taken into consideration in determining the duty to defend. See *American Econ. Ins. Co. v.*

*DePaul Univ.*, 890 N.E.2d 582 (Ill. App. 2008); and *American Econ. Ins. Co. v. Holabird & Root*, 886 N.E.2d 1166 (Ill. App. 2008).

After an insured tenders its defense to an insurer, and the insurer evaluates its duty to defend, the insurer has several options:

1. Accept the tender of defense, and defend the insured against the claim.
2. Accept the tender of defense under a reservation of rights, and defend the insured against the claim.
3. Deny the tender of defense.

Once it is established that the insurer has a duty to defend, this duty to defend includes not only the obligation to defend the insured through trial but also the duty to appeal any adverse judgments against the insured.

If the insured decides to defend the insured under a reservation of rights or deny the tender of defense, the insurer may file a declaratory judgment action to obtain a judicial declaration of the parties' respective rights under the policy. If an insurer refuses to defend the insured despite the existence of potential coverage and fails to seek a timely declaration of its obligations under the policy, the insurer may be found to have breached its duty to defend. When an insurer breaches its duty to defend, it is estopped from raising noncoverage as a defense in any subsequent action. See *Employers Ins. of Wausau v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 708 N.E.2d 1122 (1999).

In those situations in which an insurer owes a duty to defend, and it chooses to defend its insured under a reservation of rights, the insurer may lose its right to control the insured's defense if a conflict of interest exists. If the insurer's reservation of rights letter raises a coverage issue that may be affected by the defense in the underlying litigation, the insured is entitled to select independent counsel to defend its interests in the underlying litigation, and the insurer is obligated to reimburse the fees incurred by the insured for independent counsel. See *Maryland Cas. Co. v. Peppers*, 64 Ill. 2d 187, 355 N.E.2d 24 (1976); and *San Diego Navy Federal Credit Union v. Cumis Ins. Co.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984).

In those situations in which an insurer agrees to defend its insured against a claim, several states recognize an insurer's ability to reserve its right to seek reimbursement of any paid defense costs in the event that a court later determines that the insurer was not obligated to defend. See *Buss v. Superior Ct.*, 16 Cal. 4th 35, 65 Cal. Rptr. 2d 346, 939 P.2d 766 (1997). The relevant criteria for such a determination (e.g., when is the determination made? or is the determination dependent on a finding of no duty to defend as opposed to a finding of no duty to indemnify?) varies from jurisdiction to jurisdiction, but virtually all jurisdictions require the insurer to expressly advise the insured of any potential claim for reimbursement in its reservation of rights.

Certain jurisdictions, such as Illinois, expressly forbid such recoupment unless the policy specifically provides for it. See *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 215 Ill. 2d 146, 828 N.E.2d 1092 (2005). In addition to the ability to seek reimbursement of past defense costs, several jurisdictions also allow an insurer to reserve its rights for recoupment of any settlement payments for claims that are not covered under the policy. See *Blue Ridge Ins. Co. v. Jacobsen*, 25 Cal. 4th 489 (2001).

Once it is established that the insurer has a duty to defend, this duty to defend includes not only the obligation to defend the insured through trial but also the duty to appeal any adverse judgments against the insured. An insurer, though, is not obligated to prosecute an appeal for the insured when there are no reasonable grounds to do so. See *Illinois Founders v. Guidish*, 248 Ill. App. 3d 116, 618 N.E.2d 436, 187 Ill. Dec. 845 (1st Dist. 4th Div. 1993).

### ***THE ADDITIONAL INSURED BOOK***

*The Additional Insured Book*, sixth edition, examines approaches, problems, and caselaw associated with additional insured endorsements for property and liability insurance. It offers suggestions for modifying coverage to correspond with contractual risk transfers, critiques the good and potentially troublesome areas of manuscript or insurer-drafted additional insured endorsements, and explains how certificates of insurance can be used in tandem with insurance policies to broaden or limit the extent to which coverage may apply to additional insureds. Coverage attorneys rely on *The Additional Insured Book* so heavily that it was referred to as "the Bible" on this topic by a speaker at a continuing legal education seminar. Up to date with the latest forms, coverage analysis, and court decisions (including more than 300 case citations) as of August 2011, the book discusses not only commercial general liability insurance, but also property, auto, workers compensation, marine, and aircraft issues.

## EXCLUSIONS

### WHAT IS “CONCURRENT CAUSATION”?— DOUGLAS W. GASTÉLUM

- *Garvey v. State Farm Fire & Cas. Co.*, 48 Cal. 3d 395, 257 Cal. Rptr. 292 (1989)
- *State Farm Mut. Auto. Ins. Co. v. Partridge*, 10 Cal. 3d 94, 109 Cal. Rptr. 811 (1973)

Concurrent causation issues may arise where a loss results from more than one cause, one or more of which is excluded under the policy at issue. This situation may arise in either first-party or third-party coverage cases.

#### *FIRST-PARTY COVERAGE*

Most states follow the efficient proximate cause rule, and in those states, first-party coverage is triggered if the “efficient proximate cause” is a risk covered under the policy, even if excluded perils may have contributed to or been the “immediate cause” of the loss. See, e.g., *Garvey v. State Farm Fire & Cas. Co.*, 48 Cal. 3d 395 (1989) (landslide damage may be covered, even when earth movement is excluded, if it results primarily from third-party negligence).

In *Sabella v. Wisler*, 59 Cal. 2d 21 (1963), for example, Sabella bought a home built by Wisler and then insured it with National Union Fire Insurance Co. of Pittsburgh, Pennsylvania. Approximately 4 years after the house was built, the sewer pipe from the house began to leak at a point near the house, causing the sewer outflow from the house to infiltrate the earth near and below the foundation. The trial court found that “the cause of said sewer pipe so breaking and leaking was either the settling and consolidation of the inadequately compacted fill material upon which it (the sewer pipe) was placed, or the improper closure of certain joints therein, or a combination of both these causes.”

While subsidence and earth movement were excluded perils under the National Union policy, negligence of the builder resulting in leaking pipe joints was not excluded. The court held that National Union was liable for the damage to the house because the rupture of the sewer line attributable to the negligence of the third-party contractor, rather than subsidence or earth movement, was the efficient proximate cause of the loss. The court based its

holding, in part, on a quote from 6 Couch, Insurance (1930), Section 1466, which states as follows.

**WHERE THERE IS A CONCURRENCE OF DIFFERENT CAUSES, THE EFFICIENT CAUSE, THE ONE THAT SETS OTHERS IN MOTION, IS THE CAUSE TO WHICH THE LOSS SHOULD BE ATTRIBUTED, THOUGH THE OTHER CAUSES MAY FOLLOW IT, AND OPERATE MORE IMMEDIATELY IN PRODUCING THE DISASTER.**

The court went on to interpret Sections 530 and 532 of the California Insurance Code. National Union cited Section 532 for the proposition that the loss would not have occurred but for the excluded peril of subsidence. The court took a different view saying:

*Section 532 must be read in conjunction with related Section 530.... It is thus apparent that if Section 532 were construed in the manner contended for by defendant insurer, where an excepted peril operated to any extent in the chain of causation so that resulting harm would not have occurred “but for” the excepted peril’s operation, the insurer would be exempt even though an insured peril was the proximate cause of the loss. Such a result would be directly contrary to the provision in Section 530, in accordance with the general rule, for liability of the insurer where the peril insured against proximately results in the loss.*

### **THIRD-PARTY COVERAGE**

The rules are different in third-party (liability) coverage cases. Where injury or damage results from the concurrence of truly independent causes, one of which was an insured risk, coverage exists if the insured risk was a concurrent proximate cause of the third party’s injuries. It is immaterial that an excluded cause was also involved or even if it was the “prime” or “moving” cause. *State Farm Mut. Auto. Ins. Co. v. Partridge*, 10 Cal. 3d 94, 109 Cal. Rptr. 811 (1973).

In *Partridge*, a passenger was injured by a bullet when the insured’s pistol accidentally discharged while the insured was driving his insured truck on unpaved terrain. The injury resulted in part from the insured having filed down the pistol’s trigger mechanism to make it a “hair trigger.” The insured’s



homeowners policy covered his liability for negligent acts, including the modification of the trigger mechanism, but excluded injuries “arising out of the use of an automobile.” Therefore, because the modification of the pistol was independent contributing negligence, the insured’s homeowners policy covered the claim as well as the auto policy.

Where the “concurring causes” are not truly “independent,” each originating from an independent act of negligence, ultimately joining together to produce injury, *Partridge* cannot apply. See, e.g., *Auto-Owners Ins. Co. v. Selisker*, 435 N.W.2d 866 (Minn. Ct. App. 1989). In *Selisker*, after failing to take medication for epilepsy, the insured had a seizure while driving and caused a collision. Only the auto coverage, and not the homeowners policy, was triggered because the failure to take the medication was not a divisible, independent cause of the collision. In other words, even though the failure to take the medication may have been the cause that set the other in motion, it was not an independent cause of the loss and therefore not negligence covered by the homeowners policy.

On the other hand, where an insured’s employee shot a third party while acting in the scope of employment, and the liability policy excluded liability arising from use of a firearm, the use of the firearm did not prevent coverage because the third party alleged that the insured was negligent in hiring and retaining the employee, a known violent person. The negligent hiring and retention of employee was held to be a “separate and independent cause” of injury, and not indivisibly related to the use of a firearm. See *Underwriters Ins. Co. v. Purdie*, 145 Cal. App. 3d 57 (1983).

### **COMMERCIAL PROPERTY INSURANCE**

**Commercial Property Insurance** is the authoritative IRMI reference service covering all aspects of property, inland marine, crime, equipment breakdown, and other direct damage insurance. It explains the nuances of coverage in plain English, detailing industry practices and court interpretations of policy language. Included are recommendations for assuring broad coverage with explanations of important issues that may arise when determining how coverage applies to claims. Also receive copies of ISO and AAIS commercial property forms.

## CONDITIONS

## WHAT IS “NOTICE”?—ABIGAIL PELUSO

- *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303, 32 Cal. Rptr. 827, 384 P.2d 155 (1963)
- *Country Mut. Ins. Co. v. Livorsi Marine, Inc.*, 222 Ill. 2d 303, 856 N.E.2d 338, 305 Ill. Dec. 533 (2006)

To secure coverage, the insured must promptly report any claims to the insurer and cooperate with the insurer in its investigation and defense of the claim. The purpose of these important obligations is to give the insurer the best opportunity to investigate, defend, and settle a claim effectively.

Whether an insured’s notice of a claim complies with its contractual obligation is the focus in the “late notice” cases. In a majority of jurisdictions, an insurer can only escape coverage if it can demonstrate that it was prejudiced by the insured’s failure to give timely notice. Conversely, even in the absence of prejudice, some courts hold the insurer is excused from providing coverage if the insured inexcusably did not give prompt notice.

Some jurisdictions treat timely notice as a condition precedent to coverage and that, as such, an unexcused delay in giving the notice required by the policy will automatically result in a loss of coverage. These jurisdictions do not require the insurer to prove that it was prejudiced by the late notice. The fact that the insured did not comply with the notice requirement, without just excuse, necessarily results in the insurer no longer having to cover the claim. See, e.g., *Country Mut. Ins. Co. v. Livorsi Marine, Inc.*, 222 Ill. 2d 303, 856 N.E.2d 338, 305 Ill. Dec. 533 (2006). What constitutes a reasonable excuse will often determine the outcome, even in “no prejudice” jurisdictions. Courts will read a reasonable standard into the determination of whether notice was “as soon as practicable” or “prompt.”

Other jurisdictions, however, state that an insurer may assert defenses based on an insured’s breach of a condition of the policy, such as a cooperation or notice clause, but the breach cannot be a valid defense unless the insurer was substantively prejudiced as a result. These cases note that the purpose of providing notice is to give the insurer the opportunity to properly investigate and defend a claim. Thus, if the insured’s tardy notice to the insurer did not prejudice the insurer’s ability to investigate and defend the claim, there is no relief to the insurer’s duty. See, e.g., *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d

303, 32 Cal. Rptr. 827, 384 P.2d 155 (1963); and *Clemmer v. Hartford Ins. Co.*, 22 Cal. 3d 865, 151 Cal. Rptr. 285, 587 P.2d 1098 (1978).



**DAVID H. ANDERSON**  
Hoke LLC

## WHAT IS THE “DUTY TO COOPERATE”? — DAVID H. ANDERSON

➤ *Waste Mgmt., Inc. v. International Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 579 N.E.2d 322 (1991)

Another basic building block of the conditions section is the insured’s duty to provide information and support to the insurer in the defense of the liability and damages suit. It is also one of the most contentious issues in the relationship between an insurer and policyholder in situations in which the insurer has reserved its rights. The insured’s obligation to provide information so that the insurer can assess liability, damages, and coverage invariably must be balanced with the need to protect the insured’s attorney-client privilege with defense counsel.

Liability policies typically include, as a condition to coverage, a provision requiring the insured to cooperate with the insurer. The typical “cooperation” clause states that “the insured shall cooperate with the company and, upon, the company’s request, assist in making settlements, in the conduct of suits ... ; and the insured shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses.”

In *Juvland v. Plaisance*, 96 N.W.2d 537 (Minn. 1959), the court described the purpose of the cooperation clause as follows:

**IT IS A MATERIAL PART OF THE POLICY ... DESIGNED TO AFFORD THE INSURER AN OPPORTUNITY TO DEFEND, AND TO PROTECT IT AGAINST POSSIBLE COLLUSION BETWEEN THE INSURED AND PERSONS CLAIMING COVERED DAMAGES, AND IN THE ABSENCE OF WAIVER OR ESTOPPEL, A SUBSTANTIAL BREACH OF SUCH PROVISION, RESULTING IN THE PREJUDICE TO THE INSURER, WILL RELIEVE IT OF RESPONSIBILITY FOR BOTH THE INSURED AND THE INJURED PARTIES.**

One important question raised by the existence of cooperation clauses in liability policies is the extent to which the clause operates as a contractual waiver of the insured's attorney-client privilege in the event of coverage litigation between the insured and its insurer.

In Illinois, insureds, insurers, and defense counsel must follow the Illinois Supreme Court's decision in *Waste Mgmt., Inc. v. International Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 579 N.E.2d 322 (1991). In *Waste Mgmt.*, the insurers requested production of insured's defense counsel's files from the underlying actions at issue. The insured claimed that its counsel's files were protected under the attorney-client privilege and refused to produce them. The supreme court ordered production, ruling that the attorney-client privilege is not waived in the insurer/insured relationship, due to both the cooperation clause in the policy, and the common interest doctrine. The *Waste Mgmt.* court further held that production of an otherwise privileged document to the insurer does not waive any privilege accorded to the document as to other third parties, such as the insured's opponents in the underlying litigation.

*Waste Mgmt.* is not only the minority view, but it has been widely rejected. For example, in *State v. Hydrite Chem. Co.*, 220 Wis. 2d 51, 582 N.W.2d 411 (1998), the court expressly rejected *Waste Mgmt.* and found that the common interest doctrine is not an exception to the attorney-client privilege unless the two parties seeking to share the privilege with the attorney have both retained the attorney as counsel. *See also*:

- ◆ *Owens-Corning Fiberglass Corp. v. Allstate Ins. Co.*, 74 Ohio Misc. 2d 174, 660 N.E.2d 765 (1993) (holding, in an insurance coverage dispute, the insured and insurer "could not be more at odds," therefore the "common interest exception" did not apply, and the work-product privilege protected the documents from disclosure to the insured)
- ◆ *North River Ins. Co. v. Philadelphia Reins. Corp.*, 797 F. Supp. 363 (D.N.J. 1992) (explicitly rejecting *Waste Mgmt.* and finding that (1) the common interest doctrine is not applicable to allow privileged communications to be exchanged with reinsurer, because the common interest doctrine only applies in context of dual representation, and (2) the cooperation clause does not require the insured to "give up wholesale its right to preserve the confidentiality of any consultation it may have with its attorney concerning the underlying claim")
- ◆ *Bituminous Cas. Corp. v. Tonka Corp.*, 140 F.R.D. 381 (D. Minn. 1992)

- ◆ *Eastern Air Lines v. U.S. Aviation Underwriters*, 716 So. 2d 340 (Fla. App. 1998)
- ◆ *In re Imperial Corp. of Am.*, 167 F.R.D. 447 (S.D. Cal. 1995)
- ◆ *Northwood Nursing & Convalescent Home v. Continental Ins.*, 161 F.R.D. 293 (E.D. Pa. 1995)
- ◆ *Remington Arms v. Liberty Mut. Ins.*, 142 F.R.D. 408 (D. Del. 1992)

The problem is particularly acute where production of privileged attorney-client communications is ordered in one jurisdiction under the common interest doctrine, but the question of whether the privilege exists is determined in a jurisdiction that has rejected the common interest doctrine between an insurer and insured where the insurer has reserved its rights or denied coverage altogether. Another complicating factor can occur when the coverage action is proceeding prior to resolution of the underlying action against the insured, particularly in states such as Illinois, where underlying plaintiffs must be joined as necessary parties to the coverage litigation. Insurers must take great care not to prejudice the insured's position in the underlying litigation by producing the insured's privileged communications to the underlying plaintiffs in the coverage action.

A confidentiality agreement is absolutely necessary because it establishes the insured's legitimate expectation of confidentiality once the material or information is shared with the insurer.

In both *Waste Mgmt.* and non-*Waste Mgmt.* jurisdictions, it is almost universally necessary to use a confidentiality agreement and protective order to shield the insured from the waiver of the attorney-client privilege. In executing the confidentiality agreement, the insured seeks to prevent a waiver of any privileges or protections with its disclosure of information to the insurer protected under the attorney-client privilege, the attorney work product doctrine, or any other privilege or protection. A confidentiality agreement is absolutely necessary because it establishes the insured's legitimate expectation of confidentiality once the material or information is shared with the insurer.

In *United States v. American Tel. & Tel. Co.*, 642 F.2d 1285 (D.D.C. 1980), the court held that where the parties had a common interest and documents were exchanged, there is no waiver of the work product doctrine. Nevertheless,

when the exchange of documents is coupled with a “guarantee of confidentiality, the case against waiver is even stronger.” See also *Minnesota Sch. Board Ass’n Ins. Trust v. Employers Ins. Co. of Wausau*, 183 F.R.D. 627 (N.D. Ill. 1999). The common interest stems from the idea that the insured and the insurer wish to minimize the settlement amount or defeat the claim against the insured.



**JILL B. BERKELEY**

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## WHAT IS “CONSENT TO SETTLE”?— JILL B. BERKELEY

- *Aerojet-General Corp. v. Commercial Union Ins. Co.*, 155 Cal. App. 4th 132, 65 Cal. Rptr. 3d 803 (2007)
- *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982)
- *Qualcomm, Inc. v. Certain Underwriters at Lloyd’s of London*, 161 Cal. App. 4th 184, 73 Cal. Rptr. 4th 184 (2008)

A typical commercial general liability (CGL) insurance policy limits the insurer’s obligation to pay those sums that it has agreed to pay or those sums that the insured is found, by judgment, to be legally obligated to pay. When an insured has been sued and is being defended by its insurer, the “consent” of the insurer is not much of an issue at the time of settlement. The insurer has selected defense counsel, is getting regular reports, and does not have a reservation of rights. Therefore, it is gambling with its own money at the time of settlement.

The “consent to settle” clause becomes relevant in those situations in which the insurer either denied coverage or is defending under a reservation of rights and refuses to settle in order to avoid a possible jury verdict or judgment that will leave the insured exposed to uninsured liability.

The *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982), case from Minnesota represents those jurisdictions that allow the insured to settle the case, without the consent of the insurer, and then proceed either directly against the insurer or by giving the plaintiff a judgment or assignment to pursue the insurer if it can prove coverage. The right of an insured to enter into a settlement with an underlying claimant on terms that set up a claim against its insurer is well established under Minnesota law. Minnesota law generally permits agreements in which a defendant admits liability and consents to having a judgment entered against it on the express condition that the claimant will satisfy the

judgment only out of proceeds from the defendant's insurance instead of proceeding against the defendant personally.

In *Miller v. Shugart*, the plaintiff was injured in an automobile accident, and the owner's insurer disclaimed coverage based on its assertion that the driver, Shugart, was not the owner's agent. Shortly after the accident, the insurer commenced a declaratory judgment action to determine its coverage obligations. Judgment was entered declaring that the policy afforded coverage to the vehicle's owner and driver.

While the insurer's appeal from the declaratory judgment was pending, the claimant entered into a settlement stipulation collectible only from the insurer. The Minnesota Supreme Court held that the insured had the right to consent to entry of judgment against it in return for plaintiff's releasing the insured from personal liability.

Generally, this type of settlement will not violate the consent provision because the insurer is deemed to have breached its duty to defend or has asserted a reservation of rights that it has raised in refusing to settle. The conditions for application of the *Miller-Shugart* rule include providing notice to the insurer that it is entering into a settlement, the collection of which is dependent on coverage being proven and the settlement being fair and reasonable.

A claimant seeking to enforce a *Miller-Shugart* agreement must prove the absence of fraud and collusion and show that the settlement was reasonable. In *Koehnen v. Herald Fire Ins. Co.*, 89 F.3d 525 (8th Cir. 1996), the court displayed a certain hostility toward a liability insurer who conceded a duty to defend and tried to use the *Miller-Shugart* doctrine to "set up" another insurer who denied coverage.

Another hurdle for collecting settlements entered into without consent occurs at the excess insurance level. The excess insurer will stand behind the lack of exhaustion of the primary layer in refusing to consider making a contribution to settlement. This circumstance is illustrated in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's of London*, 161 Cal. App. 4th 184, 73 Cal. Rptr. 4th 184 (2008). The insured settled for less than the primary limit of \$20 million and sought indemnity from the follow-form excess insurer for reimbursement in excess of \$20 million. Underwriters argued that coverage was not triggered because the insured failed to exhaust the underlying limits by full payment. The court held that Underwriters issued a reimbursement policy that only required it to indemnify Qualcomm for specified losses that was



different from the duty to defend. By definition, the duty to indemnify entailed the payment of money to resolve liability.

No discussion of unauthorized settlements would be complete without mentioning the relatively recent California decision, *Aerojet-General Corp. v. Commercial Union Ins. Co.*, 155 Cal. App. 4th 132 (Cal. App. 3d Dist. 2007). Aerojet claimed that it kept its insurers apprised of its settlement strategy and negotiations; it unreasonably relied on the insurer to voice any concerns or objections. The court held that the insurers' silence could not be deemed acceptance.

A claimant seeking to enforce a *Miller-Shugart* agreement must prove the absence of fraud and collusion and show that the settlement was reasonable.

After Aerojet settled the underlying actions, the excess insurers all denied liability on the ground that the damages were not awarded against Aerojet by a court. The court focused on the issue of whether settlement costs negotiated within the context of a court suit were damages. The appellate court concluded that the settlement costs were outside the scope of the indemnity coverage of the excess insurers' policies.



**DAVID H. ANDERSON**  
Hoke LLC

## ARE "SUCCESSORS" COVERED?— DAVID H. ANDERSON

➤ *Henkel Corp. v. Hartford Acc. & Indem. Co.*, 29 Cal. 4th 934, 129 Cal. Rptr. 2d 828, 62 P.3d 69 (Cal. 2003)

Corporate transfers of assets and liabilities frequently and routinely occur in the modern American economy. To a large extent, these transactions are enabled by the contracting parties' ability to predict with reasonable certainty the risk management implications of the decisions they make in allocating outstanding liabilities among the contracting parties. Until very recently, it was a relatively safe assumption in the overwhelming majority of jurisdictions in the United States that liabilities for preexisting losses assumed contractually by a corporate successor via an asset purchase agreement would be covered by the insurance policies issued to the predecessor corporation. In other words, the general rule was that the successor acquired



the predecessor's rights to recover under the predecessor's insurance policies for losses that occurred before the corporate acquisition.

Nevertheless, in *Henkel Corp. v. Hartford Acc. & Indem. Co.*, 29 Cal. 4th 934, 129 Cal. Rptr. 2d 828, 62 P.3d 69 (Cal. 2003), the California Supreme Court rejected this general rule and has created considerable uncertainty regarding the insurance implications of corporate acquisitions, not only in California but throughout the United States, where none previously existed. More recently, the Ohio Supreme Court's December 2006 foray into *Henkel* territory has further called into question whether insurance assumed to have been transferred in corporate acquisitions will be there for the successor when needed.

In *Henkel*, the California Supreme Court considered the question of whether a corporate successor could access insurance policies issued many years previously to the predecessor of a corporation the successor had acquired. The court ultimately ruled that, because the predecessor had not acquired the underlying tort liabilities by operation of law—but rather by contract—its successor could not take advantage of prior caselaw, such as *Northern Ins. Co. of N.Y. v. Allied Mut. Ins.*, 955 F.2d 1353 (9th Cir. 1992), holding that the right to insurance proceeds followed the transfer of liabilities by operation of law. Instead, the court found the contractual assignment of insurance policies to be “defined and limited” by those policies and upheld the policies’ prohibition against assignment without consent of the insurers. In other words, the successor was left without coverage for the tort liabilities of the predecessor of the company it had acquired, notwithstanding the fact that the alleged bodily injury occurred both during the periods of the occurrence-based policies and before the contractual assignment of the predecessor's assets and liabilities.

This decision was a significant departure from a long line of cases allowing the successor in merger or asset purchase transactions to retain the coverage of the acquired corporation and its predecessors without having to obtain the consent of their insurers, as long as the loss(es) occurred before the transfer of assets. *See, e.g.:*

- ◆ *A.J. Maggio Co. v. Willis*, 316 Ill. App. 3d 1043, 738 N.E.2d 592 (1st Dist. 2000)
- ◆ *Conrad Bros. v. John Deere Ins. Co.*, 640 N.W.2d 231 (Iowa 2001)
- ◆ *Guaranty Nat'l Ins. Co. v. McGuire*, 192 F. Supp. 2d 1204 (D. Kan. 2002)
- ◆ *Henning v. Cont'l Cas. Co.*, 254 F.3d 1291 (11th Cir. 2001)

No court outside of California appears to have yet adopted the reasoning of *Henkel*, although the Ohio Supreme Court came close. In December 2003, the U.S. District Court for the Western District of Michigan initially adopted *Henkel's* reasoning that a nonassignment clause must be given effect unless the assignment occurs after covered damages have been assessed in *Century Indem. Co. v. Aero-Motive Co.*, 318 F. Supp. 2d 530 (W.D. Mich. 2003). The court later reconsidered its ruling in *Century Indem. Co. v. Aero-Motive Co.*, 2004 U.S. Dist. LEXIS 31180 (W.D. Mich. Mar. 12, 2004). There it held that the *Henkel* approach was inconsistent with the occurrence-based nature of the liability policies at issue, noting that:

**IN CASES INVOLVING OCCURRENCE-BASED LIABILITY POLICIES, SUCH AS THOSE AT ISSUE HERE, WHEN THE EVENT GIVING RISE TO THE INSURER'S COVERAGE LIABILITY OCCURS WITHIN THE POLICY PERIOD AND PRIOR TO THE ASSIGNMENT, THERE IS NO VALID REASON FOR NOT ENFORCING THE ASSIGNMENT.**

In July 2004, an Indiana circuit court distinguished *Henkel* and held that the imposition of Comprehensive Environmental Response Compensation and Liability Act (CERCLA) liability and a preassignment event giving rise to a claim justified assignment in *P.R. Mallory & Co. v. American States Ins. Co.*, 2004 WL 1737489, at \*7–8 (Ind. Cir. Ct. July 29, 2004).

In December 2004, an Ohio appellate court in *Glidden Co. v. Lumbersmens Mut. Cas. Co.*, 2004 WL 2931019 (Ohio App. Dec. 17, 2004), refused to follow *Henkel* and held as follows:

**A CORPORATION WHICH SUCCEEDS TO LIABILITY FOR PRE-ACQUISITION OPERATIONS OF ANOTHER ENTITY ACQUIRES RIGHTS OF COVERAGE BY OPERATION OF LAW. THIS THEORY APPLIES EVEN WHERE THE ACQUISITION WAS A PURCHASE OF ASSETS OR ONLY PART OF A PREDECESSOR CORPORATION.**

In May 2005, the Ohio Supreme Court accepted that case for review in *Glidden Co. v. Lumbergens Mut. Cas. Co.*, 828 N.E.2d 115 (Ohio 2005). In February 2005, a federal district judge in the Northern District of Ohio certified *Henkel*-related questions to the Ohio Supreme Court in *Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*, Case No. 3:01 CV 7617–JGC (N.D. Ohio Feb. 15, 2005) (unreported opinion, available electronically via PACER as Docket No. 199). The Ohio Supreme Court accepted certification on April 27, 2005, and agreed to answer the following questions:

1. Whether the demand by Pilkington North America for defense and indemnification, as asserted in this case, constituted a chose in action, as that term is defined under Ohio law;
2. Whether the policies' antiassignment clauses barred acquisition by Pilkington North America of such chose in action; and
3. Whether, by operation of law, insurance benefits for transferred liabilities were conveyed, along with those liabilities, so that Pilkington North America might, notwithstanding the antiassignment clauses, pursue insurance under the original LOF Glass's policies for the environmental liabilities at issue here, which arose out of the original LOF Glass's operations.

*Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*, 826 N.E.2d 313 (Ohio 2005).

The Ohio Supreme Court issued its twin decisions in *Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*, 861 N.E.2d 121 (Ohio 2006), and *Glidden Co. v. Lumbergens Mut. Cas. Co.*, 861 N.E.2d 109 (Ohio 2006), on December 20, 2006. The rulings in *Pilkington* are those of an extremely divided court, clearly wrestling with the public policy implications of the *Henkel* decision. On the first issue certified, the court held 4–3 that a chose in action arises under an occurrence-based policy at the time of the covered loss, thus narrowly rejecting *Henkel's* formulation that a loss can only be assignable when it has been reduced to a sum of money due or to become due under the policy.

On the second issue certified, a four-justice majority held that an insurance policy's antiassignment clause did not preclude the assignment of a chose in action to recover indemnity coverage for a loss that already has occurred. But even the majority was split evenly on the issue of whether the same rule should apply to coverage for defense costs. Justices Thomas J. Moyer and Maureen O'Connor, in a concurring opinion, adopted the *Henkel* court's concern that, in certain circumstances, transfer of the right to demand a defense "may

constitute a material change in the duties of the insurer, who could be obligated to defend multiple parties.” Such a transfer “may also constitute a material increase in the insurer’s obligations, as the cost of defense in such a circumstance would not almost certainly be higher.” Yet, Justices Paul E. Pfeifer and Alice R. Resnick, in a separate opinion concurring in part and dissenting in part, articulated their belief that coverage for the cost of defense—as part of the chose in action—is always freely transferable postloss.

On the third issue certified, the court held 5–2 that when a covered occurrence under an insurance policy occurs before liability is transferred to a successor corporation, coverage does not arise by operation of law when the liability was assumed by contract. The *Pilkington* case settled shortly after the supreme court’s ruling.

In the *Glidden* case, the supreme court reversed the appellate court and denied coverage to the successor, finding that the chose in action, i.e., the right to recover insurance benefits, was transferred contractually by a corporate entity that did not own the insurance policies at the time of the purported transfer.

Given the split within the majority as to the conditions under which defense cost benefits are assignable postloss, insurers may be able to block defense cost coverage to corporate successors in Ohio....

The Ohio court’s holdings in *Pilkington* and *Glidden* are significant because they presented the first opportunity, post-*Henkel*, for the high court of any state to consider the extent of insurance coverage for successor liabilities, and the court very nearly adopted *Henkel*. Given the split within the majority as to the conditions under which defense cost benefits are assignable postloss, insurers may be able to block defense cost coverage to corporate successors in Ohio in circumstances where the underlying plaintiff names multiple entities in the corporate succession chain as defendants. Insurers likely will be emboldened by just how close the *Pilkington* decision was, increasingly assert *Henkel*-related defenses to coverage, and take the issue up the appellate courts of additional jurisdictions.

## LIMITS OF LIABILITY



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## WHAT ARE “SIRs/DEDUCTIBLES”?—AMY FINK

- *Missouri Pac. R.R. Co. v. International Ins. Co.*, 288 Ill. App. 3d 69, 679 N.E.2d 801 (1997)
- *Montgomery Ward & Co., Inc. v. Imperial Cas. & Indem. Co.*, 81 Cal. App. 4th 356, 97 Cal. Rptr. 2d 44 (2000)

In a commercial setting, it is not unusual for liability policies to contain a deductible or a self-insured retention (SIR) requiring the policyholder to bear a portion of a covered loss before the insurer’s obligations are triggered. In general, a deductible reduces policy limits. In contrast, where there is an SIR, the insurer’s obligations (including the duty to defend) commence only after a certain amount has been spent by the insured on defense or indemnity costs. The applicability of deductibles and SIRs can lead to numerous coverage issues, particularly in determining allocation and exhaustion issues.

When considering the issues of exhaustion and allocation, a number of courts that have addressed the SIR issue in cases involving continuous injury have concluded that those time periods where the policyholder had an SIR should not be included with the periods where the policyholder had insurance. For example, in *Montgomery Ward & Co., Inc. v. Imperial Cas. & Indem. Co.*, 81 Cal. App. 4th 356, 97 Cal. Rptr. 2d 44 (2000), the California Court of Appeal stated:

**WE CONCLUDE SIRs ARE NOT PRIMARY INSURANCE AND THE PRINCIPLE OF HORIZONTAL EXHAUSTION DOES NOT APPLY.**

The court ruled that there was no basis in the insurance policies, or in applicable law, to conclude that Montgomery Ward’s SIRs were the equivalent of policies of primary insurance.

However, not all jurisdictions are in accord with this conclusion. The *Montgomery Ward* decision directly contradicts the findings of other courts regarding this same issue, such as the earlier determination by the Appellate Court of Illinois, Second District, in *Missouri Pac. R.R. Co. v. International Ins. Co.*, 288 Ill. App. 3d 69, 679 N.E.2d 801 (1997). There, the court held that the policyholder’s SIR constituted primary coverage and required Missouri Pacific to horizontally exhaust all SIRs before looking to its excess insurers for coverage. The

court found SIRs, as primary insurance, to be comparable to fronting policies and uninsured periods.

Thus, the law concerning the exhaustion of SIRs varies between jurisdictions. In many other coverage disputes, an SIR is considered “self-insurance” and therefore not insurance at all. See Berkeley, “Self-Insurance: A Survey of Issues—Update 1999,” *CGL Reporter*, Section 760, IRMI (Dallas: Fall 1999).

## LONG-TAIL LIABILITY ISSUES



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## ALLOCATION—HELEN K. MICHAEL

- *Aerojet-General Corp. v. Transport Indem. Co.*, 17 Cal. 4th 38, 70 Cal. Rptr. 2d 118, 948 P.2d 909 (1997)
- *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993)
- *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994)
- *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994)
- *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995)

In cases involving continuous or progressive injuries, courts have reached sharply differing conclusions about the principles that should govern the allocation of losses among multiple policies and policy periods. Two major competing theories have emerged: (1) the so-called all sums approach, which also has been described as the “joint and several,” “pick and choose,” or “vertical” allocation approach; and (2) the “pro rata” or “horizontal” allocation approach. When coverage is being sought for long-tail injuries, such as environmental contamination and other toxic tort claims, or construction defect claims that may run into many millions of dollars, the theory that is employed can have a profound impact on the policyholder’s total recovery and the amounts insurers are obligated to pay.

Policyholders favor the “all sums” approach because it enables them to choose which, among multiple triggered policies, will pay particular losses, and thereby to avoid periods in which they may have been uninsured, self-insured, or otherwise had gaps in their insurance coverage. After the policyholder has obtained reimbursement from the insurance policies of its choosing, this approach then shifts to the selected insurers the costs of obtaining contribution from nonselected insurers providing coverage in other policy years triggered by the loss.

Insurers generally favor the “pro rata” approach because it limits their exposure only to the proportional share of coverage sold by each triggered policy and because this method requires the policyholder to bear the costs of at least those periods in which the policyholder chose to go uninsured or failed to purchase adequate available insurance. This approach also reduces insurers’ transaction costs by requiring the policyholder to pursue each individual insurer on the risk for coverage.

### ***THE “ALL SUMS” APPROACH***

The “all sums” approach represents the majority rule of allocation for long-tail liabilities. It has been adopted by the appellate courts of 10 states and by 1 federal appellate court. See:

- ◆ *Aerojet-General Corp. v. Transport Indem. Co.*, 17 Cal. 4th 38, 70 Cal. Rptr. 2d 118, 948 P.2d 909 (1997)
- ◆ *Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049 (Ind. 2001)
- ◆ *American Nat’l Fire Ins. Co. v. B&L Trucking & Const. Co.*, 951 P.2d 250 (Wash. 1998)
- ◆ *Armstrong World Ind. v. Aetna Cas. & Sur. Co.*, 45 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690 (1996)

Policyholders favor the “all sums” approach because it enables them to choose which ... policies, will pay.... Insurers generally favor the “pro rata” approach because it limits their exposure only to the proportional share of coverage sold by each triggered policy....

- ◆ *Caterpillar, Inc. v. Century Indem. Co.*, 2007 Ill. App. 1420 (Ill. App. Feb. 2, 2007)
- ◆ *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 769 N.E.2d 835 (Ohio 2002)
- ◆ *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481 (Del. 2001)
- ◆ *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993)
- ◆ *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982), *reh’g denied*, 456 U.S. 951 (1982) (multiple states’ laws)



- ◆ *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994) (applying Missouri law)
- ◆ *Rubenstein v. Royal Ins. Co.*, 694 N.E.2d 381 (Mass. App.), *aff'd in part*, 707 N.E.2d 367 (Mass. 1998)
- ◆ *Sentinel Ins. v. First Ins. of Haw.*, 875 P.2d 894 (Haw. 1994)
- ◆ *Texas Prop. & Cas. Ins. Guar. Ass'n v. Southwest Aggregates, Inc.*, 982 S.W.2d 600 (Tex. App. 1998)

The basic rationale for the all sums approach is that the language in each successive policy for which the policyholder paid substantial premiums over the years expressly states that the insurer will defend “any suit” and pay “all sums” incurred by the policyholder. As the appeals court of Massachusetts summarized this rationale:

*The policy contains standard language providing that the insurer will pay on behalf of the insured “all sums which the insured shall become legally obligated to pay as damages....” Courts ... have interpreted this same language to mean that, when multiple policies are triggered to cover the same loss, each policy provides indemnity for the insured’s entire liability, and each insurer is jointly and severally liable for the entire claim. [Citations omitted]. Of course, there is no bar against an insurer obtaining a share of indemnification or defense costs from other insurers under the doctrine of equitable contribution....*

The distinction between the *trigger* of coverage (must the policy respond) and the *scope* of coverage (how much must the policy pay) is critical to deciding between the all sums and pro rata allocation approaches. As the U.S. Court of Appeals for the District of Columbia explained in its seminal decision first recognizing the all sums approach:

EACH POLICY HAS A BUILT-IN TRIGGER OF COVERAGE. ONCE TRIGGERED, EACH POLICY COVERS [THE POLICYHOLDER’S] LIABILITY. THERE IS NOTHING IN THE POLICIES THAT PROVIDES FOR A REDUCTION OF THE INSURER’S LIABILITY IF AN INJURY OCCURS ONLY IN PART DURING A POLICY PERIOD. AS WE INTERPRET THE POLICIES, THEY COVER [THE POLICYHOLDER’S] ENTIRE LIABILITY ONCE THEY ARE TRIGGERED. THAT INTERPRETATION IS BASED ON THE TERMS OF THE POLICIES THEMSELVES.



See, e.g.:

- ◆ *Accord Allstate*, 759 N.E.2d at 1057–58 (“There is no language in the coverage grant ... that limits Allstate’s responsibility to indemnification for liability derived solely for that portion of damages taking place within the policy period.”)
- ◆ *Armstrong World Ind. v. Aetna Cas. & Sur. Co.*, 45 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690 (1996) (“Although a policy is triggered only if property damage takes place ‘during the policy period,’ once a policy is triggered, the policy obligates the insurer to pay ‘all sums’ which the insured shall become liable to pay as damages for bodily injury or property damage. The insurer is responsible for the full extent of the insured’s liability (up to policy limits), not just for the part of the damage that occurred during the policy period.”)
- ◆ *B&L Trucking*, 951 P.2d at 256 (“If the insurer wished to limit its liability through a pro rata allocation of damages once a policy is triggered, the insurer could have included that language in the policy.”)

A number of courts adopting the “all sums” approach also have reasoned that the definition of “occurrence” in CGL policies shows that the parties intended that all of the resulting damages fall within the indemnification obligation of the insurer:

*An “occurrence” includes “continuous or repeated exposure to conditions which result in bodily injury.” The insurers which drafted the definition obviously contemplated the possibility of injury resulting from continuous or repeated exposure to conditions, and specified that the process of exposure was to constitute one occurrence.*

*If prolonged exposure, constituting one occurrence, resulted in injury, and if the injury occurred during the time a given policy was in effect, then the injury is an insurable risk under the terms of that policy. Being defined as one “occurrence,” the entire injury, and all damages resulting therefrom, fall within the indemnification obligation of the insurer. In other words, once the liability of a given insurer is triggered, it is irrelevant that additional exposure or injury occurred at times other than when the insurer was on the risk. The insurer in question must bear potential liability for the entire claim.*

*J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993).

See *Aetna Cas. & Sur. Co. v. Pintlar Corp.*, 948 F.2d 1507 (9th Cir. 1991) (“Coverage is limited to ‘damages’ occurring during the policy period; it also includes ‘damages’ occurring after the period, as long as those ‘damages’ are caused by an ‘occurrence’ that is a release which results in injury during the policy.”) (applying Idaho law).

Other courts have concluded that the standard CGL policy language is at least ambiguous and accordingly have applied the rule of *contra proferentem*, which requires conflicting policy interpretations to be construed against the insurer and in favor of coverage. As the Washington Supreme Court reasoned in adopting the “all sums” approach:

*Looking at the policy in light of our rules of construction, we find the language is, at the least, fairly susceptible to different, reasonable interpretations and is, therefore, ambiguous. If the insurer wished to limit its liability through a pro rata allocation of damages once a policy is triggered, the insurer could have included that language in the policy. Here, there is no such language.... Because the language is, at the least, ambiguous, and because we discern no extrinsic evidence from the record indicating an intent by both parties to exclude coverage, we must resolve the ambiguity in favor of the insured. We hold that once a policy is triggered, the policy language requires the insurer to pay all sums for which the insured becomes legally obligated, up to the policy limits. Once coverage is triggered in one or more policy periods, those policies provide full coverage for all continuing damage, without any allocation between insurer and insured.*

*B&L Trucking*, 951 P.2d at 256 (citations and footnote omitted). See, e.g., *Hercules*, 784 A.2d at 489–94 & 492 n. 30.

Insurers generally assert that the all sums allocation method provides a windfall to policyholders by holding insurers liable for damages occurring outside of their policy periods. Insurers also object that this method may allow policyholders to receive coverage for which they did not bargain by enabling them to avoid high self-insured retentions and periods in which they choose to purchase little or no insurance.

### ***THE “PRO RATA” APPROACH***

Under this method, the policyholder’s loss is divided proportionally among all liable insurance companies based on the portion of the loss that occurred during the time each insurer’s policy was in place. This minority approach has been adopted by six state appellate courts. See:

- ◆ ***Carter-Wallace, Inc. v. Admiral Ins. Co.***, 154 N.J. 312, 712 A.2d 1116 (N.J. 1998) (mixed time-on-the-risk and percentage of coverage)
- ◆ ***Commercial Union Ins. Co. v. Sepco Corp.***, 918 F.2d 920 (11th Cir. 1990) (holding Alabama Insurance Guaranty Association liable for insolvent insurer’s proportionate share based on approval of district court’s time-on-the-risk allocation)
- ◆ ***Consolidated Edison Co. v. Allstate Ins. Co.***, 774 N.E.2d 687 (N.Y. 2002) (adopting “pro rata” allocation approach but not deciding which “pro rata” methodology applies)
- ◆ ***Domtar, Inc. v. Niagara Falls Ins. Co.***, 563 N.W.2d 724 (Minn. 1997) (time-on-the-risk allocation)
- ◆ ***Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.***, 633 F.2d 1212 (6th Cir. 1980) (applying Illinois and New Jersey law, time-on-the-risk), *cert. denied*, 455 U.S. 1007 (1982)
- ◆ ***Jones v. Liberty Mut. Ins. Co. (In re Wallace & Gale Co.)***, 385 F.3d 820 (4th Cir. 2004) (applying Maryland law, time-on-the-risk)
- ◆ ***Owens-Illinois, Inc. v. United Ins. Co.***, 650 A.2d 974 (N.J. 1194) (mixed time-on-the-risk and percentage of coverage allocation)
- ◆ ***Porter v. American Optical Corp.***, 641 F.2d 1128 (5th Cir. 1981) (applying Louisiana law, time-on-the-risk allocation)
- ◆ ***Public Serv. Co. v. Wallis & Cos.***, 986 P.2d 924 (Colo. 1999) (time-on-the-risk allocation)
- ◆ ***Sentinel Ins. Co. v. First Ins. Co.***, 875 P.2d 894 (Haw. 1994) (time-on-the-risk allocation)
- ◆ ***Sharon Steel Corp. v. Aetna Cas. & Sur. Co.***, 931 P.2d 127 (Utah 1997) (time-on-the-risk and percentage of coverage allocation)

- ◆ *Spartan Petrol. Co. v. Federated Mut. Ins. Co.*, 162 F.3d 805 (4th Cir. 1998) (applying South Carolina law, time-on-the-risk allocation)
- ◆ *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995) (applying New York and Texas law, time-on-the-risk allocation)

Insurers prefer the “pro rata” approach because it may reduce their overall liability by requiring policyholders to contribute for periods in which they did not purchase coverage, have lost their policies, or have other gaps in coverage.

*See, e.g.:*

- ◆ *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995) (allocation to insured for years where policyholder did not purchase coverage is appropriate, proration to policyholder where coverage excluded is not)
- ◆ *Owens-Illinois*, 650 A.2d at 995 (“When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable.”)

This method also places the burden of transaction costs principally on policyholders because they must pursue each individual insurer on the risk for coverage.

### ***THE “TIME-ON-THE-RISK” APPROACH***

Most courts adopting the “pro rata” approach allocate the loss among liable insurers based on the proportional time that each insurer covered the risk. The *Public Service* court summarized this approach as follows:

**WE HOLD THAT WHERE PROPERTY DAMAGE IS GRADUAL, LONG-TERM, AND INDIVISIBLE, THE TRIAL COURT SHOULD MAKE A REASONABLE ESTIMATE OF THE PORTION OF THE “OCCURRENCE” THAT IS FAIRLY ATTRIBUTABLE TO EACH YEAR BY DIVIDING THE TOTAL AMOUNT OF LIABILITY BY THE NUMBER OF YEARS AT ISSUE. THE TRIAL COURT SHOULD THEN ALLOCATE LIABILITY ACCORDINGLY TO EACH POLICY YEAR, TAKING INTO ACCOUNT PRIMARY AND EXCESS COVERAGE, SIRS, POLICY LIMITS, AND OTHER INSURANCE ON THE RISK....**

Courts adopting this form of allocation often focus on policy provisions limiting coverage to “occurrences” taking place during the policy period. See, e.g., *Porter*, 641 F.2d at 1145; *Public Serv.*, 986 P.2d at 939. In *Consolidated Edison*, The New York Court of Appeals’ reasoning is illustrative:

*Although more than one policy may be implicated by a gradual harm, joint and several allocation is not consistent with the language of the policies providing indemnification for “all sums” of liability that resulted from an accident or occurrence “during the policy period.” ... Most fundamentally, the policies provide indemnification for liability incurred as a result of an accident or occurrence during the policy period, not outside that period. [The policyholder’s] singular focus on “all sums” would read this important qualification out of the policy.*

Other courts have concluded that equity demands allocation among insurers based on time periods covered by their policies. See *Sentinel*, 875 P.2d at 919 (“Equity, under the circumstances of this case, dictates that the court allocate contribution among liable insurers in proportion to the time periods their policies covered.”); *Public Serv.*, 986 P.2d at 941 (“In our view, the most equitable method of allocation is a system of time on the risk that also takes into account the degree of the risk assumed.”).

In considering the equitable justifications for adopting a pro rata allocation approach, some courts have emphasized that a critical inquiry with respect to the fairness of requiring the policyholder to accept a proportionate share of the risk is whether the policyholder “elected to assume” the risk, “either by declining to purchase available insurance or by purchasing what turned out to be an insufficient amount of insurance.” *Stonewall*, 73 F.3d at 1204. This inquiry dictates that the policyholder should be required to absorb only losses allocable to policy periods in which the policyholder failed to purchase available insurance, and not those in which insurance coverage for the particular risk ceased to be available (ruling that “proration to the insured should” not have been “applied to years after 1985 when asbestos liability insurance was no longer available”).

Insurers typically maintain that the pro rata, time-on-the-risk approach is the most equitable method of allocating a loss because the approach limits their exposure only to the proportional share of the cost of the risk. In contrast, policyholders generally disfavor this approach because the time on the risk allocation method leaves a substantial risk that some portion of their liability may go unreimbursed.

### ***THE “OWENS-ILLINOIS/PERCENTAGE OF LIMITS” APPROACH***

A few courts that have adopted the “pro rata” allocation approach have developed an alternative apportionment theory. Instead of allocating based on each insurer’s time on the risk, these courts divide the liability into shares across the triggered period with heavier weighting for years in which the policyholder purchased more coverage.

This version of pro rata allocation was first adopted in *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994), and, thus, is often called the *Owens-Illinois* approach. The decision sought to strike a middle ground between the extremes imposed by the all sums and pro rata approaches. The New Jersey Supreme Court reasoned that, because “[t]he language of the policies does not itself yield either result and the usual rules of [contract] interpretation are less helpful in this context,” it would be guided by public interest factors bearing on the fairness of requiring particular insurers or policyholders to bear a portion of the risk.

Applying these public interest factors, the court concluded allocation of coverage for a long-tail loss should be spread horizontally among triggered insurers in proportion to the amount of coverage available in each policy period. The New Jersey Supreme Court subsequently clarified as follows in *Carter-Wallace*, 154 N.J. 312, 712 A.2d at 1123 (1998) (quoting *Chemical Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co.*, 978 F. Supp. 589 (D.N.J. 1997)):

**THE *OWENS-ILLINOIS* METHOD INTENTIONALLY ASSIGNS A GREATER PORTION OF INDEMNITY COSTS TO YEARS IN WHICH GREATER AMOUNTS OF INSURANCE WERE PURCHASED, BASED ON THE VIEW THAT THIS MEASURE OF ALLOCATION IS MORE CONSISTENT WITH THE ECONOMIC REALITIES OF RISK RETENTION AND RISK TRANSFER.**

The court concluded that although this percentage of the limits approach is admittedly imperfect, it is the most fair and efficient method of allocation.



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## WHEN IS COVERAGE TRIGGERED?—SETH LAMDEN

- *Eagle-Picher Ind., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12 (1st Cir. 1982)
- *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980)
- *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981)
- *Koppers Co., Inc. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440 (3d Cir. 1996)
- *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 283 Ill. App. 3d 630, 670 N.E.2d 740 (2d Dist. 1996)
- *U.S. Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 643 N.E.2d 1226 (1st Dist. 1994)
- *Zurich Ins. Co. v. Raymark Ind. Inc.*, 514 N.E.2d 150 (Ill. 1987)

The term “trigger” is the timing element for coverage to respond to a claim. A standard form commercial general liability (CGL) insurance policy provides coverage for damages for bodily injury or property damage that occurs *during the policy period* if the bodily injury or property damage is caused by an occurrence, as defined in the policy. The question of whether the bodily injury or property damage occurred during the policy period is the subject of many opinions, six of which we include in our summary of the “50 most significant” coverage cases.

For claims seeking damages for bodily injury or property damage that occurs over multiple policy periods (often referred to as “long-tail claims”), the analysis is not straightforward. Some examples of long-tail claims include gradual environmental pollution, defective construction, and disease caused by exposure to asbestos or other harmful substances. To determine which policy(ies) are triggered by long-tail claims, courts have developed a number of different analyses to determine when the bodily injury or property damage occurred.

Courts have employed five theories to ascertain when property damage or bodily injury occurred when determining which consecutive liability policies are triggered by a long-tail occurrence:

1. **Exposure**—Bodily injury or property damage is deemed to take place when the claimant or the environment is injuriously exposed to a toxic substance (e.g., inhalation of asbestos fibers, exposure of environmental contaminants to the groundwater, or even the exposure of a child molester to the victim in sexual molestation cases).



2. **Manifestation**—The policy in effect when the property damage becomes known or apparent is triggered (e.g., the date on which a disease can be diagnosed due to the presence of symptoms).
3. **Injury in fact**—Each policy in effect at any time when property damage or bodily injury actually takes place, even if the injury is not immediately known or manifested, is triggered.
4. **Multiple**—Each policy in effect when discrete events occur is triggered (e.g., inhalation of asbestos and manifestation of disease).
5. **Continuous**—All policies on the risk from the time of the initial exposure through the manifestation of injury, or in some cases through the assertion of the claim, are triggered.

In the earliest cases, in the asbestos bodily injury context, a number of courts adopted the exposure trigger to determine during which policy period(s) asbestos bodily injury occurs (those in effect when the asbestos claimant inhaled the asbestos fibers). The “seminal” case adopting the exposure rule is *Insurance Co. of N. Am. v. Forty-Eight Insulations*, 633 F.2d 1212 (6th Cir. 1980), *aff’d on reh’g*, 657 F.2d 814 (6th Cir. 1981), *cert. denied*, 454 U.S. 1109 (1981), *reh’g denied*, 455 U.S. 1009 (1982). The “exposure” theory is predicated on the basis that bodily injury or property damage occurs at the time of initial exposure to a hazardous substance.

Many courts continue to adopt the exposure trigger in connection with cases involving asbestos bodily injury, equating exposure to asbestos with “bodily injury.” See *Shook & Fletcher Asbestos Settlement Trust v. Safety Nat’l Cas. Corp.*, 909 A.2d 125 (Del. 2006) (applying exposure trigger); and *A.W. Chesterton Co. v. Massachusetts Insurers Insolvency Fund*, 838 N.E.2d 1237 (Mass. 2005) (same).

In contrast to the exposure cases is the manifestation trigger applied by the court in *Eagle-Picher Ind., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12 (1st Cir. 1982). Pursuant to the manifestation trigger, bodily injury or property damage is deemed to occur at the time it manifests itself or is discovered. The court in *Eagle-Picher* found that asbestos bodily injury occurred only when disease resulting from the asbestos inhalation “becomes clinically evident, that is, when it becomes reasonably capable of medical diagnosis,” because the microscopic scarring of the lungs that occurred at the time of inhalation of asbestos fibers does not constitute bodily injury.

While the manifestation trigger is rarely used, some courts have applied it in coverage litigation for property damage claims due to mold and defective



construction, finding that policies in effect at the time the damage is discovered (manifested) are triggered. See:

- ◆ *Audubon Trace Condominium Ass’n, Inc. v. Brignac-Derbes, Inc.*, 924 So. 2d 1131 (5th Cir. 2006) (manifestation trigger applies to defective construction claim)
- ◆ *Bayou Bend Homes, Inc. v. Scottsdale Ins. Co.*, 2006 U.S. Dist. LEXIS 48887 (S.D. Tex. July 18, 2006)
- ◆ *DeLuca Ent. v. Assurance Co.*, 911 A.2d 190 (Pa. Super. 2006) (table) (manifestation trigger applies to defective construction claim)

The “continuous” trigger combines the “exposure” and “manifestation” triggers and specifies that every policy in effect from the time of the initial harmful exposure through the manifestation of the injury is triggered. The continuous trigger remains the most widely accepted trigger theory in toxic tort and defective construction. See:

- ◆ *Essex Ins. Co. v. Massey Land & Timber, LLC*, 2006 U.S. Dist. LEXIS 36748 (S.D. Miss. May 22, 2006) (defective construction)
- ◆ *Koppers Co., Inc. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440 (3d Cir. 1996) (pollution)
- ◆ *Norfolk Southern Corp. v. California Union Ins. Co.*, 859 So. 2d 167 (1st Cir. 2003) (pollution)
- ◆ *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 283 Ill. App. 3d 630, 670 N.E.2d 740 (2d Dist. 1996) (pollution)
- ◆ *Plum v. West Am. Ins. Co.*, 2006 Ohio 452 (Ohio Ct. App., Hamilton County Feb. 03, 2006)
- ◆ *Standard Fire Ins. Co. v. Spectrum Cmty. Ass’n*, 46 Cal. Rptr. 3d 804 (Cal. App. 2006) (defective construction)
- ◆ *U.S. Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 643 N.E.2d 1226 (1st Dist. 1994) (asbestos property damage)

The continuous trigger also has been employed in coverage cases involving allegations of bodily injury caused by exposure to asbestos [see *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981)] and lead paint. See:

- ◆ *Maryland Cas. Co. v. Hanson*, 902 A.2d 152 (Md. App. 2006)
- ◆ *Moore v. Aetna*, No. A-4423-01T2F, 2003 WL 1904383, at \*3 (N.J. Super. App. Div. Jan. 14, 2003)
- ◆ *Riley v. United Servs. Auto. Ass’n*, 871 A.2d 599 (Md. Ct. Spec. App. 2005)

### **COMMERCIAL LIABILITY INSURANCE**

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## **HOW MANY “OCCURRENCES”?— DOUGLAS W. GASTÉLUM**

- *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56 (3d Cir. 1982)
- *Lee v. Interstate Fire & Cas. Co.*, 86 F.3d 101 (7th Cir. 1996)
- *Nicor, Inc. v. Associated Electric & Gas Ins. Servs. Ltd.*, 223 Ill. 2d 407, 860 N.E.2d 280 (2006)

At the end of any coverage dispute, the one issue that all parties must face is how much money is the insurer obligated to pay for settlement or judgment. The answer to the question “how many occurrences?” is often crucial to determining the amount available. The resolution of the “number of occurrences” issue will affect the limits of liability, as well as the number of deductibles or retained limits applicable. It pits the policyholder, the primary insurer, and the excess insurer in adversarial roles that can change dramatically depending on the specific facts and damages at issue.

The court succinctly described the issue of the number of occurrences in *Lee v. Interstate Fire & Cas. Co.*, 86 F.3d 101 (7th Cir. 1996), regarding coverage for a Roman Catholic diocese facing liability for multiple acts of one of its employees:

*Winners and losers will change with the circumstances. Interstate [the excess insurer] today wants to call sustained sexual abuse multiple occurrences to increase the number of deductibles the Diocese must*

*cover and the number of contributions the primary carrier must make. But if tomorrow the victim's loss exceeds the maximum coverage for a single occurrence, the roles will be reversed. The excess carrier would want to call the sexual abuse a single occurrence to cap its own exposure, while the Diocese would favor multiple occurrences in order to maximize its insurance coverage.*

The types of claims can vary widely, and the policies can be either first party or third party, but the arguments revolve around the principle set forth above.

Occurrences from which covered injuries arise are not necessarily contemporaneous with the injuries themselves, may have taken place outside the policy period, and may each spawn multiple injuries or may combine to cause a single injury. Occurrences are more closely related to events or decisions that cause allegations of liability. Accordingly, the number of occurrences that apply is directly related to a policyholder's involvement in the events alleged to have caused injury.

The number of occurrences may not affect retentions and limits equally. Some policies have retentions that are "per occurrence," where others have retentions that are triggered "per claim." Similarly, some policies have per occurrence limits of liability with different aggregate limits, and some have limits set out per claim or per person. Each different configuration can materially change the value of the insurance coverage, depending on how it is applied to the number of occurrences.

Virtually all courts agree that the number of occurrences is determined by referring to the cause of the policyholder's potential liability or loss rather than to the number of individual claims or injuries. Even some courts that refer to an "effects" test ultimately look to the cause of liability to determine the number of occurrences.

The factors implicit in this general rule include, at a minimum, the language of the policy, the cause of the liability or loss, and whether any intervening business decisions or causes contributed to the injuries or losses alleged.

### ***POLICY LANGUAGE***

Obviously, one of the most important clauses to determine the number of occurrences applicable to claims on an insurance policy is its definition of "occurrence." Most CGL policies define occurrence to mean something like

“an accident, including continuous or repeated exposure to substantially the same general harmful conditions.” See, Insurance Services Office, Inc. (ISO), Form CG 00 01 11 88.

Other parts of a policy that might be useful to determine the number of occurrences include:

- ◆ The declarations page or retention endorsement that describes how a retention applies
- ◆ The limits of liability section, which may provide that the insurer will not be liable for more than the occurrence limit, irrespective of the number of claims made per occurrence
- ◆ The policyholder’s duties in the event of an occurrence, claim, or suit section may differentiate between duties in the event of an occurrence and duties in the event of a claim, indicating that they are not the same
- ◆ If a policy has a provision for notice of a potential claim that may provide insight as to the meaning of occurrence (or claim) as well

### *CAUSE OF LIABILITY*

Some courts focus on the cause of liability rather than the number or cause of injuries. Many cases have resulted in single occurrence conclusions even as applicable to multiple claims or lawsuits. For example, in *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56 (3d Cir. 1982), the court held that injuries alleged in a class action suit alleging a discriminatory employment policy was a single occurrence for the purposes of the policy deductible. In *Appalachian*, there were many plaintiffs, with at least some alleging multiple injuries, and the insurer wanted to impose a separate retention for each of them, which would have had the retention swallow the available limits.

Instead, the court found that the only occurrence that caused liability at issue in this underlying lawsuit was a single adoption of employment policies that limited employment opportunities for women in Liberty Mutual’s claim organization. Therefore, Liberty Mutual was subject to only a single retention, and the policy benefits were triggered.

Similarly, in *Mead Reins. v. Granite State Ins. Co.*, 873 F.2d 1185 (9th Cir. 1989), the court held that the policyholder city’s potential liability arising from injuries alleged in 11 lawsuits claiming that the city had adopted a policy condoning police brutality constituted a single occurrence. See also *E.I DuPont de*

*Nemours v. Allstate Ins. Co.*, 879 A.2d 929 (Del. Super. 2004), where the court ruled that to correctly determine the number of occurrences, the court must look at the “relevant occurrences” and that events that could not give rise to liability were “irrelevant.”

A subtly more precise statement of the general rule is found in *Newmont Mines Ltd. v. Hanover Ins. Co.*, 784 F.2d 127 (2d Cir. 1986). There, the court was applying New York law to a number of occurrences question in a first-party coverage case but referred nevertheless to third-party cases for a rule on determining the number of occurrences. The court found that the “business purpose sought to be achieved by the parties” should inform the court’s reasoning on this issue and held that “it is eminently reasonable to look to the underlying conduct or cause of [the] liability” that was insured.

In *EOTT Energy v. Storebrand Int’l Ins.*, 45 Cal. App. 4th 565 (1996), the court aggregated hundreds of individual first-party losses into a single occurrence on a “common scheme or plan” basis. It reasoned, as the *Newmont Mines* court had, that first- and third-party cases have some common features that should govern the question.

### ***INTERVENING ACTS CAUSING MULTIPLE OCCURRENCES***

In contrast, courts have found that a single business policy or practice can lead to multiple occurrences if the liability arises from the implementation rather than the policy. In *Eureka Fed. Sav. & Loan Ass’n v. American Cas. Co. of Reading, Pa.*, 873 F.2d 229 (9th Cir. 1989), for instance, the court held that, although the losses alleged in the underlying complaints all arose from a single aggressive lending strategy adopted by the board of directors, each of the 200 or more failing loans was a separate occurrence because they resulted from “numerous intervening business decisions that took place after the [business] policy was initiated that required the exercise of independent judgment.”

In *Mason v. Home Ins. Co. of Ill.*, 532 N.E.2d 526 (Ill. App. 1988), where multiple visitors to a restaurant became ill after being served tainted onions on their meals, the court held that each act of serving contaminated food to a customer over a 3-day period was a separate occurrence. The court explained that while “continuous or repeated exposure to conditions” and “exposure to substantially the same general conditions” constituted only a single occurrence, the serving of food to various patrons constituted distinct acts, “each of which resulted in exposure to liability.”

In *Mason*, the retentions were not at issue, only the number of policy limits that would be paid to victims. Because the court determined that each meal was a separate occurrence, the policy's \$1 million limit applied separately to each customer who had been served. That is, the court found that because independent decisions and acts were taken with respect to each person served, and no liability would have attached without serving a tainted meal, each meal served was a separate occurrence.

Arguably, under that rule, if the onions had been supplied in a single batch by a supplier, that supplier could have been a codefendant in each of the claims made by the same plaintiffs but have had only a single occurrence applicable to the entire set of injuries.

Following the reasoning of *Mason*, the Illinois Supreme Court in *Nicor, Inc. v. Associated Electric & Gas Ins. Servs. Ltd.*, 223 Ill. 2d 407, 860 N.E.2d 280 (2006), found that spills of mercury in 195 of the several hundred thousand homes served by Nicor were separate occurrences. The court agreed with the appellate court, which had held that the spills "were the product of separate and independent acts, occurring 'in an isolated number of cases as a result of [individual servicemen's] actions or the particular circumstances in each residence.'" The court held that where liability arose from neither an inherently defective product design, nor from a systemwide policy or procedure, but from "intervening human act[s, which each] increased the insured's exposure to liability," each spill was an occurrence.

**THE GENERAL RULE IS THAT AN OCCURRENCE IS DETERMINED BY THE CAUSE OR CAUSES OF THE RESULTING INJURY.**

*Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56 (3d Cir. 1982).

In conclusion, then, if the cause is singular, and there are no intervening causes that change, exacerbate, or provide opportunity to stop or reduce the number of injuries resulting therefrom, there will likely be a single occurrence. If, on the other hand, the policyholder is accused of distinct acts from which distinct liabilities arise, no matter how similar they may be, there may be multiple occurrences, measured by the number of such distinct acts.

## BAD FAITH



**ERNEST SUMMERS III**  
Baker & Daniels

## WHAT CONSTITUTES “BAD FAITH”?— ERNEST SUMMERS AND DOUGLAS W. GASTÉLUM

- *Crisci v. Security Ins. Co. of New Haven, Conn.*, 66 Cal. 2d 425, 58 Cal. Rptr. 13, 426 P.2d 173 (1967)
- *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 157 Cal. Rptr. 482, 598 P.2d 452 (1979)
- *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 108 Cal. Rptr. 480 (1973)
- *Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544 (Tex. Comm’n App. 1929)
- *Waller v. Truck Ins. Exch., Inc.*, 11 Cal. 4th 1, 44 Cal. Rptr. 2d 370, 900 P.2d 619 (1995)
- *White v. Western Title Ins. Co.*, 40 Cal. 3d 870, 221 Cal. Rptr. 509 (1985)

In an insurance claim situation, insurers are required to do many things: act in good faith, investigate both promptly and thoroughly the events leading up to and surrounding the claim, be fair in their investigation and adjustment of the claim, and always act reasonably. When insurers fail to do so, accusations of bad faith can arise.

**THERE IS AN IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING IN EVERY CONTRACT THAT NEITHER PARTY WILL DO ANYTHING WHICH WILL INJURE THE RIGHT OF THE OTHER TO RECEIVE THE BENEFITS OF THE AGREEMENT.**

*Comunale v. Traders & General Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198 (1958).

It is well settled that this principle is applicable to insurance policies. See also *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 108 Cal. Rptr. 480 (1973); and *Waller v. Truck Ins. Exch., Inc.*, 11 Cal. 4th 1, 44 Cal. Rptr. 2d 370, 900 P.2d 619 (1995). Moreover, “the obligations of insurers go beyond meeting reasonable expectations of coverage [and] ... encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary.” *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 157 Cal. Rptr. 482, 598 P.2d 452 (1979).

The *sine qua non* of good faith is that an insurer must give at least as much consideration to the policyholder's interest as it gives to its own interest. Insurers may run afoul of the rules requiring them to act in good faith if, among other things, they fail to adequately investigate claims, take unreasonable positions adverse to their policyholders, or delay acting or paying on claims or suits.

### ***DUTY TO PROMPTLY AND FULLY INVESTIGATE CLAIMS***

Pursuant to this implied duty of good faith and fair dealing, an insurer is obligated to do many things, including to “process all claims submitted to it promptly and competently, even in those instances where no coverage will ultimately be provided.” *Travelers Ins. Co. v. Leshner*, 187 Cal. App. 3d 169 (1986). As such:

*Delayed payment based on inadequate or tardy investigations, oppressive conduct by claims adjusters seeking to reduce the amounts legitimately payable, and numerous other tactics may breach the implied covenant because” they frustrate the insured’s right to receive the benefits of the contract in “prompt compensation for losses.*

*Waller*, citing *Love v. Fire Ins. Exch.*, 221 Cal. App. 3d 1136 (1990).

An insurer's failure thoroughly and timely to investigate claims before rendering a coverage decision is evidence of bad faith, whether in the context of the duty to defend or the duty to indemnify. See, e.g., *Waller* (insurer is obligated to promptly and adequately investigate and process claims before rendering a decision on the duty to defend or indemnify) and *Egan* (“an insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial”).

The *sine qua non* of good faith is that an insurer must give at least as much consideration to the policyholder's interest as it gives to its own interest.

Moreover, “[a]n insurer may breach the covenant of good faith and fair dealing when it fails to properly investigate its insured's claim.” *Egan* at 817. See *Waller* (an unreasonable delay in processing a claim or providing payment under the policy or an ultimate coverage decision is a breach of the implied covenant of good faith and fair dealing); see also *American Med. Int'l, Inc. v. National Union Fire Ins. Co. of Pittsburgh*, 244 F.3d 715



(9th Cir. 2001) (jury could find that insurers’ “initial delay” in providing coverage owed under the policy violated the implied covenant of good faith and fair dealing).

Indeed, under California law, an insurer cannot reasonably and in good faith deny payments to its insured without fully investigating the claim and obtaining all information relevant to coverage issues before denying coverage. *See*:

- ◆ *Egan*, 24 Cal. 3d at 819
- ◆ *Frommoethelydo v. Fire Ins. Exch.*, 42 Cal. 3d 208 (1986)
- ◆ *Mariscal v. Old Republic Life Ins. Co.*, 42 Cal. App. 4th 1617 (1996)
- ◆ *Shade Foods, Inc. v. Innovative Products Sales & Mktg., Inc.*, 78 Cal. App. 4th 847 (1st Dist. 2000)

### ***DUTY TO INVESTIGATE AND ADJUST CLAIMS FAIRLY***

Insurers are obligated to protect the objectively reasonable expectations of their policyholders and not engage in unreasonable or “arbitrary” interpretation of their policies. *See Amadeo v. Principal Mut. Life Ins. Co.*, 290 F.3d 1152 (9th Cir. 2002). An insurance company’s duty to act in good faith toward its insureds means that it has a duty not to unreasonably withhold the benefits that are due under a policy. An insurance company acts in bad faith when it refuses, without proper cause, to pay for a loss that is covered under the policy. *See Gruenberg* and *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 54 Cal. Rptr. 104 (1966).

Further, a policyholder can prove that an insurer breached its implied covenant of good faith and fair dealing by showing it unreasonably withheld policy benefits or failed to negotiate a reasonable settlement, even if the insurer is not proved to have acted with actual dishonesty, fraud, or improper motives. *See*:

- ◆ *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 58 Cal. Rptr. 13, 426 P.2d 173 (1967)
- ◆ *Johansen v. California State Auto. Ass’n Inter-Ins. Bur.*, 15 Cal. 3d 9 (1975)
- ◆ *Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544 (Tex. Comm’n App. 1929) (holding approved)

### *DUTY TO ACT REASONABLY*

One important facet of an insurer's obligation to give the insured's interest as much consideration as it does its own is the duty to reasonably inform an insured of the insured's rights and obligations under the insurance policy. *See*:

- ◆ *Davis v. Blue Cross of No. Cal.*, 25 Cal. 3d 418 (1979)
- ◆ *Gruenberg* (While coverage litigation is pending "insurers cannot be heard to say that they are privileged to act in bad faith and deal unfairly with their insured.")
- ◆ *White v. Western Title Ins. Co.*, 40 Cal. 3d 870, 221 Cal. Rptr. 509, (1985) (An insurer's duty of good faith and fair dealing survives the onset of litigation, and evidence of the insurer's conduct during litigation, such as a continued failure to investigate or adjust the claim, is admissible to show the insurer's breach of the covenant of good faith and fair dealing.)

An insurance company is acting in bad faith if it forces an insured to file a lawsuit in order to enforce its rights under the insurance policies. *See Comunale* and *Crisci*.

Policyholders proving that their insurers acted unreasonably, not necessarily dishonestly, and not so badly that punitive damages may attach, are nevertheless entitled to an award of attorney fees and other litigation expenses incurred to obtain policy benefits. *See Brandt v. Superior Ct.*, 37 Cal. 3d 813 (1985); and *White*.

## CASE SUMMARIES

This list of our top 50 coverage cases is presented below and in the case summaries that follow in alphabetical order for ease of reference. Links back to the analysis and implications follow each case summary.

1. *Aerojet-General Corp. v. Commercial Union Ins. Co.*, 155 Cal. App. 4th 132, 65 Cal. Rptr. 3d 803 (2007)
2. *Aerojet-General Corp. v. Superior Ct.*, 211 Cal. App. 3d 219, 257 Cal. Rptr. 621 (1989). Previously published at 209 Cal. App. 3d 973, 211 Cal. App. 3d 216. Opinion on denial of rehearing, 258 Cal. Rptr. 684, 209 Cal. App. 3d 238.
3. *Aerojet-General Corp. v. Transport Indem. Co.*, 17 Cal. 4th 38, 70 Cal. Rptr. 2d 118, 948 P.2d 909 (1997)
4. *AIU Ins. Co. v. Superior Ct.*, 51 Cal. 3d 807, 274 Cal. Rptr. 820, 799 P.2d 1253 (1990)
5. *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56 (3d Cir. 1982)
6. *Buss v. Superior Ct.*, 16 Cal. 4th 35, 65 Cal. Rptr. 2d 366, 939 P.2d 766 (1997)
7. *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303, 32 Cal. Rptr. 827, 384 P.2d 155 (1963)
8. *Central Ill. Light Co. v. Home Ins. Co.*, 213 Ill. 2d 141, 821 N.E.2d 206 (2004)
9. *Country Mut. Ins. Co. v. Livorsi Marine, Inc.*, 222 Ill. 2d 303, 856 N.E.2d 338, 305 Ill. Dec. 533 (2006)
10. *Crisci v. Security Ins. Co. of New Haven, Conn.*, 66 Cal. 2d 425, 58 Cal. Rptr. 13, 426 P.2d 173 (1967)
11. *Eagle-Picher Ind., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12 (1st Cir. 1982)
12. *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 157 Cal. Rptr. 482, 598 P.2d 452 (1979)
13. *Eljer Mfg., Inc. v. Liberty Mut. Ins. Co.*, 972 F.2d 805 (7th Cir. 1992)
14. *Employers Ins. of Wausau v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 708 N.E.2d 1122 (1999)
15. *Garvey v. State Farm Fire & Cas. Co.*, 48 Cal. 3d 395, 257 Cal. Rptr. 292 (1989)
16. *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 215 Ill.2d 146, 828 N.E.2d 1092 (2005)
17. *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 54 Cal. Rptr. 104 (1966)
18. *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 108 Cal. Rptr. 480 (1973)
19. *Henkel Corp. v. Hartford Acc. & Indem. Co.*, 29 Cal. 4th 934, 129 Cal. Rptr. 2d 828, 62 P.3d 69 (2003)
20. *Horace Mann Ins. Co. v. Barbara B.*, 4 Cal. 4th 1076, 17 Cal. Rptr. 2d 210, 846 P.2d 792 (1993)
21. *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980)
22. *J.C. Penney Cas. Ins. Co. v. M.K.*, 52 Cal. 3d 1009, 278 Cal. Rptr. 64, 804 P.2d 689 (1991)
23. *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993)
24. *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981)

25. *Koppers Co., Inc. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440 (3d Cir. 1996)
26. *Lee v. Aetna Cas. & Sur. Co.*, 178 F.2d 750 (2d Cir. 1949)
27. *Lee v. Interstate Fire & Cas. Co.*, 86 F.3d 101 (7th Cir. 1996)
28. *Maryland Cas. Co. v. Peppers*, 64 Ill. 2d 187, 355 N.E.2d 24 (1976)
29. *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982)
30. *Missouri Pacific R.R. Co. v. International Ins. Co.*, 288 Ill. App. 3d 69, 679 N.E.2d 801 (1997)
31. *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994)
32. *Montgomery Ward & Co., Inc. v. Imperial Cas. & Indem. Co.*, 81 Cal. App. 4th 356, 97 Cal. Rptr. 2d 44 (2000)
33. *Nicor, Inc. v. Associated Electric & Gas Ins. Servs. Ltd.*, 223 Ill. 2d 407, 860 N.E.2d 280 (2006)
34. *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 283 Ill. App. 3d 630, 670 N.E.2d 740 (2d Dist. 1996)
35. *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994)
36. *Powerine Oil Co., Inc. v. Superior Ct.*, 37 Cal. 4th 377, 33 Cal. Rptr. 3d 562, 118 P.3d 589 (Cal. 2005) (*Powerine II*), and *Certain Underwriters at Lloyd's of London v. Superior Ct.*, 24 Cal. 4th 945, 103 Cal. Rptr. 2d 672, 16 P.3d 94 (2001) (*Powerine I*)
37. *Qualcomm, Inc. v. Certain Underwriters at Lloyd's of London*, 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770 (2008)
38. *San Diego Navy Fed. Credit Union v. Cumis Ins. Co.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984)
39. *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 15 Cal. Rptr. 2d 815 (1993)
40. *State Farm Mut. Auto. Ins. Co. v. Partridge*, 10 Cal. 3d 94, 109 Cal. Rptr. 811 (1973)
41. *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995)
42. *Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929)
43. *Travelers Ins. Co. v. Eljer Mfg., Inc.*, 757 N.E.2d 481 (Ill. 2000)
44. *U.S. Fid. & Guar. Co. v. Wilkin Insulation Co.*, 578 N.E.2d 926 (Ill. 1991)
45. *U.S. Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 643 N.E.2d 1226 (1st Dist. 1994)
46. *Vandenberg v. Superior Ct.*, 21 Cal. 4th 815, 88 Cal. Rptr. 2d 366, 982 P.2d 229 (1999)
47. *Waller v. Truck Ins. Exch., Inc.*, 11 Cal. 4th 1, 44 Cal. Rptr. 2d 370, 900 P.2d 619 (1995)
48. *Waste Mgmt., Inc. v. International Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 579 N.E.2d 322 (1991)
49. *White v. Western Title Ins. Co.*, 40 Cal. 3d 870, 221 Cal. Rptr. 509 (1985)
50. *Zurich Ins. Co. v. Raymark Ind. Inc.*, 514 N.E.2d 150 (Ill. 1987)

# 1. *Aerojet-General Corp. v. Commercial Union Ins. Co.*, 155 Cal. App. 4th 132, 65 Cal. Rptr. 3d 803 (2007)

In 2000 and 2001, various water entities in the State of California filed suits alleging that Aerojet was liable for Comprehensive Environmental Response Compensation and Liability Act (CERCLA) response costs arising out of ground-water contamination in the San Gabriel Valley. Aerojet settled the suits, agreeing to pay \$175 million. That amount exceeded its primary and excess insurance coverage limits for the period 1958 to 1970.

Aerojet gave notice to each of its excess insurers, but no excess insurer accepted the tender of defense or indemnity. After Aerojet settled the underlying actions, the excess insurers all denied liability on the ground that, under *Powerine I*, the damages were not awarded against Aerojet by a court.

Aerojet filed this suit for breach of contract and declaratory judgment. The trial court granted the insurers' summary judgment motion on the "no damages" and "no exhaustion" issues. The trial court reasoned that under *Powerine I*, the insurers' obligation "to pay as damages is limited to sums Aerojet was ordered to pay by the court. The monies paid in settlement do not meet this definition." Aerojet appealed.

The California appellate court held that the *Powerine I* case compelled the court to affirm the grant of summary judgment. The appellate court reviewed a number of California decisions, beginning with *Foster-Gardner*, 18 Cal. 4th 857, 959 P.2d 265 (1998), explaining how the courts determine the duty to defend and the narrower duty to indemnify. The court then noted that this case presents the "next question" in the line of ongoing opinions, "whether settlement costs negotiated within the context of a court suit are 'damages.'"

The appellate court stated that there can be no dispute that the term "damages," as interpreted in *Powerine I* and used in the policies, means only money ordered by a court to be paid. The term has a "clear and literal meaning" and cannot be held to be ambiguous. The appellate court stated that the record contained no evidence that the court ordered Aerojet to pay any sum of money. For this reason, the appellate court concluded that the settlement costs were outside the scope of the indemnity coverage of the excess insurers' policies.

Summary judgment in favor of the insurers was affirmed.

*Read the [implications](#).*

## 2. *Aerojet-General Corp. v. Superior Ct.*, 211 Cal. App. 3d 219, 257 Cal. Rptr. 621 (1989). Previously published at 209 Cal. App. 3d 973, 211 Cal. App. 3d 216. Opinion on denial of rehearing, 209 Cal. App. 3d 238, 258 Cal. Rptr. 684.

Since the 1950s, the insureds operated a research and development facility where they developed rocket engines, rocket components, and related products for America's aerospace and defense programs. In 1979, government regulatory agencies discovered that toxic chemicals had entered the soil and groundwater and had leached into groundwater of neighboring properties and the American River. The government brought suit against the insureds.

The insureds sought to recoup their response costs. Their insurers contended that the damages covered by their policies only referred to legal damages, not any form of equitable relief.

The trial court granted summary judgment in favor of the insurers, finding that no portion of environmental cleanup imposed on Aerojet-General and Cordova Chemical Co. constituted damages.

On appeal, the court found that the term "damages" was susceptible to two reasonable interpretations of its ordinary meaning. One could mean damages at law or equitable monetary relief designed to correct damage to property. From the standpoint of the insured, damages could well include any sum expended under sanction of law, including both money damages and sums paid out to an insured party.

The court also rejected the insurers' argument that the government was not alleging property damage. The state's ownership of water rights was based on its right to use. The state and federal governments, therefore, were held to be third-party property owners for the purposes of insurance coverage. "Pollution of the ground and river waters is damage to public property, as well as direct injury to public welfare."

Finally, the court dealt with the insurers' argument that Comprehensive Environmental Response Compensation and Liability Act (CERCLA) cleanup costs were restitutionary. Although, in its typical sense, restitution is the return of something wrongfully received, response costs, whether incurred directly by the polluter or paid to reimburse the government for its efforts, did not fit easily into this definition.

The court specifically rejected the insurers' reliance on the Eighth Circuit decision, *Continental Ins. v. Northeastern Pharm.*, 842 F.2d 977 (8th Cir. 1988), applying the law of Missouri and the Fourth Circuit decision, *Maryland Cas. Co. v. Armco, Inc.*, 822 F.2d 1348 (4th Cir. 1987), applying the law of Maryland, as based on rules of interpretation or construction adverse to California law.

The California Court of Appeal reversed the trial court's grant of summary judgment to the insurers.

*Read the [implications](#).*

### ***POLLUTION COVERAGE ISSUES***

*Pollution Coverage Issues* will save you untold hours scouring treatises, law review articles, and caselaw to determine the status of coverage for long-tail environmental claims under the 1973 and post-1986 editions of the ISO commercial general liability (CGL) insurance policy. With more than 800 court cases, this powerful reference gives you a bird's eye view of how all 50 states are ruling on issues such as coverage triggers, the known loss doctrine, and allocation. *Pollution Coverage Issues* includes a quarterly newsletter that reports on trends and developments in environmental coverage with an emphasis on coverage caselaw. With *Pollution Coverage Issues*, you will receive:

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- ◆ Relevant caselaw deciding almost any aspect of the application of the sudden and accidental or absolute pollution exclusion in any state.
- ◆ Trends in the caselaw involving sudden and accidental as well as absolute pollution exclusions.

### 3. *Aerojet-General Corp. v. Transport Indem. Co.*, 17 Cal. 4th 38, 70 Cal. Rptr. 2d 118, 948 P.2d 909 (1997)

The California Supreme Court adopted the “all sums” allocation approach in rejecting an allocation that would have required the policyholder to share in the defense costs incurred in an environmental claim simply because it was “self-insured” for certain years. Seeking to recover costs incurred in various administrative and other environmental proceedings, the policyholder, Aerojet-General Corp., had brought suit against multiple insurers that provided coverage over a 20-year period before it became self-insured.

The California Court of Appeal had, among other things, affirmed the trial court’s ruling that the policyholder must pay a pro rata portion of its defense costs based on the 8 years of “fronting” policies purchased from Insurance Company of North America (INA), which covered part of the period in which the environmental property damage took place. (Though issued by an insurance company, a “fronting” policy nonetheless makes the policyholder financially responsible for any payments under that policy.)

The California Supreme Court disagreed, ruling that such “fronting” policies need not contribute to the loss:

**ALTHOUGH INSURERS MAY BE REQUIRED TO MAKE AN EQUITABLE CONTRIBUTION TO DEFENSE COSTS *AMONG THEMSELVES*, THAT IS ALL: AN INSURED IS NOT REQUIRED TO MAKE SUCH A CONTRIBUTION *TOGETHER WITH INSURERS*. EQUITABLE CONTRIBUTION APPLIES *ONLY* BETWEEN INSURERS, ... AND *ONLY* IN THE ABSENCE OF CONTRACT.... IT THEREFORE HAS NO PLACE BETWEEN INSURER AND INSURED, WHICH HAVE CONTRACTED THE ONE WITH THE OTHER. NEITHER DOES IT HAVE ANY PLACE BETWEEN AN INSURER AND AN UNINSURED OR “SELF-INSURED” PARTY. (EMPHASIS ADDED.)**

The supreme court reasoned that Aerojet’s decision to assume the risk of defending claims potentially covered by its fronting policies served to relieve other insurers of the duty to defend *only* to the extent particular claims involved harm potentially occurring solely after expiration of such insurers’



policy periods. Recognizing the distinction between trigger of coverage and scope of coverage commonly invoked by courts adopting the “all sums” approach, the California Supreme Court concluded that, while the *trigger* of the duty to defend is limited to the policy period, the extent of the duty to defend is not.

The court also rejected the court of appeal’s conclusion that “fairness” dictated that the policyholder should contribute for years of INA’s “fronting” coverage. The California Supreme Court emphatically directed that courts must refrain from rewriting policy language based on equitable considerations:

*Beneath the court of appeal’s concern about “fairness” and “justice” is, apparently, a belief that, without an approach like the [pro-rata allocation] it adopted, [the policyholder] might get a windfall from the insurers. That is not the case. We shall assume for argument’s sake that [the policyholder] has enjoyed great good luck over against the insurers. But the pertinent policies provide what they provide. [The policyholder] and the insurers were generally free to contract as they pleased. They evidently did so. They thereby established what was “fair” and “just” inter se. We may not rewrite what they themselves wrote.... As a general matter at least, we do not add to, take away from, or otherwise modify a contract for “public policy considerations.”*

*Id.* at 75–76 (citations omitted).

The California Supreme Court reversed the court of appeal’s decision, instead holding for the policyholder.

Recognizing the distinction between trigger of coverage and scope of coverage commonly invoked by courts adopting the “all sums” approach, the California Supreme Court concluded that, while the *trigger* of the duty to defend is limited to the policy period, the extent of the duty to defend is not.

*Read the [implications](#).*

## 4. *AIU Ins. Co. v. Superior Ct.*, 51 Cal. 3d 807, 274 Cal. Rptr. 820, 799 P.2d 1253 (1990)

Real party in interest FMC Corp. sued more than 60 of its primary and excess general liability insurers to determine whether they were obligated to provide coverage for cleanup and other response costs incurred pursuant to the Comprehensive Environmental Response Compensation and Liability Act (CERCLA). The trial court held that FMC was entitled to be reimbursed whether the environmental cleanup costs were incurred directly by FMC pursuant to injunction or reimbursed to the government agencies. It was immaterial whether the costs were incurred out of the exercise of equitable rather than legal authority. The California Court of Appeal reversed the trial court and entered judgment in favor of the insurers.

On appeal, the California Supreme Court noted that the court of appeal decision was out of sync with nearly every other state appellate decision that addressed the issue of whether cleanup costs incurred under environmental statutes were covered by commercial general liability (CGL) policies. The court analyzed the policy language “legally obligated” and concluded that the term encompasses the types of relief sought in the third-party suits.

With regard to the interpretation of the word “damages,” the court began with its ordinary and popular definition found in dictionaries and applied it for insurance purposes. It noted that some courts focused on narrower technical meanings, such as the distinction between law and equity. It also reviewed those courts that distinguished between restitution and damages. The court concluded, however, that the label of restitution is not dispositive. The costs of injunctive relief—whether incurred for prophylactic, mitigative, or remedial purposes—do not readily satisfy the statutory or dictionary definition of damages.

The court found it unlikely that parties to CGL policies intended to cover reimbursement of response costs but not the costs of injunctive relief, where the latter costs are incurred for exactly the same purposes. “It would exalt form over substance to interpret CGL policies to cover one remedy but not the other.”

The court also addressed the term of the policy “because of property damage.” It noted that some claims do not allege cleanup because of property damage. However, it found that contamination of the environment satisfies this requirement:

*... the mere fact that governments may seek reimbursement of response costs or injunctive relief without themselves having suffered any tangible harm to a proprietary interest does not exclude the recovery of cleanup costs....*

The court found it immaterial whether the motivation is protection of property, protection of the health of persons living near the site, regulatory or proprietary. The event precipitating legal action is contamination of property.

The Supreme Court of California reversed the California Court of Appeal, holding that the policies cover the costs of reimbursing government agencies and complying with injunctions ordering cleanup under CERCLA.

*Read the [implications](#).*

## 5. *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56 (3d Cir. 1982)

Liberty Mutual Insurance, the policyholder, paid a multimillion dollar settlement of class action litigation involving sex discrimination. Because there were many employees in Liberty's claims department who filed charges, at least some of them alleging multiple injuries, the question arose whether there were many occurrences, or just one. The court noted that if there were multiple occurrences, the \$25,000 retention per occurrence would mean that the Appalachian policy would never respond because no single class member received a distribution in excess of \$25,000.

The employees brought their charges in May 1971 before the Equal Employment Opportunity Commission (EEOC), alleging that certain employment policies that Liberty adopted in 1965, applicable to female employees and relating to its claims department, discriminated against women. After satisfying certain administrative prerequisites, these claimants, on February 28, 1972, filed a complaint containing class action allegations. The plaintiffs alleged that Liberty committed sex discrimination in its claims department in hiring, promoting, and compensating females. The district court certified the class and found that Liberty's employment policy did discriminate against female employees on the basis of sex.

**THE GENERAL RULE IS THAT AN OCCURRENCE IS DETERMINED BY THE CAUSE OR CAUSES OF THE RESULTING INJURY.**

On appeal, applying the general rule stated above to the facts of this case, the Third Circuit Court of Appeals held that:

*The injuries for which Liberty was liable all resulted from a common source: Liberty's discriminatory employment policies. Therefore, the single occurrence, for purposes of policy coverage, should be defined as Liberty's adoption of its discriminatory employment policies in 1965. The fact that there were multiple injuries and that they were of different magnitudes and that injuries extended over a period of time does not alter our conclusion that there was a single occurrence. As long as the injuries stem from one proximate cause there is a single occurrence.*

The Third Circuit therefore agreed with the district court's finding that there was but one occurrence, holding for the insurer.

*Read the implications.*

## 6. *Buss v. Superior Ct.*, 16 Cal. 4th 35, 65 Cal. Rptr. 2d 366, 939 P.2d 766 (1997)

Buss owned several Los Angeles-based sports teams (including the Los Angeles Lakers) and sports facilities. In the course of its operation of these teams and facilities, Buss entered into various contracts with H&H Sports, Inc., under which H&H Sports provided advertisement services. Following Buss's unilateral termination of these contracts, H&H Sports sued Buss and asserted 27 causes of action, including a claim for defamation. Buss tendered H&H Sports' complaint to its liability insurers.

With the exception of Transamerica Insurance Company, all of Buss's insurers denied coverage of the H&H Sports' action against Buss. Transamerica—which issued two general liability policies to Buss—accepted the defense of the H&H Sports action because it believed that the liability policies potentially covered the defamation cause of action. Because Transamerica recognized its obligation to defend an entire action when the complaint alleged at least one potentially covered claim, it agreed to defend Buss against the H&H Sports action. But, despite its willingness to defend the entire action, Transamerica expressly reserved its right to recoup or obtain an allocation of attorney fees in the action “if it is determined that there is no coverage.”

Buss ultimately settled the action for \$8.5 million, and although Buss had requested contribution from Transamerica for this settlement payment, Transamerica refused the request. But by the time the case settled, Transamerica had spent more than \$1 million in defense costs in the H&H Sports action. Buss sued Transamerica and alleged that Transamerica failed to defend the H&H Sports action in its entirety and improperly denied any duty to contribute to the settlement of the action.

The court acknowledged that the insurer's obligation to defend the entirety of a “mixed” action is not an obligation under the policy; rather, it is an obligation imposed by law in support of the policy.

Both the trial court and appellate court ruled that Transamerica was not obligated to contribute to the settlement and that Buss was required to

reimburse Transamerica for the costs to defend any counts of the complaint that were not potentially covered under the liability policies.

In the subsequent appeal, the California Supreme Court explained that, in an action where all the claims are potentially covered, the insurer has a duty to defend. Contrarily, in an action where none of the claims are potentially covered, the insurer does not have a duty to defend. But when confronted with a “mixed” action—“in which some of the claims are at least potentially covered and the others are not”—the insurer has a duty to defend the action in its entirety. The court acknowledged that the insurer’s obligation to defend the entirety of a “mixed” action is not an obligation under the policy; rather, it is an obligation imposed by law in support of the policy.

Based on its analysis of the insurer’s obligation to defend the insured against both potentially covered actions and “mixed” actions, the California Supreme Court affirmed the lower courts’ decisions and held that when an insurer pays for the defense costs in a “mixed” action, it is permitted to seek reimbursement for those defense costs that relate solely to claims that are not potentially covered under the policy. The court further held that the insurer carries the burden of proof to establish, by clear and convincing evidence, its right to reimbursement of defense costs for noncovered claims.

*Read the [implications](#).*

## 7. *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303, 32 Cal. Rptr. 827, 384 P.2d 155 (1963)

The insured, Hammer, rear-ended the plaintiffs' vehicle while it was stopped at red light. On the day of the accident, Hammer notified his insurer, Allstate Insurance, of the accident. Thereafter, Allstate attempted to contact Hammer to get a statement as to his version of the accident, but Hammer had moved out of the state, and Allstate was unable to find him. Likewise, the plaintiffs were unable to contact Hammer. Eventually, a default judgment was entered against Hammer.

The plaintiffs sued Allstate to collect on the default judgment. Allstate argued that Hammer breached the "cooperation clause" of the insurance agreement by failing to respond to its requests to provide a statement as to his version of the accident. As such, Allstate argued, prejudice "must be presumed" as a matter of law, citing *Margellini v. Pacific Auto. Ins. Co.*, 33 Cal. App. 2d 93 (1939). The trial court found in favor of Allstate, holding that Hammer's failure to cooperate raised a presumption of prejudice.

On appeal, the California Supreme Court explained that:

**AN INSURER MAY ASSERT DEFENSES BASED ON A BREACH OF THE INSURED OF A CONDITION OF THE POLICY SUCH AS A COOPERATION CLAUSE, BUT THE BREACH CANNOT BE A VALID DEFENSE UNLESS THE INSURER WAS SUBSTANTIALLY PREJUDICED THEREBY.**

The court went on to state that, similarly, "prejudice must be shown with respect to a breach of notice clause." It held that Allstate was unable to show that it had been prejudiced by Hammer's breach of a condition in the insurance agreement. Hammer was responsible for the accident, so even if Hammer had complied with all of the conditions of the policy, Allstate would have been liable as his insurer. Finally, the court stated that the reasoning previously proffered in *Margellini* was unsound as there was no basis for the "presumption of prejudice."

The California Supreme Court reversed the trial court's decision in favor of Allstate.

*Read the [implications](#).*

## 8. *Central Ill. Light Co. v. Home Ins. Co.*, 213 Ill. 2d 141, 821 N.E.2d 206 (2004)

Central Illinois Light Company (CILCO) sued its excess liability insurers under policies issued between 1948 and 1985 for indemnification of amounts incurred to investigate and remediate three former manufactured gas plant (MGP) sites under an agreement reached with the Illinois Environmental Protection Agency.

The Illinois Supreme Court held that a “legal obligation” exists under state and federal environmental laws to clean up environmental contamination at former MGP sites even though no “suit” was filed against CILCO. In reaching its holding, the court relied on the plain language of the policies’ insuring agreements, which did not contain the word “suit,” but instead provided coverage for a “legal obligation” or liability “imposed by law.” The court further found that:

**THE CONCEPT OF A “LEGAL OBLIGATION” OR “LIABILITY IMPOSED BY LAW” IS BROADER THAN A “SUIT” OR JUDGMENT.**

The court rejected the notion that CILCO’s cleanup of the sites was voluntary, finding that a “legal obligation” exists under state and federal environmental laws to clean up environmental contamination even though no “suit” was filed against CILCO. According to the court, CILCO was responding to a claim, the Illinois EPA’s “tacit threat of formal state or federal intervention,” if CILCO did not voluntarily remediate the sites, thus, CILCO was performing under a legal obligation. Further, the court concluded that because CILCO’s expenditures were in response to the Illinois EPA’s claim for strict liability and were for a remedial purpose, they constituted “damages” within the meaning of the policies at issue.

The court expressly rejected two contrary decisions by the Illinois First District Court of Appeals that read the word “suit” into the policies’ insuring agreements and required a “lawsuit”:

- ◆ *Zurich Ins. Co. v. Carus Corp.*, 293 Ill. App. 3d 906, 689 N.E.2d 130 (Ill. App. 1st Dist. 1997), *appeal denied*, 690 N.E.2d 1388 (Ill. 1998)
- ◆ *Northern Ill. Gas Co. v. Home Ins. Co.*, 334 Ill. App. 3d 38, 777 N.E.2d 417 (Ill. App. 1st Dist. 2002), *appeal denied*, 787 N.E.2d 158 (Ill. 2002).



Instead, the court found that the better approach is reflected in the decisions of several other states addressing the issue. *See*:

- ◆ *Bausch & Lomb Inc. v. Utica Mut. Ins. Co.*, 330 Md. 758, 625 A.2d 1021 (Md. 1993) (The tacit threat of state intervention through Maryland environmental regulations constituted a legal obligation to pay even though the state of Maryland had not filed suit or issued any order.)
- ◆ *Weyerhaeuser Co. v Aetna Cas. & Sur. Co.*, 123 Wash. 2d 891, 874 P.2d 142 (1994) (Insurer may be legally obligated to pay for property damage where insured engages in the voluntary cleanup of contamination in cooperation with an environmental agency by reason of state environmental statutes.)
- ◆ *Metex Corp. v. Federal Ins. Co.*, 290 N.J. Super. 95, 675 A.2d 220 (1996) (“Since there is nothing in the policy so limiting the coverage, a reasonable insured would assume that it is equally as legally obligated to comply with statutory mandates as it is to comply with an administrative directive or a court decree; in other words, the source of the legal obligation is of no consequence.”)

The court further concluded that because CILCO’s expenditures came in response to Illinois Environmental Protection Agency’s claim for strict liability and were made for a remedial purpose, they constituted damages within the meaning of the policies.

The CILCO appellate court [342 Ill. App. 3d 940 (2003)] also addressed missing policy issues. In this regard, the court held that under a preponderance of evidence standard, CILCO presented enough secondary evidence of its missing policies (including correspondence, evidence of reinsurance, placing slips, and actual policy language in previous and subsequently renewed policies) to go to a jury but also was entitled to additional discovery of sample or form policy language from the insurance companies. The Illinois Supreme Court did not disturb this ruling.

*Read the [implications](#).*

## 9. *Country Mut. Ins. Co. v. Livorsi Marine, Inc.*, 222 Ill. 2d 303, 856 N.E.2d 338, 305 Ill. Dec. 533 (2006)

The defendants, Gaffrig Performance Industries, Inc., and Livorsi Marine, Inc., each carried commercial general liability (CGL) policies with Country Mutual Insurance. In December 1999, Livorsi brought a lawsuit against Gaffrig for alleged trademark violations. In response, Gaffrig filed a lawsuit with similar allegations against Livorsi.

The language of both Gaffrig's and Livorsi's insurance policies contained an "advertising injury" clause that arguably covered the patent infringement claims. As a condition to coverage, the policies required Gaffrig and Livorsi to notify Country Mutual of any lawsuit "as soon as practicable." Although both defendants filed their lawsuits in December 1999, neither party informed Country Mutual of the suit until August 2001. Country Mutual filed a declaratory action on the issue of "late notice."

The trial court found that the patent infringement claims potentially fell within the insurance policies' advertising injury clause and that it triggered coverage. The court went on to state, however, that the defendants offered no evidence of any justification or excuse for their 21-month delay in giving notice to Country Mutual. Accordingly, the court entered judgment in favor of Country Mutual.

The court stated that an insurer does not need to prove prejudice in order to deny coverage when the insured did not give prompt notice of an occurrence or lawsuit.

The Illinois appellate court, which affirmed the decision of the trial court, premised its decision on two concessions found in the parties' briefs. First, it determined that Gaffrig and Livorsi conceded that the notice they gave Country Mutual was unreasonably and inexcusably late. Second, the court determined that Country Mutual conceded that it could not prove it was prejudiced by the late notice. The court found that Country Mutual did not have to prove prejudice in order to deny coverage.

On appeal, the Illinois Supreme Court stated that, even if there is no prejudice to the insurer, a policyholder still must give reasonable notice according to

the terms of the insurance policy, citing *Simmons v. Iowa Mut. Cas.*, 121 N.E.2d 509 (Ill. 1954). The court reasoned that under *Simmons*, lack of prejudice may be a factor in determining whether notice was reasonable, but the dispositive issue was whether notice was reasonable.

The court reviewed *Rice v. AAA Aerostar, Inc.*, 690 N.E.2d 1067 (Ill. App. 1998), in which the Illinois appellate court distinguished between the insured's obligation to give notice of an occurrence and notice of a lawsuit. The Illinois Supreme Court rejected the holding in *Rice*. The court stated that an insurer does not need to prove prejudice in order to deny coverage when the insured did not give prompt notice of an occurrence or lawsuit.

The Illinois Supreme Court affirmed the appellate court's decision in favor of the insurer.

*Read the [implications](#).*

## 10. *Crisci v. Security Ins. Co. of New Haven, Conn.*, 66 Cal. 2d 425, 58 Cal. Rptr. 13 (1967)

A tenant in an apartment building owned by Crisci was descending the apartment's outside wooden staircase when a tread gave way. The tenant fell through the resulting opening up to her waist and was left hanging 15 feet above the ground, suffered physical injuries, and developed severe mental illness. The tenants brought suit against Crisci, alleging that the step broke because Crisci was negligent in inspecting and maintaining the stairs and that the mental illness was caused by the accident. Plaintiffs sought \$400,000 in damages.

Crisci had a commercial general liability (CGL) policy with a \$10,000 limit issued by Security Insurance Company of New Haven, Connecticut. Security hired an experienced lawyer to handle the case for Crisci. Both counsel and Security's claims manager believed that a jury would find that the accident precipitated the mental illness. Both also believed that a verdict of not less than \$100,000 would be returned if the case were tried.

Although the tenants made a settlement demand of \$10,000, Security was only willing to pay \$3,000. Security also rejected a \$9,000 settlement demand when Crisci offered to pay \$2,500 of a settlement demand. A jury ultimately awarded the tenants more than \$100,000 and, after an appeal, Security paid its \$10,000 policy limits. The tenants then sought to collect the balance from Crisci. Crisci, an immigrant widow of 70, became indigent, which caused both physical and mental injury to her.

The California Supreme Court held that:

**IN DETERMINING WHETHER AN INSURER HAS GIVEN CONSIDERATION TO THE INTERESTS OF THE INSURED, THE TEST IS WHETHER A PRUDENT INSURER WITHOUT POLICY LIMITS WOULD HAVE ACCEPTED THE SETTLEMENT OFFER.**

The court held that it could find bad faith without finding actual dishonesty, fraud, or concealment and that:

*Liability based on an implied covenant exists whenever the insurer refuses to settle in an appropriate case and that liability may exist when the insurer unwarrantedly refuses an offered settlement where the most reasonable manner of disposing of the claim is by accepting the settlement. Liability is imposed ... for failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing.*

The court held that in cases like this, the insurer was liable for the full amount of the judgment rendered after the insurer refused to settle within policy limits. In addition, the court granted damages, in accordance with the “general rule of damages in tort,” for Crisci’s “mental suffering” because it found that her suffering was caused by Security’s bad faith failure to settle.

*Read the [implications](#).*

# 11. *Eagle-Picher Ind., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12 (1st Cir. 1982)

An insured manufacturer of asbestos-containing insulation materials sought coverage from its commercial general liability (CGL) insurers for thousands of asbestos bodily injury lawsuits arising from exposure to Eagle-Picher's products that occurred over several decades. Depending on the periods for which they issued policies to Eagle-Picher, Eagle-Picher's insurers argued either that the exposure to asbestos or manifestation of asbestos disease during the policy period triggered their policies.

The *Eagle Picher* court considered medical evidence submitted by both the insurers and the insured to determine whether asbestos disease "'results' soon after initial and subsequent exposure to asbestos, or whether the disease 'results' when it becomes clinically evident or manifest."

Finding significant that the CGL policies at issue distinguished between the event that causes injury (the "occurrence") and the resulting bodily injury or disease, the *Eagle-Picher* court found that:

ONLY THE POLICIES IN EFFECT WHEN THE ASBESTOS DISEASE MANIFESTED ITSELF WERE TRIGGERED "[B]ECAUSE THE RESULTING INJURY, NOT THE EXPOSURE, MUST TAKE PLACE DURING THE POLICY PERIOD TO TRIGGER COVERAGE."

The court explained its holding by noting that:

*The common, ordinary meaning of the policy language supports the manifestation theory. An individual with tiny subclinical insults to her lungs would not say that she had any injury or disease, given one expert's testimony that "over 90 percent of all urban city dwellers have asbestos-related scarring." Rather, she would say that a disease resulted when she had symptoms which impaired her sense of well-being, or when a doctor was able to detect sufficient scarring to make a prognosis that the onset of manifested disease was inevitable. "Injury" is defined by Webster as "hurt, damage, or loss sustained"; it is a broad term which covers the "result of inflicting on a person or thing something that causes loss, pain, distress, or impairment." As sweeping as this definition is, it is difficult to*

*consider subclinical insults to the lung to constitute an “injury” when these insults do not cause “loss, pain, distress, or impairment” until, if ever, they accumulate to become clinically evident or manifest.*

The court further explained that neither exposure to asbestos nor the time during which asbestos fibers remained in the lungs constituted “bodily injury” because it was “uncontested that even subclinical injury to the lung does not occur simultaneously with the inhalation of asbestos [and] the existence of subclinical injury [is not] an inevitable byproduct of exposure, since the body’s natural mechanisms may remove the fibers before they become embedded in the lungs.”

*Read the [implications](#).*

## 12. *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 157 Cal. Rptr. 482, 598 P.2d 452 (1979)

In 1962, Egan purchased a health and disability insurance policy from Mutual of Omaha. The policy provided benefits of \$200 per month if Egan became totally disabled as a result of either an accidental injury or sickness that caused confinement to his residence. Benefits for a nonconfining illness were payable for a period not to exceed 3 months.

Between 1963 and 1970, Egan claimed and received payments for three separate back-related disabling injuries. In May 1970, he made a fourth claim for accidental back injury suffered during the course of his employment. Portions of the claim form were completed by Egan, and others were completed by his physician. The physician estimated Egan would be able to return to work in August 1970.

Egan filed a supplemental claim in October 1970, stating he was unable to return to work. Because his physician indicated on the claim form that Egan could have returned to work on September 29, Claims Manager McEachen reviewed records that disclosed that Egan and the examining physician had earlier agreed he would return to work on July 1, 1970. He was not able to do so. In October 1970, Egan met in person with McEachen and obtained the first benefits he received for this injury, for May through July.

On November 20, McEachen visited Egan at home, because Egan was medically unable to leave home. Although aware of Egan's good faith efforts to work, McEachen called Egan a fraud and told him that he sought benefits only because he did not want to return to work, advised Egan he was not entitled to any further payments, and told him that past benefits received were also unwarranted, despite his bona fide claim of accidental injury. When Egan expressed his concern regarding the need for money during the approaching Christmas season and offered to submit to examination by a physician of Mutual's choice, McEachen only laughed, reducing Egan to tears in the presence of his wife and child.

In February 1971, McEachen sent Egan a letter with a check and stated that the check represented full payment of benefits due under the policy.

On February 26, 1971, surgery was performed on Egan's back, and he submitted another claim. The physician's portion of this claim form included an



estimate by the surgeon that Egan could return to work “Possibly 3–6 months from date of surgery.” This claim was assigned to Segal.

Mutual reviewed records of the Workers’ Compensation Appeals Board and the hospital where Egan’s surgery was performed. The doctors said, among other things, that Egan’s medical history appeared consistent with a man with probable discogenic disease “with multiple aggravations over the last several years, finally culminating in a specific incident a little over 7 months ago ...,” and “I would apportion 50 percent of his current subjective complaints to his industrial injury, and 50 percent to the natural progression of his preexisting pathology of degenerative wear and tear osteoarthritis of the spine.”

Mutual made no effort to contact Egan’s physicians. Efforts to discuss the case with attending physicians would ordinarily have been made by a claims adjuster. Based on Segal’s review of medical records, Mutual reclassified Egan’s condition from injury to nonconfining illness.

In May 1971, Segal visited Egan at home, telling him he suffered from an illness, not an injury. Segal handed Egan a check for medical costs and 3 months’ maximum disability payments. Egan did not cash the check. He refused Segal’s offer for a larger check if Egan would surrender his policy. After discussing the matter with Dr. Carpenter, Egan wrote to Segal concerning his reclassification but received no answer.

Subsequently, Egan received a 73 percent disability rating on his workers compensation claim. Not returning to work, he remained under medical care.

In 1973, Egan sued Mutual of Omaha for compensatory and punitive damages arising from a bad faith breach of a disability policy. The trial court ruled as a matter of law that Mutual’s failure to have Egan examined by a doctor of its choice, or to consult with Egan’s treating physicians and surgeon, violated the covenant of good faith and fair dealing. The court submitted to the jury the issues of causation, compensatory, and punitive damages. The jury returned verdicts against all defendants. Mutual was held liable for general damages, emotional distress, and punitive damages.

Noting that Mutual failed to properly investigate Egan’s claim, the California Supreme Court held that breach of the implied covenant of good faith and fair dealing had been established as a matter of law. The court concluded that:

1. An insurer may breach the covenant of good faith and fair dealing when it fails to properly investigate its insured’s claim.
2. The implied promise requires each contracting party to refrain from doing anything to injure the right of the other to receive the benefits of the agreement.
3. The precise nature and extent of the duty imposed by such an implied promise depends on the contractual purposes.

The court reiterated its rule that, at least in the first-party context:

**WHEN THE INSURER UNREASONABLY AND IN BAD FAITH WITHHOLDS PAYMENT OF THE CLAIM OF ITS INSURED, IT IS SUBJECT TO LIABILITY IN TORT.**

Further, the court noted that Civil Code Section 3294, providing for punitive damages, could apply to insurers. It held that, with respect to insurers, “the principal purpose of Section 3294 is to deter acts deemed socially unacceptable and, consequently, to discourage the perpetuation of objectionable corporate policies.” The court cited commentators who had stated that:

*The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary. Insurers hold themselves out as fiduciaries, and with the public’s trust must go private responsibility consonant with that trust.*

Noting that the relationship of insurer and insured is inherently unbalanced, the court held that the availability of punitive damages reflects an attempt to restore balance in the contractual relationship. The court held that the record, discussed in part above, supported the jury’s decision to assess punitive damages, because it showed that Mutual “acted maliciously, with an intent to oppress, and in conscious disregard of the rights of its insured.”

Mutual argued that it was not responsible for the actions of its employees because they were not “managerial employees.” The court, however, held that “the critical inquiry is the degree of discretion the employees possess in

making decisions that will ultimately determine corporate policy. When employees dispose of insureds' claims with little if any supervision, they possess sufficient discretion for the law to impute their actions concerning those claims to the corporation." The court further held that the insurer "should not be allowed to insulate itself from liability by giving an employee a nonmanagerial title and relegating to him crucial policy decisions." Accordingly, the actions of the adjusters exposed Mutual to bad faith and punitive damages.

The court held that the individual adjusters acted as Mutual's agents and were not parties to the insurance contract or subject to the implied covenant, so they could not have breached it and were not liable for breach thereof.

*Read the [implications](#).*

# 13. *Eljer Mfg., Inc. v. Liberty Mut. Ins. Co.*, 972 F.2d 805 (7th Cir. 1992)

Eljer manufactured and sold a defective plumbing system, which was installed in numerous buildings between 1979 and 1986. A large number of the systems developed leaks after installation, resulting in property damage claims against Eljer.

Liberty Mutual Insurance, Eljer's commercial general liability (CGL) insurer (1973 edition Insurance Services Office, Inc., policy), contended that property damage did not occur until a system actually leaked, resulting in physical injury to the surrounding walls, floors, or ceilings. Eljer claimed that the physical injury occurred when the system was installed.

On appeal, the Seventh Circuit Court of Appeals held that the incorporation of a defective product into another product constitutes property damage, as physical injury to tangible property, at the moment of incorporation. The court based its decision on Illinois cases, which it read as holding that the absence of physical injury in the ordinary sense was immaterial, as long as the insured's defective product reduced the value of the finished product.

The Eljer opinion takes the Illinois courts' pronouncements regarding incorporation of a defective product into another product to address the issue of when the property damage has occurred, finding that the damage occurs before any leaking exists. As the dissent put it:

**THERE IS IMMEDIATELY SOMETHING COUNTERINTUITIVE ABOUT SAYING THAT PHYSICAL INJURY HAS BEEN DONE TO A HOUSE IN WHICH A FUNCTIONING PLUMBING SYSTEM HAS BEEN INSTALLED.**

*Read the implications.*

## 14. *Employers Ins. of Wausau v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 708 N.E.2d 1122 (1999)

Employers Insurance of Wausau, a general liability insurer, brought a declaratory judgment action against the liquidating trust of the insured, Ehlco Liquidating Trust, to determine its coverage obligations for the environmental contamination and property damage at sites in Mena, Arkansas, and Albany County, Wyoming. Each underlying claim for property damage arose from Ehlco's operation of industrial wood-treatment facilities that dispersed hazardous wastes into the environment and subsequently resulted in separate lawsuits relating to the Mena and Wyoming sites.

With respect to the Mena site, the U.S. Environmental Protection Agency (EPA) advised Ehlco that it may be a potentially responsible party (PRP) liable for the costs of investigating and responding to environmental contamination at the site. On multiple occasions, Ehlco notified Wausau of the EPA's intentions and requested coverage. In response, Wausau advised Ehlco that the policies did not appear to provide coverage for the potential claim.

With respect to the Wyoming site, the State of Wyoming filed suit against Union Pacific for damages caused by the environmental contamination at the site. Union Pacific then sued Ehlco under an indemnification agreement. Ehlco promptly notified Wausau of the suit and requested a defense. With the exception of requesting information from Ehlco regarding the claim, Wausau did nothing else. Ehlco ultimately settled the lawsuit—without contribution from Wausau—for \$1.3 million.

The circuit court found that Wausau breached its duty to defend Ehlco as to each underlying matter. As a result, the circuit court held that Wausau was estopped from asserting any defenses to coverage of the underlying matters. The Illinois appellate court agreed with the circuit court's finding that Wausau was estopped from raising defenses to coverage, except the appellate court ruled that Wausau was not estopped from raising Ehlco's alleged late notice defense because timely notice is a condition precedent to coverage and, thus, not subject to estoppel.

On appeal, the Illinois Supreme Court explained that:

**AN INSURER'S DUTY TO DEFEND UNDER A LIABILITY INSURANCE POLICY IS SO FUNDAMENTAL AN OBLIGATION THAT A BREACH OF THAT DUTY CONSTITUTES A REPUDIATION OF THE CONTRACT.**

For this reason, when an insurer takes the position that a complaint potentially alleging coverage is not covered under a policy that includes a duty to defend, it cannot simply refuse to defend its insured; rather, the insurer has two options: it must either defend the lawsuit under a reservation of rights or seek a declaratory judgment that there is no coverage. An insurer's failure to exercise one of these available options constitutes a breach of the duty to defend. Once an insurer breaches its duty to defend, the estoppel doctrine applies and operates to bar the insurer from raising policy defense to coverage, including late notice.

The Illinois Supreme Court reversed the appellate court's decision regarding late notice estoppel, holding instead for the insured.

*Read the [implications](#).*

## 15. *Garvey v. State Farm Fire & Cas. Co.*, 48 Cal. 3d 395, 257 Cal. Rptr. 292 (1989)

Garvey owned a home that was insured by State Farm Fire & Casualty. The State Farm policy provided coverage for “all risks of physical loss to the property covered” except as otherwise excluded or limited and excluded coverage for losses “caused by, resulting from, contributed to or aggravated by any earth movement, including but not limited to earthquake, volcanic eruption, landslide, mud flow,” etc. Several years after purchasing the home, Garvey noticed that an addition built onto the original structure had begun to pull away. Garvey also discovered damage to a deck and garden wall.

Garvey submitted a claim to State Farm in August 1978 and received a letter in October 1979 stating that State Farm believed the damage was not covered but proposing to pay and then sue for declaratory relief and precluding Garvey’s opportunity to seek bad faith damages. Rather than accept State Farm’s offer, Garvey brought his own suit against State Farm, including claims for coverage and bad faith.

Garvey argued that while earth movement may have been an excluded peril, the loss was proximately caused by the room addition contractor’s negligence, which was not expressly excluded, and that the loss should therefore be covered under the “all-risk” portion of the policy.

The trial court agreed and ruled in favor of Garvey. The California Court of Appeal reversed. Because the trial court had based its decision in part on *State Farm Mut. Auto. Ins. Co. v. Partridge*, 10 Cal. 3d 94, 109 Cal. Rptr. 811 (1973), the California Supreme Court took the opportunity to differentiate the analyses that should be employed in third-party cases from that which applies in first-party cases.

In this case, the California Supreme Court made an opportunity to rein in what it saw as misinterpretation and misapplication of its earlier holding in *Partridge*. The court expressed concern that other courts had “allowed coverage in first-party property damage cases under our holding in *Partridge* by inappropriately using the *Partridge* concurrent causation approach as an alternative to *Sabella’s* efficient proximate cause analysis.”

The California Supreme Court reaffirmed that first-party causation questions, such as Garvey’s, should be analyzed according to an “efficiency” theory,

following the rationale of *Sabella v. Wisler*, 59 Cal. 2d 21 (1963), to determine proximate cause, and not considering the concurrent causation theory set out in *Partridge*. Under the proper analysis, the cause that “sets the others in motion” is the proximate cause and the one that determines whether there is coverage for the loss. The court held that where the proximate cause was a nonexcluded peril, coverage exists under the preexisting law of *Sabella*.

Under the proper analysis, the cause that “sets the others in motion” is the proximate cause and the one that determines whether there is coverage for the loss.

The California Supreme Court affirmed the judgment of the court of appeal, directing the case back to the trial court where coverage would be determined by a jury under an efficient proximate cause analysis.

*Read the [implications](#).*

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## 16. *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 215 Ill. 2d 146, 828 N.E.2d 1092 (2005)

The City of Chicago sued Midwest Sporting Goods Company for creating a public nuisance caused by Midwest's sale of guns to inappropriate purchasers. Midwest tendered the lawsuit to General Agents Insurance Company, and General Agents initially denied coverage. After the City of Chicago filed an amended complaint, General Agents agreed to defend Midwest under a reservation of rights. In its reservation of rights letter, General Agents advised Midwest that it was reserving its right to "recoup any defense costs paid in the event that it is determined that the Company does not owe the Insured a defense in this matter." General Agents subsequently filed a declaratory judgment action against Midwest, seeking a declaration of its duty to defend the underlying action.

Following a hearing on cross-motions for summary judgment, the trial court entered summary judgment in favor of General Agents, declaring that General Agents had no duty to defend Midwest in the underlying litigation. The appellate court affirmed this ruling.

The trial court subsequently granted General Agents' motion for entry of judgment, which sought reimbursement of the defense costs that General Agents had paid to Midwest's independent counsel in the underlying litigation. The appellate court affirmed the trial court, finding that General Agents' payments to Midwest were not made pursuant to the insurance policy, but rather were an accommodation pending litigation to determine whether General Agents owed Midwest a defense under the insurance policy.

The Illinois Supreme Court noted that the lower courts' decision to allow reimbursement of the past defense costs would be appropriate if Illinois followed the majority rule espoused in *Buss v. Superior Ct.*, 16 Cal. 4th 35, 65 Cal. Rptr. 2d 346, 939 P.2d 766 (1997). But the court nonetheless reversed the judgments in the lower courts, based on its finding "the analysis of those decisions refusing to allow reimbursement to be more persuasive and more on point with Illinois caselaw" than the majority rule in *Buss*.

As a matter of public policy, the court refused to condone an arrangement where an insurer could unilaterally modify its contract, through a reservation of rights, to allow for reimbursement of defense costs in the event a court later

finds that the insurer owes no duty to defend. The court held that when an insurer pays defense costs pursuant to a reservation of rights, the insurer protects itself at least as much as it protects its insured. Accordingly, an insurer is not unjustly enriched when its insurer tenders a defense in order to protect its own interests, even if it is later determined that the insurer did not owe a defense. Absent a provision in the insurance contract allowing the insurer to retain a right to seek reimbursement from its insured, the court said:

**AN INSURER CANNOT LATER ATTEMPT TO AMEND THE POLICY BY INCLUDING THE RIGHT TO REIMBURSEMENT IN ITS RESERVATION OF RIGHTS LETTER.**

*Read the implications.*

## 17. *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 54 Cal. Rptr. 104 (1966)

In *Gray*, the insured brought an action against its insurer for failure to defend an action stemming from a complaint alleging that he committed a sexual assault. According to the allegations of the complaint against him, the insured, Dr. Gray, “willfully, maliciously, brutally, and intentionally assaulted” the plaintiff, Mr. Jones.

The insured provided notice of the lawsuit to Zurich and requested a defense, but Zurich refused to defend him because the allegations of the complaint alleged an intentional tort that fell outside the scope of the policy.

Dr. Gray was the named insured under an insurance policy issued by Zurich. The policy contained a “Comprehensive Personal Liability Endorsement,” which provided that the insurer would:

*pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage, and the company shall defend any suit against the insured alleging such bodily injury or property damage and seeking damages which are payable under the terms of this endorsement, even if any of the allegations are groundless, false or fraudulent; but the company may make such investigation and settlement of any claim or suit as it deems expedient.*

The policy excluded coverage for bodily injury or property damage caused intentionally by or at the direction of the insured.

The policyholder claimed, however, that he acted in self-defense. The insurance company denied a defense of the lawsuit, reasoning that liability for intentional torts was not covered by the policy. The court held, however, there was a potential that the policyholder might be found liable not for assault and battery, but merely for the negligent use of unreasonable force in the altercation. That potential liability thus created the possibility of a judgment for a negligent tort, not an intentional one, and if the judgment came down that way, the insurance company would have to pay for it. And, because the insurance company might have to pay for such a judgment, it definitely had an obligation to defend.

The court made its pronouncement in words that have been cited probably thousands of time since:

**DEFENDANT CANNOT CONSTRUCT A FORMAL FORTRESS OF THE THIRD-PARTY'S PLEADINGS AND RETREAT BEHIND ITS WALLS. THE PLEADINGS ARE MALLEABLE, CHANGEABLE, AND AMENDABLE.**

**TO RESTRICT THE DEFENSE OBLIGATION OF THE INSURER TO THE PRECISE LANGUAGE OF THE PLEADING WOULD NOT ONLY IGNORE THE THRUST OF THE CASES BUT WOULD CREATE AN ANOMALY FOR THE INSURED.**

Further:

*... the complainant in the third-party action drafts his complaint in the broadest terms; he may very well stretch the action which lies in only nonintentional conduct to the dramatic complaint that alleges intentional misconduct. In light of the likely overstatement of the complaint and of the plasticity of modern pleading, we should hardly designate the third party as the arbiter of the policy's coverage.*

*An insurer, therefore, bears a duty to defend its insured whenever it ascertains facts which give rise to the potential of liability under the policy.*

*Read the implications.*

## 18. *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 108 Cal. Rptr. 480 (1973)

*Gruenberg* was decided on appeal from the sustaining of a demurrer, so its holdings are based on the allegations of the complaint and go to the very essence of what constitutes bad faith and what damages are available in the event the claim is proved.

Gruenberg was the owner of a business that was insured against fire loss by Aetna Insurance. A fire occurred at the business, after which Gruenberg became involved in an argument with a member of the arson detail of the fire department and was placed under arrest.

Gruenberg alleged that the defendant insurers' claims adjuster, who went to the business to investigate the fire and inspect the premises, told an arson investigator that the plaintiff had excessive coverage under his fire insurance policies. A few days later, Gruenberg was charged with the crimes of arson and defrauding an insurer.

The insurers demanded that Gruenberg submit to an examination under oath (EUO) and to produce certain documents before his criminal proceeding had occurred. Gruenberg's attorney explained that Gruenberg could not make any statements concerning the fire loss while criminal charges were pending and requested that the insurers waive the requirement of an examination until the criminal charges lodged against plaintiff were concluded. The insurers refused and warned that failure to appear for the EUO would void coverage under the policies. When he failed to show, the insurers advised Gruenberg that they were denying liability under the policies.

A preliminary hearing was held on the criminal charges, and the insurers' inspector appeared and restated his belief that Gruenberg had excessive fire insurance coverage for his business. The charges were dismissed by the magistrate for lack of probable cause.

Gruenberg advised that he was then prepared to submit to the EUO, but the insurers reaffirmed their denial of liability. Gruenberg then sued, alleging that the insurers had acted in concert to falsely imply that the plaintiff had a motive to deliberately set fire to and burn down his place of business and that they did so to avoid paying the amounts due under the policies. Gruenberg alleged that as a "direct and proximate result of the outrageous conduct and

bad faith of the defendants,” he suffered “severe economic damage,” “severe emotional upset and distress,” loss of earnings, and various special damages. Plaintiff sought both compensatory and punitive damages.

Citing its prior holdings in *Comunale v. Traders & General Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198 (1958), and *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 58 Cal. Rptr. 13, 426 P.2d 173 (1967), the California Supreme Court held that the duty to deal fairly and in good faith with its insured may give rise to a cause of action in tort for breach of an implied covenant of good faith and fair dealing in first-party as well as third-party coverage actions. The court held that because Gruenberg had alleged that the insurers had willfully and maliciously schemed to deprive him of the benefits of the policies and used his failure to appear as a pretense for denying liability under the policies, the complaint alleged a breach of the duty of good faith and fair dealing.

The insurers argued that Gruenberg’s failure to sit for the EUO as called for by the policy absolved them of their duties under the policy, including their duty of good faith and fair dealing. The court held instead that the crucial issue was the nature of insurers’ duty, which was unconditional and independent of the performance of plaintiff’s contractual obligations. The existence of a contract could not insulate the insurers from liability that is “ordinarily visited upon tortfeasors” for interfering with a property interest of the insured in receiving the benefits of the agreement. Therefore, even though the duty allegedly assumed by defendant insurers arose from a contract, this duty is independent of the performance of plaintiff’s contractual obligations.

Finally, the court took up the insurers’ contention that Gruenberg could not recover for emotional distress because he had failed to allege conduct that was “extreme” and “outrageous.” Relying on its holding in *Crisci*, the court held that mental suffering constitutes an aggravation of damages when it naturally ensues from the act complained of. Because Gruenberg had alleged other damages—including loss of earnings, that he was compelled to go out of business and was unable to pay his business creditors, that he incurred costs of defending lawsuits brought against him by his creditors, and incurred medical expenses—the complaint was sufficiently pleaded with respect to mental suffering damages. The court therefore held for the insured plaintiff Gruenberg.

*Read the [implications](#).*

# 19. *Henkel Corp. v. Hartford Acc. & Indem. Co.*, 29 Cal. 4th 934, 129 Cal. Rptr. 2d 828, 62 P.3d 69 (2003)

The *Henkel* claim involved a series of corporate acquisitions, starting with Amchem Products, Inc. (“Amchem No. 1”), a Pennsylvania corporation with two product lines: agricultural and metallic chemicals. Amchem No. 1 sold the metallic chemicals (which help paint adhere to metal) to car and airplane manufacturers, including the aerospace company Lockheed.

Amchem No. 1 purchased liability insurance from Hartford Accident and Indemnity and a number of other insurers. In 1977, Union Carbide acquired Amchem No. 1 via a stock purchase and merger. In 1979 Amchem No. 1, now a Union Carbide subsidiary, created a new Delaware corporation also known as Amchem Products, Inc. (“Amchem No. 2”). Amchem No. 1 then contractually transferred all of its metallic chemical business assets<sup>1</sup> and liabilities to Amchem No. 2. Thus, after the 1979 transaction, there were two separate subsidiaries of Union Carbide: Amchem No. 1 (specializing in agricultural products) and Amchem No. 2 (specializing in metallic chemicals).

In 1980, Union Carbide sold all of the stock in Amchem No. 2 to Henkel Corp., resulting in Henkel acquiring all of the assets and liabilities of Amchem No. 2. In 1986, Union Carbide sold Amchem No. 1 to Rhone Poulenc (now known as Aventis CropScience USA), with Rhone obtaining the rights and obligations of Amchem No. 1.

In 1989, current and former Lockheed employees sued Henkel and “Amchem Products, Inc.”—without distinguishing between Amchem No. 1, a Rhone Poulenc subsidiary in 1989, and Amchem No. 2, which by 1989 had merged into Henkel—for alleged injuries arising out exposure to Amchem No. 1’s metallic chemicals during the period from 1959 to 1976. Henkel tendered its defense to Hartford and the other insurers that had insured Amchem No. 1 during portions of the period of alleged exposure. Each of the insurers denied coverage.

In 1992, the Lockheed employees served their complaint on Rhone Poulenc, named as “Amchem Products, Inc.” After Rhone Poulenc moved to quash service, the Lockheed plaintiffs stipulated to the motion to quash on grounds

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1. Other than a transfer of “assets,” there was no specific reference to any insurance policies in the transfer agreement between Amchem No. 1 and Amchem No. 2.

that Rhone Poulenc had satisfactorily established that Henkel Corp. was responsible for the metallic chemicals-related liabilities of Amchem Products, Inc. That left the Lockheed plaintiffs' suit against Henkel, which was settled in 1995 for \$7.6 million. After Amchem No. 1's insurers refused to contribute to the settlement, Henkel brought a declaratory judgment action against Amchem No. 1's insurers as well as its own insurers.

Finding no specific language in the agreements whereby insurance policies or insurance policy benefits were assigned to Henkel or its predecessor, Amchem No. 1, and no documents in which Amchem No. 1's insurers consented to any assignment, the trial court entered summary judgment for the defendant insurers. The California Court of Appeal reversed, reasoning that in the absence of explicit language disclaiming any assignment, the right to insurance benefits passed to Henkel as a matter of law without the need for consent from the insurers [106 Cal. Rptr. 2d 341 (Cal. App. 2 Dist. 2001)].

The California Supreme Court first rejected Henkel's argument that it should be entitled to Amchem No. 1's insurance protection as a matter of law pursuant to the decision of the Ninth Circuit Court of Appeals in *Northern Ins. Co. of N.Y. v. Allied Mut. Ins.*, 955 F.2d 1353 (9th Cir. 1992). The court distinguished *Northern Ins.* on the grounds that the reasoning behind the Ninth Circuit's holding that insurance coverage followed tort liability required the tort liability of Amchem No. 1 to be imposed on Henkel as a matter of law. Finding that Henkel's liability for injuries caused by Amchem No. 1 arose from contract—not by operation of law—the court held that *Northern Ins.* was inapplicable to the facts of the case.

The supreme court next held that even if Amchem No. 1 assigned any benefits under the insurance policies to Amchem No. 2, any such assignment would be invalid because it lacked the insurer's consent. The court initially agreed with the proposition that an antiassignment provision in an insurance policy does not preclude the assignment of money due or to become due under the contract, or of money damages for the breach of the contract. But then—citing absolutely no authority whatsoever—the court held that in 1979, when Amchem No. 2 assumed the liabilities of Amchem No. 1, the duty of Amchem No. 1's insurers to defend and indemnify Amchem No. 1 from the claims of the Lockheed plaintiffs “had not become an assignable chose in action” because “[t]hose claims had not been reduced to a sum of money due or to become due under the policy.”



The court further rejected Henkel’s argument that allowing the assignment would place no additional risks or burdens on the insurers beyond what they had originally bargained to assume. According to the court, an additional burden “may arise” whenever the predecessor corporation still exists or can be revived, because of the potential for disputes over the assignment and the possibility that the insurer might be forced to defend both the predecessor and the successor corporation.

In a lone dissent, Justice Carlos R. Moreno noted that the court’s decision was contrary to well-settled assignment law and constituted an unfair windfall for the insurers, who collected years of premiums in connection with Amchem No. 1’s operations but were not required to provide any coverage, notwithstanding that their risk and exposure appear not to have increased at all as a result of the corporate transactions resulting in Amchem becoming a part of Henkel. Also troubling to Justice Moreno was the manner in which the majority of the California Supreme Court changed the rules regarding insurance policy assignment in a way that benefits insurers without admitting that it departed from what appeared to be well-settled law. What is perhaps most troubling about the *Henkel* case is that the reasons supporting the court’s holding are so weak.

The key to the majority’s decision in *Henkel* is its novel and unsupported conclusion regarding the date on which an assignee is in possession of an assignable chose in action. Justice Moreno’s dissent took the majority to task on this issue:

*The majority’s abandonment of the general rule that “assignment is valid following occurrence of the loss insured against and is then regarded as a chose in action rather than transfer of actual policy” seems predicated on a misconception of when a party has a “chose in action.” The majority equates a chose in action with a claim that has been reduced to a sum of money due or to become due. Under the majority’s view, it seems that a party must file a claim, and this claim must result in a legal finding of liability, for a chose in action to lie.*

A chose in action, however, is not necessarily a claim that has been reduced to a sum of money; it is much broader. In California, a chose in action, also known as a “thing in action,” is statutorily defined as a “right to recover money or other personal property by a judicial proceeding.” A claim need not have been filed, or a judicial determination made, for there to be a chose in action. Instead, only a right to recover needs to exist.

Under *Henkel*, it is no longer sufficient for the loss to have taken place for an insurance policy to become assignable. Instead, the loss also must “have been reduced to a sum of money due or to become due under the policy.”<sup>2</sup> This apparently requires not only a loss but, in addition, either a judgment or settlement of any claims arising out of the loss.

**ALTHOUGH NOTHING IN THE OPINION NECESSARILY WOULD ALERT THE UNSUSPECTING READER TO ANY SUCH REVELATION, THE *HENKEL* COURT’S HOLDING AMOUNTS TO A SEISMIC SHIFT IN THE LAW OF INSURANCE POLICY ASSIGNMENT.**

In most states, assignment is freely permitted without the insurer’s consent after loss even if there has been no such reduction to judgment or a sum certain. In California before *Henkel*, there also appears to have been no such requirement. The California Supreme Court departed from precedent based on an overly restrictive definition of chose in action, for which it cited no authority and that is contrary to at least one California statute—Cal. Civ. Code Section 953 (West 2007).

*Read the implications.*

2. None of the assignability precedent cited by the court requires that the losses incurred have been reduced to a sum certain. See, e.g., *Westoil Terminals Co. v. Harbor Ins. Co.*, 86 Cal. Rptr. 2d 636 (Cal. App. 2 Dist. 1999); *Quemetco, Inc. v. Pac. Auto. Ins. Co.*, 29 Cal. Rptr. 2d 627 (Cal. App. 2 Dist. 1994); *Greco v. Oregon Mut. Fire. Ins. Co.*, 12 Cal. Rptr. 802 (Cal. App. 4 Dist. 1961); Walter Croskey, et al., *California Practice Guide: Insurance Litigation* ¶ 7.431 (2002).

## 20. *Horace Mann Ins. Co. v. Barbara B.*, 4 Cal. 4th 1076, 17 Cal. Rptr. 2d 210, 846 P.2d 792 (1993)

Barbara B. was a 13-year-old student who sued her band teacher, Lee, for injuries caused by the Lee's negligent and intentional conduct. The conduct allegedly consisted of sexual molestation and other harassing conduct. Lee plead *nolo contendere* to a violation of California Penal Code Section 288(a), arising out of his molestation of Barbara B.

Lee tendered his defense to Horace Mann Insurance, the school's liability insurer. Horace Mann accepted the tender, reserving its rights to later disclaim coverage. In its reservation of rights letter, Horace Mann advised Lee that in light of his criminal conviction, the allegations of the complaint did not fall within the scope of the policy because the claim policy only covered occurrences in the course of the insured's educational employment activities. Horace Mann further advised Lee that the policy did not cover civil suits arising out of acts that have been held to be a crime or any damages that were the intended consequence of actions taken by the insured.

Despite Barbara B.'s later amendment of her complaint to include misconduct by Lee that did not amount to sexual molestation, the trial court ruled that all of Lee's acts were either sexual or intentional in nature, thereby eliminating any coverage under the Horace Mann policy. The appellate court affirmed the decision in favor of the insurer.

In its review of the lower decisions, the California Supreme Court noted that an insurer owes a broad duty to defend its insured against claims that create a potential for indemnity coverage. Otherwise stated, an insurer must defend its insured against any claim that potentially seeks damages covered under a policy. To determine whether an insurer owes a duty to defend under its policy, the allegations of the complaint must be compared to the terms of the policy, and, to the extent that they reveal that the claim may be covered under the policy, any facts extrinsic to the complaint must also be considered.

Horace Mann argued that it did not have a duty to defend Lee because Lee's *nolo contendere* plea for his violation of Penal Code Section 288(a) established that Lee molested Barbara B., thereby eliminating any potential duty to indemnity—and thus any duty to defend the claims under the liability policy. According to Horace Mann, the admitted molestation was the dominant factor

in this case, so Lee's alleged misconduct apart from the molestation could not give rise to a duty to defend under the policy.

The California Supreme Court indicated that Horace Mann's reasoning was flawed because it incorrectly assumed that all of the other alleged misconduct in the complaint constituted molestation rather than some other type of misconduct that took place in the course of Lee's educational activities. The court noted that the second amended complaint alleged injury resulting from Lee's negligent, careless, and reckless sexual and nonsexual conduct. Although lacking any specificity, the complaint left open the possibility that Lee would be liable for damages for his nonsexual conduct.

While the court agreed that the extrinsic evidence relating to Lee's violation of Penal Code Section 288(a) existed, the court did not believe that the exclusion of Lee's sexual misconduct necessarily eliminated Horace Mann's duty to defend Lee against the other allegations of misconduct. The court reasoned that Lee's molestation of Barbara B. did not eliminate his potential liability to Barbara B. for other negligent acts that were separate and distinct from the molestation, namely, his conduct that took place in front of the other students in the classroom resulting in Barbara B.'s alleged public embarrassment.

At the time of the summary judgment proceedings, there were unresolved factual disputes regarding Lee's conduct apart from the molestation of Barbara B. Because neither the complaint nor the materials submitted in connection with the summary judgment proceedings allowed Horace Mann to unequivocally determine that those allegations in the complaint were solely related to the uncovered molestation or that the other alleged misconduct was beyond the scope of Lee's educational employment activities, the court concluded that Horace Mann owed a duty to defend Lee against the claims asserted in Barbara B.'s second amended complaint.

*Read the implications.*

## 21. *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980)

In *INA v. Forty-Eight Insulations, Inc.*, the Sixth Circuit joined the growing number of appellate courts confronting the allied questions of what trigger of coverage theory should govern asbestos-bodily injury claims and what allocation methodology should be applied to apportion the costs of such claims among triggered policies. The trial court ruled that an exposure trigger of coverage and a “pro rata” allocation approach should apply. The Sixth Circuit Court of Appeals affirmed.

The Sixth Circuit agreed with the trial court’s reasoning that an exposure trigger of coverage, which treated asbestos as a “continuing tort” obligating all policies on risk from the time of the worker’s initial exposure to the actual manifestation of disease to provide a defense and indemnification. The Sixth Circuit ruled that this trigger of coverage approach best corresponded with the medical evidence that “[a]sbestos is a slowly progressive disease” in which tissue damage occurs shortly after the inhalation of asbestos fibers and continues to build up with each additional inhalation. The appellate court also ruled that, although the contractual terms “bodily injury” and “occurrence” are inherently ambiguous as applied to such progressive disease, an application of exposure trigger of coverage was most consistent with these terms.

**THE COURT EMPHASIZED THAT THERE IS NO TRULY SATISFACTORY SOLUTION TO THE PROBLEM CREATED BY THE INSURANCE INDUSTRY’S FAILURE TO APPRECIATE THE EXTENT OF POTENTIAL LIABILITY FOR ASBESTOS-CAUSED INJURIES, BUT THAT THE EXPOSURE THEORY STRUCK THE BEST BALANCE.**

The court rejected the insurers’ contention that a manifestation trigger of coverage, which would obligate only those policies on the risk at the time asbestos disease became apparent, should apply. The court reasoned that cumulative asbestos disease cases differ from “the ordinary accident or disease situation” because of the disease process and because the underlying tort liability theory in such cases is that the asbestos manufacturers’ continuing failure to warn workers of the health hazards permitted them to continue breathing asbestos fibers until asbestosis progressed to the point of serious injury or death. The court

concluded that comprehensive general liability policies were designed to insure manufacturers against product liability suits and that asbestos manufacturers would reasonably expect the coverage afforded to parallel the theory of liability.

The Sixth Circuit also approved the trial court's application of a pro rata allocation approach to apportion the policyholder's defense costs, which obligated the policyholder to pay a proportional share of the costs for the periods in which it had not purchased insurance. The policyholder had agreed that such a pro rata apportionment was appropriate with respect to indemnity costs but contended that the trial court had erred in also prorating the defense costs incurred in the underlying lawsuits. The policyholder relied on cases involving a mix of potentially covered and noncovered claims in which courts had refused to apportion defense costs between the insurer and the insured. The appellate court ruled that the reasoning of those cases was inapplicable to the present case in which defense costs for the period in which there was no insurance could readily be apportioned to the policyholder.

In his dissenting opinion, Judge Gilbert S. Merritt Jr. argued that there was a better solution to the problems posed by long-tail asbestos injuries than either the exposure or manifestation theories advocated by several of the litigants. In Judge Merritt's view, the exposure theory, although facially appealing, was problematic because some asbestos may be safely inhaled without ever causing disease, and because imposing liability on insurers before some identifiable bodily injury to a given claimant had occurred was at odds with insurance and tort law, and fairness. Judge Merritt agreed with the majority, however, that the manifestation theory also was problematic for several reasons, including that it construed ambiguities in the policy terms "disease" and "occurrence" most favorably to the insurer, was inconsistent with the medical evidence that asbestos is a harmful, discoverable disease before it reaches the advanced or "manifestation" stage, and would encourage insurers to refuse to insure the manufacturers known to have generated a large risk pool of individuals whose injuries may manifest themselves in the future.

The Sixth Circuit subsequently granted rehearing en banc and extended its earlier decision regarding the applicable trigger of coverage to mesothelioma and other asbestos cancer suits brought against the policyholder. The en banc court declined, however, to reconsider its ruling that a "pro rata" allocation approach should apply to both defense and indemnity costs.

*Read the [implications](#).*

## 22. *J.C. Penney Cas. Ins. Co. v. M.K.*, 52 Cal. 3d 1009, 278 Cal. Rptr. 64, 804 P.2d 689 (1991)

The California Supreme Court addressed the issue of whether liability coverage for an insured's sexual molestation of a child was excluded by the terms of his homeowners insurance policy and California Insurance Code Section 533. The insurer, J.C. Penney, argued that coverage under the policy was excluded because the molestations were intentional. The plaintiffs (the mother and child molestation victim) responded by arguing that even an intentional and wrongful act is not excluded from coverage unless the insured acted with a "preconceived design to inflict injury."

The court ruled that as a matter of law, California Insurance Code Section 533 precludes liability insurance coverage for an insured's sexual molestation of a child. The court considered the child molester's subjective intent to be irrelevant to the question of coverage because:

**THERE IS NO SUCH THING AS NEGLIGENT OR EVEN RECKLESS SEXUAL MOLESTATION.... THE ACT IS THE HARM. THERE CANNOT BE ONE WITHOUT THE OTHER. THUS, THE INTENT TO MOLEST IS, BY ITSELF, THE SAME AS THE INTENT TO HARM.**

Because the court determined that Section 533 excluded coverage, it did not decide the issue of whether child molestation is an "occurrence" within the meaning of the policy.

*Read the [implications](#).*

## 23. *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993)

In this case, the Pennsylvania Supreme Court followed the “all sums” ruling articulated in *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981). Like *Keene*, *J.H. France* involved a coverage dispute about the scope of insurers’ duty to defend and provide indemnification for long-tail claims for asbestos bodily injuries. On the second appeal in the case, the Pennsylvania Supreme Court reviewed the Pennsylvania Superior Court’s rulings with respect to trigger of coverage and allocation, as well as other issues.

The Pennsylvania Supreme Court approved the Pennsylvania Superior Court’s adoption of a multiple-point trigger of coverage for determining the scope of the insurers’ indemnity obligation. This theory served to trigger the obligations of every policy that was on the risk when at least one of the following three events occurred:

- ◆ exposure to asbestos (or silica);
- ◆ progression of the pathological or injurious process; or
- ◆ manifestation of the disease.

The Pennsylvania Supreme Court reasoned that both the standard form insurance policy language at issue and the evidence regarding the etiology and pathogenesis of asbestos-related disease compelled adoption of such a trigger of coverage theory.

With respect to the policy language, the court pointed to the standard form insuring agreement, which covers, among other things “all sums the Insured becomes obligated to pay as damages because of bodily injury to which this insurance applies,” and the definition of “bodily injury,” which encompasses “bodily injury, sickness or disease” that occurs during the policy period. The court also pointed to the standard form “occurrence” definition, which conferred coverage for “an accident, including continuous or repeated exposure to conditions, which result in bodily injury.”

*Applied in light of the medical evidence that asbestos-related injury occurs immediately upon exposure to asbestos and continues even after exposure ends throughout the progression of the disease until manifestation of the injury, the court concluded that this policy*



*language dictated that every policy on the risk at any point during progression of the pathogenic process was obligated to provide indemnification.*

The court then reversed the superior court's ruling adopting a "pro rata" allocation approach, which apportioned a share of each given loss to triggered policies based on their time on the risk and required the policyholder to pay a pro rata share for periods in which it was uninsured. The Pennsylvania Supreme Court quoted the *Keene* court's reasoning at length in concluding that the "all sums" methodology should apply. The court also emphasized that:

1. The policies specifically obligated the insurers to pay "all sums," not a pro-rata portion.
2. There was no evidence that asbestos disease progresses in a linear fashion, which would make a proration by time on the risk more reasonable.
3. To include the policyholder in the payment of costs for periods during which it was really uninsured "is to create a judicial fiction which cannot be supported."
4. The standard-form "occurrence" definition, which specifically includes "continuous or repeated exposure to conditions," proves that the drafters of the standard-form commercial general liability (CGL) policy contemplated paying for *all* of a multiyear injury as one occurrence under the policy.

The court further reasoned that authorizing the policyholder to pick which among multiple triggered policies would provide indemnification in the first instance did not serve to alter the general rules of contribution or the provisions of the other insurance clauses in the various policies at issue. The court stated that the insurers selected by the policyholder were still free to seek a share of the payments made from other insurers based on the terms of the operative other insurance provisions or principles of equitable contribution.

The court addressed the question of allocation of defense costs as well, concluding that, because defense of a claim is a right as well as a duty, the insurers should be entitled to select the company or companies to provide the defense. In the event that the insurers failed to agree, however, the court held that the policyholder would be entitled to make this selection.

The Pennsylvania Supreme Court affirmed the lower appellate court's ruling that the "products hazard" exclusion in the policies predating November 13, 1973, barred coverage for the asbestos bodily injury claims. This exclusion applied to claims for "bodily injury ... arising out the named insured products ... after physical possession has been relinquished to others." The court rejected the policyholder's argument that this exclusion was ambiguous. The court also noted that the policies at issue all prescribed that insurance was provided for special coverages, including "products," only if indicated by specific premium charges, and that such premiums were not charged for "products" coverage until after November 13, 1973.

The court also affirmed the lower court decisions denying the policyholder an award of attorney fees costs based on the insurers' alleged bad faith denial of any duty to defend. It emphasized that "excessive pluralism and disparity exists among courts entertaining similar litigation," and that "[t]here are variety of approaches and possible conclusions to the several issues raised in this case, any of which seems reasonable from some point of view."

*Read the [implications](#).*

## 24. *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981)

An insured manufacturer of asbestos-containing products sought insurance coverage from its commercial general liability (CGL) insurers for thousands of bodily injury suits brought by individuals who had worked with asbestos-containing materials manufactured by the insured and its affiliates. The CGL insurers had issued policies from 1961 through 1980, and the insured had manufactured the products at issue from 1948 through 1972. Because CGL policies are triggered when bodily injury occurs during the policy period, the *Keene* court was required to determine when asbestos-related “bodily injury” occurred to determine which policies provided coverage for the asbestos claims.

The insured argued that bodily injury occurred—and its CGL policies were triggered—whenever a claimant was exposed to asbestos and during the subsequent development of disease. The insured based its argument on medical evidence that the body incurs microscopic injury when asbestos fibers become lodged in the lungs and as the surrounding tissue reacts to the fibers thereafter. The insurers argued alternatively that only the policies in effect at the time of manifestation of disease or at the time of asbestos exposure were triggered, but the progression of asbestos disease did not trigger coverage.

The *Keene* appellate court held that the initial exposure to asbestos, the time during which the asbestos fibers were in residence in the claimants’ lungs, and the manifestation of disease all triggered coverage. As the court explained:

*We interpret “bodily injury” to mean any part of the single injurious process that asbestos-related diseases entail. Regardless of whether exposure to asbestos causes an immediate and discrete injury, the fact that it is part of an injurious process is enough for it to constitute “injury” under the policies.*

In addition to considering medical evidence submitted by the parties, the court also based its holding on the “reasonable expectations” of the insured when it purchased the policies. Because the “purpose of the contracts would be defeated if the insured had to bear the risk of disease that is latent at the time a policy is purchased,” and because the insurance industry was or should have been aware at the time the insurers sold policies to the insured that exposure to asbestos could cause asbestos disease, all policies in effect from the time of initial asbestos exposure through manifestation of disease were triggered.

*Read the [implications](#).*

## 25. *Koppers Co., Inc. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440 (3d Cir. 1996)

The Third Circuit Court of Appeals found environmental pollution claims to be analogous to asbestos bodily injury claims for purposes of triggering coverage under a commercial general liability (CGL) policy and found that each policy in effect while the migration of pollutants occurred was triggered. The court stated:

*As with asbestos-related bodily injury, environmental property damage is a progressive harm that, as a practical matter, is indivisible.... it would be impossible in this case to determine when the first molecule of contaminant damaged neighboring property, or at what rate the contamination spread.... Given the progressive nature of the environmental harms in question, finding the facts necessary [to hold each policy liable only for those harms that occurred during the policy period] usually would be administratively difficult, scientifically impossible, or both.... Like the progression of asbestosis or other insidious diseases, the migrations of contaminants over years or decades may result not from a predictable, linear process, but rather from sporadic or periodic events or conditions that vary in magnitude and frequency over the years....*

*Id.* at 1450–51 (internal citations omitted).

*Read the implications.*

## 26. *Lee v. Aetna Cas. & Sur. Co.*, 178 F.2d 750 (2d Cir. 1949)

The plaintiff wished to buy a monkey from the insured. Because monkeys were kept on an upper floor of the insured's premises, the president of the insured led the plaintiff to the door of an elevator, opened it, slid up a protecting gate, and beckoned Lee to step in. When the plaintiff stepped through the gate, the elevator was not present, and he fell to the bottom of the elevator shaft. The plaintiff alleged that he fell to the pit of the shaft because of the insured's negligence, namely, allowing the elevator shaft to remain open and unguarded.

Under the special provisions of the liability policy issued to the insured, Aetna Casualty and Surety agreed to provide coverage for bodily injury caused by an accident arising out of the ownership or use of the premises or the conduct of the business carried out at the premises. The special provisions of the policy also provided coverage for bodily injury arising out of the ownership or use of the elevators described in the declarations of the policy; however, the policy expressly excluded liability from the "ownership, maintenance, or use" of any elevator that was not specifically described in the policy. The declarations of the policy did not identify or describe any elevators, except that under the caption for "Number of Elevators," the word "none" was written.

Thus, the policy intended to exclude liabilities occasioned by the insured's use of an elevator. Based on the language of the policy, Aetna Casualty was obligated to provide coverage only if the liability of the insured did not arise out of the "use" by the insured of an elevator. Based on the facts alleged in the plaintiff's complaint, the court addressed whether the insured or plaintiff "used" the elevator within the meaning of the policy.

With respect to the duty to indemnify, the court found that the insured's president's opening of the door that led to the shaft of the elevator and pushing up the vertically sliding gate constituted a use of the elevator because the term "elevator," as used in the policy, included the shaft, hoistway, or other appliances or parts thereof. Because the court believed that one "uses" a thing when he "makes use" of it, the court found that the insured's president's invitation to the customer to step into the elevator—regardless of the presence of the elevator car—constituted a "use" of that

elevator. Accordingly, the court believed that Aetna Casualty did not have a duty to indemnify the insured for plaintiff's bodily injuries.

**WITH RESPECT TO THE DUTY TO DEFEND, THE COURT NOTED THAT AN INSURER MUST DEFEND REGARDLESS OF WHETHER THE INSURER MAY GET INFORMATION FROM THE INSURED, OR FROM ANYONE ELSE, WHICH INDICATES, OR EVEN DEMONSTRATES, THAT THE INJURY IS NOT IN FACT "COVERED" UNDER THE POLICY.**

The plaintiff's complaint alleged that he was either injured by the insured's use of the elevator or by the insured's negligent failure to guard the shaft, the former which was excluded under the policy, the latter which was covered under the policy. Because the plaintiff's complaint against the insured alleged facts that would have supported a recovery under the policy, namely, an injury that did not arise from the insured's "use" of an elevator, Aetna Casualty had a duty to defend the insured against plaintiff's complaint.

*Read the implications.*

## 27. *Lee v. Interstate Fire & Cas. Co.*, 86 F.3d 101 (7th Cir. 1996)

The Diocese of Rhode Island had been sued for damages arising from one of its priest's acts of sexual abuse against one victim, in two separate policy years, at two separate locations. The diocese's primary liability insurers sued the excess liability insurer, seeking a determination of whether the negligent supervision claim against the insured constituted a single "occurrence" or multiple "occurrences" under the policies.

The diocese and its insurers settled the victim's tort claim. The coverage litigation, decided under Rhode Island law, was to determine how much of the settlement would be borne by the diocese and its primary insurers, as opposed to the excess insurer, Interstate Fire & Casualty Company. The diocese was self-insured for the first \$100,000 per occurrence, and the primary insurers' shares likewise depended on the number of occurrences.

The court held that, although there were at least two occurrences from the victim's perspective, those intentional torts were excluded from coverage. The court noted that the diocese's liability arose from negligence of the bishop of Providence in supervising the offending priest. The district judge had held that negligent supervision is a single "occurrence" no matter how many years or places the abuse spans. The Seventh Circuit Court of Appeals noted, however, that two courts of appeals had held the same language to mean that there is one "occurrence" per priest, per abused child, per policy year.

The primary insurers argued that the victim suffered "a continuous or repeated exposure to conditions," and that repeated exposure to "substantially the same general conditions" could be only one "occurrence." They depicted a pedophilic priest as similar to hazardous waste and argued that, since the insured event is the bishop's negligent supervision, all consequences of that negligence are a single occurrence. Interstate responded that because the wrongful acts occurred at more than one location, and that sexual abuse cannot be called "continuous" because each episode was discrete, the bishop could have stopped it at any time. By continuing to commit new wrongs, it argued, the situation constituted multiple occurrences. The court noted that one of the prior litigations of the same language turned on the fact that the bishop had received reports about the priest's misconduct and had done nothing.

The court held that under Rhode Island law, if “negligent supervision” had been a unitary act, then multiple losses would arise from a single occurrence. At oral argument, counsel for the primary layer had conceded that if the priest had abused two boys in a single policy year, that would have been two “occurrences.”

The court noted that the policy language defining “cause” assumed a perspective wherein an insured tortfeasor had harmed a victim, but was a mismatch for a case in which the tort is negligent supervision of an intentional wrongdoer. Noting that “a priest is not a ‘condition’ but a sentient being, and of course the victim was never ‘exposed’ to the Diocese’s negligent supervision,” but to the priest, the court opined:

*Winners and losers will change with the circumstances. Interstate today wants to call sustained sexual abuse multiple occurrences to increase the number of deductibles the Diocese must cover and the number of contributions the primary carrier must make. But if tomorrow the victim's loss exceeds the maximum coverage for a single occurrence, the roles will be reversed. The excess carrier would want to call the sexual abuse a single occurrence to cap its own exposure, while the Diocese would favor multiple occurrences in order to maximize its insurance coverage.*

Rather than following a simple ratio approach, the Seventh Circuit found that the Rhode Island law determining the number of occurrences was a more sophisticated analysis, and that a single negligent act could produce multiple “occurrences” if the injuries are independent. Holding that “the tort is poor supervision, not negligent hiring, which occurs only once per employee-employer pair,” the court held that if an employer had received multiple warnings about an employee’s misconduct and ignored them, it would be appropriate to call those lapses “multiple occurrences” because intervention after any one of them could have avoided some of the injury. But if instead the employer had received no danger signals, and its negligence lay in failure to investigate, or if the employer acted, but its action was simply inadequate, then the negligence would more likely be a single occurrence under the policy’s definition.

Ultimately, the court held that the facts in the record could not support any judgment changing the allocation made by the parties in settlement.

*Read the [implications](#).*



## 28. *Maryland Cas. Co. v. Peppers*, 64 Ill. 2d 187, 355 N.E.2d 24 (1976)

Peppers, a home owner, fired a gun at an intruder. Peppers was sued in a complaint, filed in three counts: intentional, negligent, and willful and wanton acts. St. Paul Fire and Marine Insurance appointed counsel to defend Peppers. The insurer-appointed counsel appeared, answered, and then withdrew 24 days later. St. Paul never issued a reservation of rights letter. The court, in an opinion written by Justice Howard C. Ryan, examined whether St. Paul was estopped from raising its noncoverage issue because it had assumed the defense without a reservation of rights. The court determined that estoppel should not be applied because there had been no prejudice to the insured. The insured's personal attorney had continued to represent him and control the defense.

The major principles for which the *Peppers* case is cited are:

1. A ruling on a coverage issue in a declaratory judgment is premature and would constitute an abuse of discretion. A duty to defend exists for the negligence and willful and wanton counts.
2. A duty to defend some of the counts of the complaint creates a duty to defend the entire complaint.
3. The reservation of rights on the intentional act count creates a conflict of interest for the defense lawyer.
4. Because of this conflict between the insurer and the insured, the attorney appointed by the insurer has a serious ethical dilemma that arises under the Rules of Professional Conduct, which would prohibit the attorney from representing both clients.
5. A disclosure of the conflict by the attorney to the insured and acceptance by the insured will satisfy the ethical obligations of the attorney.
6. If the insured will not accept the insurer-retained counsel after disclosure, then the insured has the right to choose its own counsel to defend, at the insurer's expense.
7. If the insurer offers the defense subject to a reservation of rights, the insurer will be entitled subsequently to raise the defense of noncoverage.
8. When the coverage issue is one of the ultimate facts on which recovery in the underlying tort case is based, determination of the declaratory judgment action cannot be made until the underlying case is concluded.

Therefore, the Illinois Supreme Court held that an insurer that defends without reservation may be estopped from asserting a defense of noncoverage.

*Read the [implications](#).*

## 29. *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982)

Plaintiff Miller was injured in an automobile accident when a car owned by defendant Locoshonas and driven by defendant Shugart, in which Miller was a passenger, struck a tree. Locoshonas had an auto liability policy with Milbank Mutual Insurance. Milbank, however, contended Shugart, the driver of the car, was not an agent of the owner and thus not covered under the policy. To determine this coverage question, Milbank, shortly after the accident, commenced a declaratory judgment action. Milbank provided separate counsel at its expense to represent the insured and the driver.

While Milbank Mutual was litigating whether it had coverage for both the insured car owner and the driver, the insured owner and the driver settled with the injured plaintiff and confessed judgment for a stipulated sum. After the coverage question was decided adversely to Milbank, Miller commenced a garnishment action against Milbank to collect on the judgment. Milbank appealed from an order in the garnishment proceeding granting plaintiff summary judgment to collect from Milbank on defendants' confessed judgment to the extent of the policy limits, plus interest. Finding that Milbank must indemnify, the court affirmed Miller's recovery of the policy limits but reversed the ruling on interest.

**THE ISSUE FOR WHICH THE CASE HAS GAINED NOTORIETY IS WHETHER THE JUDGMENT STIPULATED TO BY THE PLAINTIFF AND THE DEFENDANT INSUREDS IS THE KIND OF LIABILITY THE INSURER HAD AGREED UNDER ITS POLICY TO PAY. THIS INVOLVES A TWO-STEP INQUIRY: (1) WHETHER THE JUDGMENT IS THE PRODUCT OF FRAUD OR COLLUSION PERPETRATED ON THE INSURER; AND (2) WHETHER THE JUDGMENT REFLECTS A REASONABLE AND PRUDENT SETTLEMENT.**

The court noted that while the defendant insureds have a duty to cooperate with the insurer, they also had a right to protect themselves against plaintiff's claim. Because the insureds were offered a settlement that effectively relieves them of any personal liability, at a time when their insurance coverage is in doubt, it cannot be said that it was not in their best interest to accept the offer. Nor, did the court think, that the insurer who is disputing coverage could compel the insureds to forego a settlement that is in their best interests.

Therefore, the court held that the insureds did not breach their duty to cooperate with the insurer, which was then contesting coverage, by settling

directly with the plaintiff. It then addressed the issue of whether the insurer should be liable to pay the judgment obtained by consent between the injured party and the insured.

As the trial court observed, it had “serious doubts about the propriety of the procedure whereby the insurer is placed in a ‘no-win’ situation as was done here.” If the insurer ignores the “invitation” to participate in the settlement negotiations, it may run the risk of being required to pay, even within its policy limits, an inflated judgment. On the other hand, if the insurer decides to participate in the settlement discussions, ordinarily it can hardly do so meaningfully without abandoning its policy defense. Nevertheless, the court found that, if a risk is to be borne, it is better to have the insurer who makes the decision to contest coverage bear the risk. Of course, the insurer escapes the risk if it should be successful on the coverage issue, and, in that event, it is the plaintiff who loses.

Lastly, there must also be a showing that the settlement on which the stipulated judgment is based was reasonable and prudent. Plainly, the “judgment” does not purport to be an adjudication on the merits; it only reflects the settlement agreement. It is also evident that, in arriving at the settlement terms, the defendants would have been quite willing to agree to anything as long as plaintiff promised them full immunity. The effect of the settlement was to substitute the claimant for the insureds in a claim against the insurer. Thus, the court noted that only the plaintiff claimant and the defendants’ insurer are in dispute, with the insureds taking a passive, disinterested role.

In these circumstances, while the judgment is binding and valid as between the stipulating parties, it is not conclusive on the insurer. The burden of proof is on the claimant, the plaintiff judgment creditor, to show that the settlement is reasonable and prudent. The test as to whether the settlement is reasonable and prudent is what a reasonably prudent person in the position of the defendant would have settled for on the merits of plaintiff’s claim. This involves a consideration of the facts bearing on the liability and damage aspects of plaintiff’s claim, as well as the risks of going to trial.

This can be compared with the somewhat analogous situation in which a joint tortfeasor seeking consideration from a co-tortfeasor must prove the settlement made was reasonable. See, e.g., *Samuelson v. Chicago, Rock Island & Pacific R.R. Co.*, 287 Minn. 264, 178 N.W.2d 620 (1970).

*Read the [implications](#).*

## 30. *Missouri Pac. R.R. Co. v. International Ins. Co.*, 288 Ill. App. 3d 69, 679 N.E.2d 801 (1997)

This action involved a dispute between Missouri Pacific Railroad and four of its excess commercial general liability (CGL) insurers regarding coverage for damages sought by current and former employees for hearing loss allegedly caused by continuous and repeated on-the-job exposure to unsafe levels of noise. The employees also sought damages for asbestos-related injuries allegedly caused by continuous and repeated exposure to unsafe levels of exposure over the course of their employment. The underlying claimants' work histories spanned over 73 years.

Missouri Pacific alleged that:

1. The hearing loss and asbestos exposure claims each arose from one proximate, uninterrupted, and continuing cause.
2. Some amount of damage occurred in each policy between 1957 and 1986; thus, it was entitled to select the policy period that would provide full indemnification for "all sums" incurred as a result of the claims.
3. Reimbursement of the claims was subject to the payment of only one self-insured retention (SIR) per claim type.

The Illinois appellate court held that it was premature for it to determine whether the hearing loss damages could be allocated to particular policy periods. The court further held that if, on remand, it was determined that the hearing loss damages were unallocable, then the best method of damage allocation would be a pro rata, time-on-the-risk allocation. The court then determined that its ruling regarding allocation applied equally to the hearing loss and the asbestos claims.

With respect to the exhaustion issue, the court discussed that under Illinois law, all underlying coverage must be exhausted before excess coverage may be reached; thus, "'horizontal exhaustion' is required because the excess coverage carries a smaller premium than primary coverage due to the lesser risk insured." The court concluded that SIRs constitute primary coverage and required Missouri Pacific to exhaust the SIRs before looking to the insurers for coverage. The court held that:

*Like the fronting insurance in U.S. Gypsum [v. Admiral Ins., 643 N.E.2d 1226 (Ill. App. 1994)], which effectively constituted self-insurance, and the*

*period of no insurance in Outboard Marine [v. Liberty Mut. Ins., 670 N.E.2d 740 (Ill. App. 1996)], which is the equivalent of self-insurance, the SIRs in the present case constitute primary coverage.*

The court reasoned that “[t]o hold otherwise would allow Missouri Pacific to manipulate the source of its recovery and avoid the consequences of its decision to become self-insured.”

Thus, the court concluded that Missouri Pacific must horizontally exhaust a full SIR per occurrence per policy period before it could look to coverage under the policies.

*Read the [implications](#).*

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## 31. *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994)

Applying Missouri law, the Delaware Supreme Court joined the growing majority of courts approving the “all sums” allocation approach. The trial court in this case had instead ruled that the policyholder must bear a pro rata share of environmental cleanup costs “for periods during which it had little or no insurance.” The Delaware Supreme Court concluded that proration language could not properly be read into the policy language, as the trial court has done here, and it adopted an “all sums” ruling instead.

In reaching this conclusion, the court emphasized that Missouri courts had recognized that pro rata allocation provisions serve as a limitation of coverage, and had refused to read into a policy coverage limitations not clearly stated therein. The Delaware Supreme Court also emphasized that the Missouri Court of Appeals had held that, when a policy is silent on the question of proration, “the insurance company is jointly and severally liable to the full extent of the policyholder’s loss (i.e., ‘all sums’).”

The Delaware Supreme Court predicted that the Missouri Supreme Court would employ this same “all sums” approach:<sup>3</sup>

*The majority of courts have held that without a pro rata clause in the policies, the insurance companies cannot limit their obligations to a pro rata share or portion of [the policyholder’s] liabilities. This court’s examination of the present status of the law in Missouri leads us to conclude that the Missouri Supreme Court would follow the majority rule and not read a pro rata allocation of coverage into [the] insurance policies. Consequently, if [the insurer] intended to reduce the limits of its coverage to the “portion [of the loss] which results in the relevant policy period,” Missouri law required it to state that pro rata liability in “plain and unequivocal terms.”*

*Id.* at 35 (citations omitted).

3. The Delaware Supreme Court later reached the same conclusion under Delaware law in *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481 (Del. 2001) (relying on “all sums” language to hold each insurer jointly and severally liable to the policyholder).

The Delaware Supreme Court also noted the Missouri Court of Appeals' authority entitling an insurance company that completely honors the policyholder's claim to obtain contribution through an apportionment action against the other insurance companies. The supreme court recognized that such authority could support a pro rata allocation among insurers, but concluded that inter-insurer apportionment was irrelevant to determining the insurers' initial obligation to the policyholder.

*Read the [implications](#).*

## 32. *Montgomery Ward & Co., Inc. v. Imperial Cas. & Indem. Co.*, 81 Cal. App. 4th 356, 97 Cal. Rptr. 2d 44 (2000)

Montgomery Ward sued four of its insurers who had issued successive comprehensive general liability policies during the period from January 1, 1962, through May 1, 1976, for declaratory relief and breach of contract with respect to coverage for defense and indemnity costs it incurred as a result of alleged environmental contamination occurring over a number of years at automotive service centers it operated.

The trial court dismissed all of Montgomery Ward's causes of action, ruling that Montgomery Ward's self-insured retentions (SIRs) (ranging from \$50,000 to \$250,000 for each policy) were the equivalent of primary insurance. The trial court then applied the principle of horizontal exhaustion, requiring that all primary insurance must be exhausted before any excess insurer has any obligation under an excess policy. Thus, the trial court required Montgomery Ward to exhaust its SIRs under as many as 20 potentially applicable policies before any of its insurers had any duty to indemnify Montgomery Ward for its losses.

The California Court of Appeal reversed, unequivocally stating:

**WE CONCLUDE SIRs ARE NOT PRIMARY INSURANCE, AND THE PRINCIPLE OF HORIZONTAL EXHAUSTION DOES NOT APPLY.**

The court of appeal rejected the ruling of the trial court, and the insurers' arguments that retained limits or SIRs are the same as primary or underlying insurance, finding "no support for this conclusion in the language of the policies themselves, nor do we find any pertinent support in California precedent." The California Court of Appeal further rejected the argument that Montgomery Ward's SIRs in all of its policies constituted "other collectible insurance with any other insurer" or "specific valid and Collectible Underlying Policies" as to which the insurers' policies were excess.

The court of appeal found support for its ruling in holdings by the California Supreme Court explaining that:

*In a strict sense, self-insurance is a "misnomer." Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or*



*liability arising from a contingent or unknown event.... [S]elf insurance ... is equivalent to no insurance.... As such, it is repugnant to the [very] concept of insurance.... If insurance requires an undertaking by one to indemnify another, it cannot be satisfied by a self-contradictory undertaking by one to indemnify oneself.*

Thus, the court concluded that there was no basis in the insurance policies, or in applicable law, to conclude that Montgomery Ward's SIRs were the equivalent of policies of primary insurance.

*Read the [implications](#).*

## 33. *Nicor, Inc. v. Associated Elec. & Gas Ins. Servs. Ltd.*, 223 Ill. 2d 407, 860 N.E.2d 280 (2006)

A public utility company that installed and serviced gas meters in hundreds of thousands of homes in Illinois exchanged meters that used mercury switches for ones that used spring activated switches. It conducted at least 200,000 such exchanges over a period of at least 40 years. In approximately 1,100 of those instances, there was evidence that its service personnel may have spilled small amounts of mercury when making the exchange.

Nicor had been insured by a number of different insurers over those years, and coverage for only 195 of the incidents was at issue in the case. While the aggregate amount of liability was enormous, topping \$90 million, the liability in each individual case was below Nicor's retention amounts, which were never below \$100,000 per occurrence.

Nicor argued that the entire liability that it faced in a class action lawsuit was a single occurrence and that its insurers should pay all of its loss in excess of a single retention amount. The insurers argued the opposite.

While the trial court had held that the liability arose from Nicor's systematic failure to use proper procedures, the intermediate appellate court held, and the Illinois Supreme Court agreed, that the spills were:

*the product of separate and independent acts, occurring "in an isolated number of cases as a result of [individual servicemen's] actions or the particular circumstances in each residence." ... "[W]here each asserted loss was the result of a separate and intervening human act or each act increased the insured's exposure to liability ... each of the 195 mercury spills subject to the London Insurers' policies constituted a separate occurrence."*

The court conducted a broad survey of Illinois law on the subject, citing cases from its own appellate courts dating from 1984 through 2003, and involving everything from automobile accidents and widespread deaths of livestock to asbestos liability and food poisoning at a restaurant. In the end, the court held that the individual spills "did not arise from any inherent defect in the old-styled gas regulators or the manner in which they were

installed in customers' homes," nor "from any systemwide policy or procedure regarding the methodology employed for removing the regulators."

**EACH ASSERTED LOSS WAS THE RESULT OF A SEPARATE AND INTERVENING HUMAN ACT, OR EACH ACT INCREASED THE INSURED'S EXPOSURE TO LIABILITY.**

On that analysis, the court held that each spill was a separate occurrence, and each triggered one retention, so that the insurers owed nothing.

*Read the [implications](#).*

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## 34. *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 283 Ill. App. 3d 630, 670 N.E.2d 740 (2d Dist. 1996)

The court in this case followed *U.S. Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 643 N.E.2d 1226 (1st Dist. 1994), and found that all commercial general liability (CGL) policies in effect while environmental pollution occurred were triggered. In this case, the insured's manufacturing operations caused PCB-containing fluid to seep from the insured's premises into Waukegan Harbor over the course of 24 years. The court followed the decision in *U.S. Gypsum* and held that all policies in effect while the PCBs migrated into the harbor were triggered because:

THE CONTAMINATION OF THE GROUNDWATER SHOULD BE REGARDED AS A CONTINUOUS PROCESS IN WHICH THE PROPERTY DAMAGE IS EVENLY DISTRIBUTED OVER THE PERIOD OF TIME FROM THE FIRST CONTAMINATION TO THE END OF THE LAST TRIGGERED POLICY...

*Read the implications.*

## 35. *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994)

In this case, the New Jersey Supreme Court adopted a variant of the “pro rata” allocation approach. The New Jersey Appellate Division had applied a continuous trigger to determine which of Owens-Illinois’s insurers had a duty to defend and indemnify it for nearly 100,000 asbestos bodily injury suits and more than 60 asbestos property damage suits, and a “joint and several liability” or “all sums” approach rendering each triggered policy on the risk independently liable up to policy limits. The New Jersey Supreme Court affirmed the lower court’s ruling on trigger of coverage but reversed its ruling on allocation.

In approving application of a continuous trigger of coverage, potentially obligating every policy on the risk from the time of each claimant’s inhalation of asbestos onward to provide coverage, the New Jersey Supreme Court ruled that:

**“THE OVERWHELMING WEIGHT OF AUTHORITY” RECOGNIZES THE PROGRESSIVE NATURE OF ASBESTOS-INDUCED DISEASE.**

The court observed that the evidence was “less persuasive” as to asbestos-related property damage, but concluded that property damage cases are analogous to the contraction of disease from exposure to toxic chemicals like asbestos, and that, because it was apparently uncontested that the injurious process was continuous, “claims of asbestos-related property damage from installation through discovery or remediation (the injurious process) trigger the policies on the risk throughout the period.”

In reversing the New Jersey Appellate Division’s ruling on the allocation methodology to be applied to apportion losses among the multiple triggered policies, the New Jersey Supreme Court concluded that the standard form policy language did not definitely call for application of either the “joint and several” or the “pro rata” approach. The court relied instead on public policy considerations to determine the fairness of requiring particular insurers or the policyholder to participate in the loss. These considerations included:

- ◆ “the extent to which our decision will make the most efficient use of the resources available to cope with environmental disease or damage”;

- ◆ “the relative bargaining power of the parties and the allocation of the loss to the better risk-bearer in a modern marketing system”;
- ◆ the need for an “efficient response” to the logistical challenges posed by complex environmental litigation; and
- ◆ “principles of simple justice.”

In the context of asbestos-related personal injury and property damage, the court concluded that these factors established that straight pro rata allocation based on annual periods on the risk was not an appropriate measure of allocation. Based on these factors, the court stated that allocation should be in proportion to the degree of risks transferred and retained during the years of exposure, and that the most equitable approach called for proration on the basis of policy limits (percentage of the risk), multiplied by years of coverage (time on the risk).

Although it rejected the New Jersey Appellate Division’s ruling that the policyholder was not obligated under any circumstance to share a portion of losses based on periods of inadequate insurance, the New Jersey Supreme Court drew a distinction between periods in which the policyholder chose not to purchase insurance or purchased insufficient insurance, and those in which insurance for the risk simply was not available. The court concluded that it was fair to require the policyholder to bear a portion of the loss in the former situation, when periods of no or insufficient insurance “reflect a decision by the actor to assume or retain a risk,” but not in the latter situation.

Based on these factors, the court stated that allocation should be in proportion to the degree of risks transferred and retained during the years of exposure, and that the most equitable approach called for proration on the basis of policy limits (percentage of the risk), multiplied by years of coverage (time on the risk).

*Read the [implications](#).*

## 36. *Powerine Oil Co., Inc. v. Superior Ct.*, 37 Cal. 4th 377, 33 Cal. Rptr. 3d 562, 118 P.3d 589 (2005) (*Powerine II*); and *Certain Underwriters at Lloyd's of London v. Superior Ct.*, 24 Cal. 4th 945, 103 Cal. Rptr. 2d 672, 16 P.3d 94 (2001) (*Powerine I*)

Powerine Oil, a defunct oil refinery, faced liability for certain governmentally imposed cleanup and abatement orders requiring it to remediate soil and groundwater pollution. Since the mid-1930s, Powerine engaged in oil refinery operations throughout the Western states. In 1985, it was forced into bankruptcy. California Water Quality Board initiated remedial administrative proceedings; two cleanup and abatement orders were issued to remediate pollution resulting from past oil refinery operations at 10 locations. The orders were not issued as a result of litigation or as part of an injunction.

The insuring agreement in the Central National policy was examined:

*The Company hereby agrees ... to indemnify the Insured for all sums which the Insured shall be obligated to pay by reason of the liability imposed upon the Insured by law ... for damages, direct or consequential and expenses, all as more fully defined by the term "ultimate net loss" on account of property damage caused by or arising out of each occurrence happening anywhere in the world.*

The court was swayed by the policy's use of the terms "damages" and "expenses." It reasoned that the use of both terms raises the inference that they were not intended to be synonymous. The addition, the term "expenses" in the central insuring clause extends coverage beyond the limitation imposed where the term "damages" is used alone, thereby enlarging the scope of coverage beyond "money ordered by a court."

In *Powerine II*, the California Supreme Court addressed the issue of whether the insurer's obligation to indemnify the insured under the wording of nine excess/umbrella insurance policies was limited to money ordered by a court in a lawsuit for damages against the insured. The court held that, pursuant to California caselaw based on a literal reading of the specific policy language of the excess/umbrella policies, the duty to defend a "suit" seeking "damages" is restricted to civil actions prosecuted in a court, initiated by the filing of a complaint, and does not include claims, which can denote proceedings conducted by administrative agencies under environmental statutes.

Likewise, the court found that:

THE DUTY TO INDEMNIFY FOR “ALL SUMS THAT THE INSURED BECOMES LEGALLY OBLIGATED TO PAY AS DAMAGES” ... IN THE SAME STANDARD PRIMARY POLICIES IS LIMITED TO MONEY ORDERED BY A COURT, AND DOES NOT INCLUDE EXPENSES SUCH AS MAY BE INCURRED IN RESPONDING TO ADMINISTRATIVE AGENCY ORDERS.

However, the *Powerine* court further found that:

*Where the express insuring language of an excess/umbrella policy broadens indemnity coverage for sums paid in furtherance of a “compromise” or “settlement” of a “claim” initiated by an administrative agency for such remedial relief, the insured’s liability for such expenses falls within the policy’s indemnification obligation even though no government suit was filed.*

*Read the implications.*



## 37. *Qualcomm, Inc. v. Certain Underwriters at Lloyd's of London*, 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770 (2008)

Qualcomm's employees filed a class action lawsuit related to their asserted right to unvested company stock options. Separate similar lawsuits were filed. Qualcomm settled the lawsuits and incurred approximately \$3.6 million in defense expenses for the class action and \$9 million in expenses in connection with the other lawsuits. Qualcomm tendered the lawsuits to its directors and officers (D&O) liability insurers.

National Union Fire Insurance Company of Pittsburgh, Pennsylvania, had issued Qualcomm a primary D&O liability insurance policy with a \$20 million limit. Certain Underwriters at Lloyd's of London had issued Qualcomm a first layer excess "follow-form" D&O policy with a \$20 million limit excess of the National policy. Underwriters' excess policy contained a "Maintenance of Underlying Policies" clause, which provided in part that Underwriters would be liable only after the insurers under the National policy had paid or been held liable to pay the full amount of the underlying limit of liability.

Qualcomm, National Union, and Underwriters participated in mediation concerning coverage. Qualcomm settled with National Union and agreed to release National Union from future obligations under the National Union policy in exchange for National Union's reimbursement of Qualcomm for additional settlement and defense expense payments, bringing National Union's total payment to \$16 million. Qualcomm sued Underwriters for breach of contract and declaratory relief under the excess policy.

Underwriters argued that coverage was not triggered because Qualcomm did not and could not meet two conditions precedent to coverage: that Qualcomm refrain from compromising the underlying National policy and that the underlying limits be exhausted by National having paid its \$20 million limit or having been held liable to pay that amount. Qualcomm argued that the coverage question raised by Underwriters was squarely decided in its favor in *Home Indem. Co. v. Mission Ins. Co.*, 251 Cal. App. 2d 942 (1967), and out-of-state authorities adopting the reasoning of *Zeig v. Massachusetts Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928).

Qualcomm also asserted that denying excess coverage would be contrary to public policy because it would work forfeiture, provide a windfall to the excess insurer, and encourage litigation.

The trial court sustained Underwriters' demurrer without leave to amend, entered judgment for Underwriters that the excess policy had not been triggered, and ruled that Qualcomm could not meet a condition precedent of the excess policy. Qualcomm appealed.

On appeal, Qualcomm argued that the exhaustion clause was ambiguous and that Underwriters was chargeable with the knowledge that the "have paid or have been held liable to pay" language had been widely interpreted to permit an insured to exhaust primary policy limits through a below-limits settlement with the primary insurer. The court of appeal did not find any ambiguity. The court held that Underwriters issued a reimbursement policy that only required it to indemnify Qualcomm for specified losses, which was different from the duty to defend. By definition, the duty to indemnify entailed the payment of money to resolve liability.

The court assessed the policy language and Qualcomm's objectively reasonable expectations as an insured with primary and excess insurance. The court found there was no dispute that the underlying limit of liability was \$20 million. The court concluded that the exhaustion clause could not have any other reasonable meaning than actual payment of no less than \$20 million, and that Underwriters' reimbursement obligation did not arise until National actually paid the full \$20 million of its underlying limit.

The court of appeal held that even assuming *arguendo* that the "have been held liable to pay" phrase was ambiguous, Qualcomm's complaint did not indicate—and Qualcomm did not argue—that the settlement between it and National required National to accept responsibility or liability for the full amount of the \$20 million in underlying limits. Qualcomm argued that the court should adopt the *Zeig* court's decision not to interpret the word "payment" in an excess policy as only relating to payment in cash. The *Zeig* court found that the word "payment" is often used as meaning the satisfaction of a claim by compromise or in other ways.

In *Zeig*, the excess insurer argued that the insured was required to actually collect the full amount of underlying insurance as a prerequisite to coverage under the excess policy. The *Zeig* court rejected the argument as unnecessarily stringent. The court of appeal was not persuaded by *Zeig* because there, the court appeared to place policy considerations above the plain meaning of the excess policy terms. The court also disagreed with the *Zeig* court's strained interpretation of the word "payment." Furthermore, the court of appeal found

that Underwriters' excess policy language explicitly required actual payment as a condition precedent to coverage.

The court of appeal found Qualcomm's reliance on non-California authorities unpersuasive. The court noted that Qualcomm itself observed that the following decisions shared the policy rationale favoring the efficient settlement of disputes between insurers and insureds, which, in the court's view, could not supersede plain and unambiguous policy language.

- ◆ *Drake v. Ryan*, 514 N.W.2d 785 (Minn. 1994)
- ◆ *Elliot Co. v. Liberty Mut. Ins. Co.*, 434 F. Supp. 2d 483 (N.D. Ohio 2006)
- ◆ *Reliance Ins. Co. v. Transamerica Ins. Co.*, 826 S.2d 998 (Fla. Dist. Ct. App. 2001)
- ◆ *Rummel v. Lexington Ins. Co.*, 945 P.2d 970 (N.M. 1997)

The court held that if contractual language in an insurance policy is clear and unambiguous, the language governs, and the court does not rewrite it for any purpose. The California Court of Appeal affirmed the decision in favor of Underwriters.

*Read the [implications](#).*

## 38. *San Diego Navy Fed. Credit Union v. Cumis Ins. Co.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984)

Eisenmann sued San Diego Navy Credit Union for general damages (\$750,000) and punitive damages (\$6.5 million). The Credit Union tendered the lawsuit to Cumis Insurance Company and requested a defense in the action. After receiving a copy of the underlying complaint, Cumis determined that it owed a duty to provide a defense and, accordingly, retained defense counsel to represent the interests of the Credit Union in the underlying action. But Cumis reserved its right to deny coverage at a later date and stated that the policy did not cover punitive damages or claims for intentional misconduct or breach of contract.

In light of Cumis's reservation of rights, the Credit Union retained its own defense counsel to protect its interests in the underlying action, and Cumis initially agreed to pay the fees and costs incurred by the Credit Union's chosen defense counsel. However, after paying two legal invoices for Credit Union's independent counsel, Cumis refused to pay any additional invoices because of its conclusion that there was not a conflict of interest such that Cumis would be required to pay the expenses of separate counsel.

The court stressed that irrespective of the insurer's and insured's common interest in a finding of total nonliability in the underlying action, "remaining interests of the two diverge to such an extent as to create an actual, ethical conflict of interest warranting payment for the insureds' independent counsel."

The Credit Union subsequently sued Cumis for all reasonable past and future defense costs for its independent counsel in an underlying action. The trial court found that Cumis was required to pay for Credit Union's independent counsel.

The appellate court affirmed the trial court, based in large part on its finding that the insurer's appointed defense counsel could not provide a full and adequate defense for the insureds. As the court explained, the basis for liability in the underlying action, "if any, might rest on conduct excluded by

the terms of the insurance policy.” Because the retained defense counsel would need to make decisions that could benefit one of its clients concerning insurance coverage while harming the other, the lawyer might be forced to walk an ethical tightrope, and not communicate relevant information beneficial to one or the other of his clients.

The court concluded that the Canon of Ethics imposes an obligation on lawyers retained by the insurer to explain to the insured and insurer the full implications of joint representation where the insurer has reserved its rights to deny coverage. If the insured does not consent to the continued representation by the lawyer, the lawyer cannot represent either the insurer or the insured. Moreover, once the insured refuses to provide consent for such representation, “the insurer must pay the reasonable cost for hiring independent counsel by the insured ... [and t]he insurer may not compel the insured to surrender control of the litigation.” The court stressed that irrespective of the insurer’s and insured’s common interest in a finding of total nonliability in the underlying action, “remaining interests of the two diverge to such an extent as to create an actual, ethical conflict of interest warranting payment for the insureds’ independent counsel.”

*Read the [implications](#).*

## 39. *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 15 Cal. Rptr. 2d 815 (1993)

Shell Oil Company sought defense and indemnification for claims concerning alleged environmental pollution liability. The insurers denied coverage, contending that Shell should have known the operations created pollution. Shell sued its insurers. The primary issues in the action involved the meaning and applicability of approximately 800 comprehensive general liability policies and California's statutory bar against insuring "willful" acts.

As an initial matter, the California Court of Appeal found that California Insurance Code Section 533, which precludes indemnity for a "willful act" is an implied exclusionary clause in every insurance contract. "The statute reflects a fundamental public policy of denying coverage for willful wrongs and discouraging willful torts." Further, as a statutory exclusion, Cal. Ins. Code Section 533 is not subject to the rule of strict construction against an insurer; instead, the court construes it according to the legislature's intent.

The court then addressed the question of whether any state of mind other than a subjective intent to injure is so culpable as to render deliberate actions uninsurable. The court discussed that it is "clear that Section 533 does not prohibit coverage for reckless conduct" and that "some forms of conduct amounting to a conscious disregard of others' safety might not constitute an uninsurable 'willful act' under Section 533."

**IT DETERMINED THAT A "WILLFUL ACT" UNDER SECTION 533 "MUST MEAN AN ACT DELIBERATELY DONE FOR THE EXPRESS PURPOSE OF CAUSING DAMAGE OR INTENTIONALLY PERFORMED WITH KNOWLEDGE THAT DAMAGE IS HIGHLY PROBABLY OR SUBSTANTIALLY CERTAIN TO RESULT."**

The court found that Section 533 prohibits indemnification of more than just intentional acts that are subjectively desired to cause harm and acts that are intentional, wrongful, and necessarily harmful regardless of subjective intent. To constitute a "willful act" under Section 533, there must also be a deliberate, liability-producing act that the individual expected to cause harm before he or she acted. The court concluded that Section 533 "precludes

indemnification for liability arising from deliberate conduct that the insured expected or intended to cause damage.”

The court then turned to the interpretation of the meaning of the term “expect” as used in policy language precluding coverage for damage that is “expected or intended.” The court rejected the insurers’ arguments that an objective test should be applied in determining whether damage was “expected” and refused to impose a “should have known” standard, instead limiting consideration to what Shell actually knew or believed. The court held that the appropriate test for “expected” damage is whether the insured subjectively knew or believed its conduct was substantially certain or highly likely to result in the kind of damage incurred.

*Read the [implications](#).*

## 40. *State Farm Mut. Auto. Ins. Co. v. Partridge*, 10 Cal. 3d 94, 109 Cal. Rptr. 811 (1973)

The California Supreme Court heard this case sitting en banc and issued its opinion authored by Justice Mathew Tobriner. The court set out the relevant (and remarkable) facts:

*The circumstances resulting in the accident at issue reveal an instance of what can only be described as blatant recklessness. Wayne Partridge, the named insured of the two insurance policies issued by State Farm, was a hunting enthusiast who owned a .357 Magnum pistol. Prior to the date of the accident, Partridge filed the trigger mechanism of his pistol to lighten the trigger pull so that the gun would have 'hair trigger action'; the trial court specifically found this modification of the gun to be a negligent act, creating an exceptionally dangerous weapon.*

On the evening of July 26, 1969, Partridge and two friends, Neilson and Albertson, were driving in the countryside in Partridge's four-wheel drive Ford Bronco. With Vanida sitting between them in the front seat, Partridge and Albertson hunted jackrabbits by shooting out of the windows of the moving vehicle; Partridge was using his modified .357 Magnum. Partridge spotted a running jackrabbit crossing the road, and, in order to keep the rabbit within the car's headlights, Partridge drove his vehicle off the paved road onto the adjacent rough terrain. The vehicle hit a bump, the pistol discharged, and a bullet entered Vanida's left arm and penetrated down to her spinal cord, resulting in paralysis.

That the automobile policy covering the Bronco would pay was not in question. The only question was "solely upon the applicability of the homeowners policy to the instant accident." The insurer argued that its exclusion for injuries "arising out of the ... use ... of a motor vehicle" made the policy inapplicable because the parties and the court had all agreed that the auto policy applied precisely because the injury arose out of the use of the Bronco.

The court, however, disagreed, noting that "an entirely different rule of construction applies to exclusionary clauses as distinguished from coverage clauses. Whereas coverage clauses are interpreted broadly so as to afford the greatest possible protection to the insured."



Applying the varying standards applicable to coverage and exclusionary clauses, the court held that “In issuing the homeowner’s policy to Partridge, State Farm agreed to protect the insured against liability accruing from non-auto-related risks,” and noted that State Farm did “not deny that Partridge’s negligence in firing the trigger mechanism of his gun was a risk covered by the homeowner’s policy.” Under those circumstances, the court disagreed with State Farm’s analysis and held that “although the accident occurred in a vehicle, the insured’s negligent modification of the gun suffices, in itself, to render him fully liable for the resulting injuries.”

While the court clearly had no sympathy for the acts of the insured, it held that the policy would nevertheless respond because:

**COVERAGE UNDER A LIABILITY INSURANCE POLICY IS AVAILABLE TO AN INSURED WHENEVER AN INSURED RISK CONSTITUTES SIMPLY A CONCURRENT PROXIMATE CAUSE OF THE INJURIES. THAT MULTIPLE CAUSES MAY HAVE EFFECTUATED THE LOSS DOES NOT NEGATE ANY SINGLE CAUSE; THAT MULTIPLE ACTS CONCURRED IN THE INFLICTION OF INJURY DOES NOT NULLIFY ANY SINGLE CONTRIBUTORY ACT.**

*Read the implications.*

## 41. *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995)

In *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, the Second Circuit Court of Appeals considered what trigger of coverage and allocation methodology should be applied to determine coverage for asbestos bodily injury and property damage cases under both New York and Texas law. The trial court had ruled that a continuous trigger of coverage should apply and employed a “pro rata” allocation methodology requiring the policyholder to contribute a proportionate share for periods in which it was uninsured.

The Second Circuit affirmed the trial court’s trigger of coverage ruling in full. However, the court limited the trial court’s ruling on allocation to require the policyholder to contribute a proportionate share only for those periods insurance was available, but it chose not to purchase insurance or bought insufficient insurance.

On the trigger of coverage issue, the Second Circuit noted that prior New York precedent supported application of an injury-in-fact trigger, but concluded that no case previously decided under New York addressed the precise question of whether, upon sufficient evidence of progressive injury, an injury-in-fact approach serves to trigger all of the policies in force during each period in which successive injuries had occurred. The appellate court answered this question affirmatively. The court also concluded that it was appropriate to employ a continuous trigger under New York law because the medical evidence was sufficient to support an injury-in-fact finding at each point in the development of asbestos or asbestos cancer. Predicting that this evidence also would suffice under Texas law, the court ruled that all policies in effect at any time during the occurring injury-in-fact disease process were triggered under both New York and Texas law.

In considering the trial court’s ruling that the policyholder should bear a proportionate share of the costs reflecting the periods in which it was not insured under a “pro rata” allocation approach, the Second Circuit observed that it would not consider the correctness of the apportionment formula itself because no party objected to the apportionment formula as applied among insurers. The court then ruled that the trial court’s proration-to-the-insured approach should be modified to apply only to the periods in which asbestos liability insurance was available, but had not been purchased by the policyholder.

Under this approach, the appellate court determined that no share of the loss associated with particular claims should be apportioned to the policyholder for any triggered period after 1985, when asbestos exclusions were implemented and coverage ceased to be available.

The appellate court rejected the challenges various of the insurers asserted with respect to the imposition of liability on both the asbestos bodily injury and property damage claims. The court ruled that the “known loss” doctrine did not serve to bar coverage for all claims against the policyholder, despite the policyholder’s awareness, prior to the inception of many of the policies, that its products presented risks of asbestosis and cancer and that it had received a large number of claims. The court agreed with the trial court’s reasoning that the prospective number of injuries, number of claims, likelihood of successful claims, and amount of ultimate losses remained highly uncertain, and that the policyholder was entitled to replace these uncertainties of its exposure with the precision of insurance premiums, while leaving it to the insurers’ underwriters to determine the appropriate premiums.

The “per occurrence” deductible provisions were not ambiguous, and the court declined to interpret them in a manner contrary to the intent of the parties just to produce a result favoring the policyholder.

The appellate court also upheld the trial court’s rulings with respect to the coverage afforded by various policies that were canceled before the stated expiration date or extended beyond the stated expiration date. The appellate court agreed that all of the policies canceled prior to the stated expiration date, except the two that were replaced with policies having higher aggregate limits, should be construed to afford full coverage during the part of the year in which such policies were in effect, because these policies contained no provision calling for a reduction of the aggregate limits in the event of cancellation. The appellate court also agreed with the trial court’s ruling that the policy extended beyond its stated expiration date should be construed to provide a second annual period of coverage. The appellate court concluded that the trial court’s interpretation was reasonable in view of the ambiguity of the policy language providing for coverage of \$5 million in “the aggregate for each annual policy period during the currency of this policy” and the policyholder’s payment of an additional premium for the extension of coverage.

The appellate court affirmed the trial court's rulings that various excess insurers had no duty to defend or pay defense costs, except with respect to the ruling that the Texas Amendatory Endorsement to certain of the policies altogether eliminated the duty to pay defense costs for claims arising in Texas. The appellate court concluded that the endorsement did not unambiguously eliminate the duty to pay defense costs, and accordingly should have been construed in favor of coverage.

The Second Circuit rejected the insurers' arguments against the imposition of liability for the asbestos bodily injury claims at issue as well. The court upheld the findings made in a jury and subsequent bench trial that the policyholder had not expected or intended to cause the asbestos bodily injuries. The appellate court rejected the insurers' contention that the trial court erred in requiring them to bear the burden of proof on this issue. The appellate court ruled that New York law controlled because the question of burden of proof is a procedural one governed by the forum state's law. The court further ruled that it was irrelevant that the exclusionary language relating to "expected" or "intended" injuries appeared in the definitions or insuring agreements of the policies because New York law dictated that the exclusionary effect of policy language, not its placement in the contract, is what requires the insurer to bear the burden of proof.

The court also rejected the insurers' contention that the trial court erred in applying a subjective standard to assess whether the policyholder expected or intended injury. The court ruled that the policies explicitly precluded coverage only if the policyholder actually expected or intended the injuries, and that a subjective standard applied under both New York and Texas law.

As an alternative basis for avoiding liability on the asbestos bodily injury claims, the insurers challenged the reasonableness of the policyholder's decision to enter into the Wellington Agreement and thereafter to participate in the Center for Claims Resolution (CCR), and the formulas by which liabilities for claim payments were allocated among the parties to these agreements. The appellate court found ample evidence that the policyholder's participation in these claims-handling agreements was beneficial. The court also ruled that the insurers were not entitled to avoid responsibility for the payments allocated to the policyholder for settlements of claims not involving the policyholder's products. The court concluded the challenged allocation formulas were consistent with the policyholder's rights under its policies to enter into reasonable good faith settlements, and that the formulas themselves were reasonable under the circumstances.

The court affirmed the trial court's rulings relating to the asbestos property damage claims, with the exception of the determination that these claims all arose from a single occurrence requiring the policyholder to pay only one per occurrence deductible per applicable policy period. The appellate court concluded that New York's unfortunate events test for determining the number of occurrences required courts to focus on the event for which the policyholder was held liable, and not some event further back in the causal chain. The court concluded that, since the policyholder's liability resulted from its manufacture of asbestos-containing products installed in claimants' buildings, each location in which the policyholder's products were installed represented a separate occurrence requiring payment of another deductible. The court also concluded that Texas law appeared to call for a finding of multiple occurrences in circumstances similar to those involved in the present case.

The Second Circuit distinguished its prior decision in *Champion Int'l Corp. v. Continental Cas. Corp.*, 546 F.2d 502 (2d Cir. 1976), in which it had held that claims based on installation of defective vinyl panels in more than a thousand vehicles all arose from a single occurrence, the insured's delivery of the panels to the vehicle manufacturers. The court concluded that *Champion* did not require a single occurrence ruling in the case before it because the *Champion* court had declined to consider the possibility that each delivery of the allegedly defective product to a manufacturer could constitute a single occurrence owing to the failure of the 26 manufacturers to seek indemnification from the policyholder. The court also observed that, unlike the policyholder in the case before it, the policyholder in *Champion* was not a manufacturer of the defective product and had been exposed to liability merely because of its delivery of this product to the vehicle manufacturers.

The Second Circuit rejected the policyholder's contention that, although "occurrence" should be deemed to mean each separate installation of its product for purposes of determining policy limits, only one "occurrence" should be found for purposes of calculating the deductible provisions. The court recognized that a contrary ruling would dictate that the deductible amount will in many cases exceed the amount sought with respect to each installation, but concluded that the "per occurrence" deductible provisions were not ambiguous and declined to interpret them in a manner contrary to the intent of the parties just to produce a result favoring the policyholder.

*Read the [implications](#).*

## 42. *Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929)

*Stowers* holds that a *defending* third-party insurer that fails to defend a third-party case in the way it would if its liability were not limited by contract will be liable for any damages in excess of the policy limits for which the policyholder ultimately becomes liable. In *Stowers*, the court considered an automobile liability coverage case where the insurer asserted the absolute right to conduct defense of lawsuits against its insured and then rejected a settlement offer of what amounted to 80 percent of the limit of liability. The insurer reasoned, and argued, that it had little to lose by going to trial because its liability was limited by the terms of the policy. The policyholder was held to be liable to the underlying plaintiff for nearly 300 percent of the policy limits in the underlying trial.

The policyholder then brought the coverage action against American Indemnity Co. The *Stowers* court rejected the insurer's argument and held that:

*Wherein an insurance company makes such a contract [giving it the exclusive right to defend]; it, by the very terms of the contract, assumed the responsibility to act as the exclusive and absolute agent of the insured in all matters pertaining to the questions in litigation, and as such agent, it ought to be held to that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business[.]*

Accordingly, the court held that the insurer was liable to Stowers for the policy limit and further duties consistent with exercising the "degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business." The *Stowers* court further held that:

*It is the duty of the court to give effect to all of the provisions of the policy, and it would certainly be a harsh rule to say that the indemnity company, in a case such this, owed no duty whatever to the insured further than the face of the policy, regardless of whether it was negligent in discharging its duties as the sole and exclusive agent of the insured, in full and complete control. Such exclusive authority to act in a case of this kind does not carry with it the right to act arbitrarily.*

The *Stowers* court did not award extracontractual damages, but remanded the case for a new trial given its rulings.

**THE *STOWERS* DOCTRINE HAS GROWN TO MEAN THAT AN INSURER IN A THIRD-PARTY CONTEXT IS LIABLE TO ITS POLICYHOLDER ON A NEGLIGENCE—RATHER THAN THE MORE DIFFICULT TO PROVE BAD-FAITH BASIS—TO MAKE THE POLICYHOLDER WHOLE ACCORDING TO THE TERMS OF THE CONTRACT.**

The *Stowers* doctrine only applies to third-party cases in which the insurer has defended or otherwise tendered coverage to its policyholder, and the policyholder argues that such defense or coverage has been inadequate. This is the point made by the Texas Court of Appeals in *Southstar Corp. v. St. Paul Surplus Lines Ins. Co.*, 42 S.W.3d. 187 (Tex. App. 2001). The *Southstar* court held that, where a policyholder alleges only that the insurer wrongfully failed to defend, the policyholder is limited to bringing claims for damages under the insurance contract and for extracontractual damages to make itself whole under the *Stowers* doctrine. Where the policyholder makes allegations that the insurer breached duties implicating public policy that arise independent of the contract terms, however, the policyholder may, in addition to its *Stowers* claims, bring claims for breach of the duty of good faith and fair dealing.

*Read the [implications](#).*

## 43. *Travelers Ins. Co. v. Eljer Mfg., Inc.*, 757 N.E.2d 481 (Ill. 2000)

Numerous insurance companies filed declaratory judgment actions against Eljer Manufacturing, Inc., U.S. Brass Corp., and Household International, Inc. (the “policyholders”), which were eventually consolidated. The policyholders had manufactured and sold Qest, a residential plumbing system that was installed in homes throughout the country. After installation, numerous home owners filed suit against the policyholders, claiming that the system leaked, causing extensive property damage to their homes.

Additionally, many home owners who did not experience leaks filed claims against the policyholders, seeking reimbursement for the cost of replacing the systems and resulting diminution in the value of their homes. Many of those claims settled.

The policyholders were insured under various commercial general liability (CGL) insurance policies. The insurers filed a motion for summary judgment, claiming that they had no duty to indemnify the policyholders for the home owners’ reimbursement claims because those systems did not leak during the policy periods. The policyholders cross-moved, claiming that the property damage covered under the policies occurred at the time the systems were installed.

The trial court granted the insurers’ motion and denied the policyholders’ motion, ruling that property damage for purposes of coverage does not occur until a system leaks.

The court noted that the policyholders were correct in contending that, under New York law, the incorporation of a defective product into a larger entity could constitute injury to tangible property, triggering the policies’ coverage without an actual leak.

On appeal, the court noted that two different types of policies were issued at different times, which changed the coverage picture. The appellate court held that for the policies governed by New York law and issued prior to 1982, no leak was required to trigger coverage. In the policies governed by Illinois law and issued after 1981, coverage was triggered only when a system



actually leaked or when a home owner caused damage to his or her property while removing a nonleaking system. Thus, the court affirmed summary judgment to the insurers as to the pre-1982 policies, but reversed as to the post-1981 policies.

On appeal to the Illinois Supreme Court, the court first looked at the policies issued prior to 1982 that were governed by New York law. The court noted that the policyholders were correct in contending that, under New York law, the incorporation of a defective product into a larger entity could constitute injury to tangible property, triggering the policies' coverage without an actual leak. Thus, the court held that the trial court erred in granting summary judgment to the insurers.

Regarding the post-1981 policies governed by Illinois law, the court disagreed with the policyholders' argument, holding that the home owners whose systems did not leak suffered no "physical injury to tangible property." The court also held that the post-1981 policies are not triggered if a home is physically damaged by a home owner replacing a nonleaking system; this does not constitute physical injury to tangible property arising from a covered occurrence under the policies. Thus, the court held that the trial court correctly granted summary judgment to the insurers as to these policies.

*Read the [implications](#).*

### ***INSURANCE FOR DEFECTIVE CONSTRUCTION***

Commercial general liability (CGL) insurance claims involving defective workmanship are complex and expensive. They involve a complex scheme of coverage, from the insuring agreement, through the definitions, particularly occurrence and property damage, and finally the business risk exclusions. *Insurance for Defective Construction* saves you time and money because the author, Patrick J. Wielinski, a practicing attorney in this field, has analyzed the latest legal trends, approaches, and theories in this area. It includes explanations of the drafting history behind the provisions governing the CGL policy's coverage for construction defect claims and carefully analyzes and comments on the cases that have interpreted them. Use this book to hone your understanding of the defective construction as an occurrence issue and get a leg up on the competition.

## 44. *U.S. Fid. & Guar. Co. v. Wilkin Insulation Co.*, 578 N.E.2d 926 (Ill. 1991)

Here, the Illinois Supreme Court examined the definition of “property damage” found in the standard commercial general liability (CGL) policy. The presence of health-threatening, asbestos-containing products released over time was noted to have contaminated buildings, therefore constituting physical injury to tangible property. The damage was not the result of the failure of the asbestos to perform its contractual function as an insulator. Rather, its detrimental impact was caused by a “wholly ancillary and coincidental phenomenon,” namely the diffusion of harmful fibers. Asbestos-related cost of repair and replacement was held to be more than merely economic damage.

This litigation originated as a result of underlying lawsuits instituted by school districts and public building owners against a multitude of defendants that collectively make up the “asbestos industry.” The complaints alleged that, upon deterioration of the asbestos-containing product itself or upon disturbance from an outside force, asbestos fibers are released into the air. The fibers were alleged to be extremely durable and lasting and were of the size and shape that permit them to remain airborne for periods of time, settle, and then become resuspended in the air to later settle at different locations throughout the buildings. Thus, the buildings and their contents (e.g., carpets, upholstery, and drapery) were virtually contaminated or impregnated with asbestos fibers, the presence of which posed a serious health hazard to the human occupants.

Relying on its own decision in the underlying litigation, the Illinois Supreme Court noted that:

*The essence of the allegations of the complaints is that the buildings have been contaminated by asbestos to the point where corrective action, under the law, must be taken. Thus, the buildings have been damaged.*

*Board of Educ. v. AC&S, Inc.*, 131 Ill. 2d 428, 546 N.E.2d 580 (1989).

The court also looked at whether the damage resulted from an accident. The continuous release of asbestos fibers constituted a harmful condition. By virtue of the “continuous or repeated exposure to the condition” of asbestos fiber release, the buildings and their contents became contaminated. It is the continuous exposure of the buildings and their contents to released asbestos fibers that constituted the “accident,” as defined by the insurance policies. Therefore, the “property damage” alleged in the underlying complaints was caused by an “occurrence,” as defined within the insurance policies.

*Read the implications.*

## 45. *U.S. Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 643 N.E.2d 1226 (1st Dist. 1994)

This case involved a property damage claim in which the insured manufacturer of asbestos-containing building materials was sued on the basis that property damage occurred to a building whenever the insured's products released asbestos fibers into the air. The commercial general liability (CGL) policies at issue in *U.S. Gypsum* provided coverage for claims for "property damage" during the policy period, which was defined as "injury to or destruction of tangible property, including the loss of use thereof."

Noting first that nothing in the language of the CGL policies connects property damage to the time it was discovered, the court held that a manifestation or discovery trigger was inapplicable and also declined to apply the *Zurich v. Raymark* "triple trigger." (See *Zurich Ins. Co. v. Raymark Ind. Inc.*, 514 N.E.2d 150 (Ill. 1987).) Instead, the court adopted a continuous trigger, stating:

*The supreme court's use of a triple trigger in Zurich recognizes that multiple policy periods can be triggered by the evolving nature of an illness resulting from the exposure to asbestos. Similarly, our application of a continuous trigger recognizes that the property damage that results from the release of asbestos fibers and the reentrainment of asbestos fibers is a continuing process which necessarily occurs over multiple policy periods.*

The *Gypsum* court based its holding in part on *Owens-Illinois, Inc. v. United Ins. Co.*, 264 N.J. Super. 460 (1993), in which:

THE COURT APPLIED A CONTINUOUS TRIGGER IN DETERMINING WHICH INSURANCE POLICY OF AN ASBESTOS MANUFACTURER WAS TRIGGERED IN A CASE INVOLVING BOTH BODILY INJURY AND PROPERTY DAMAGE CLAIMS. THE COURT, INTERPRETING LANGUAGE SIMILAR TO THAT IN THE POLICIES BEFORE US, DETERMINED THAT ALL THE INSURANCE POLICIES FROM THE EXPOSURE TO, OR INSTALLATION OF ASBESTOS, TO MANIFESTATION OR DISCOVERY OF DAMAGE, WERE TRIGGERED.

(See *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994).) As the *Gypsum* court further explained,

*The claims seeking coverage for property damage caused by asbestos fiber release are prototypes for the appropriate application of the equitable continuous trigger. The property damage in the underlying cases whether from the presence of airborne fibers or settled fibers subject to reentrainment occurs over a span of time and cannot be linked to or confined to different policy periods. The difficulty in determining precisely when the damage occurred or in following its progress or proliferation is further exacerbated by the interchangeable nature of the fibers and that their release occurs on a continuing basis. ... The burden of proving exactly when property damage occurred would be virtually impossible.*

**Read the implications.**

## 46. *Vandenberg v. Superior Ct.*, 21 Cal. 4th 815, 88 Cal. Rptr. 2d 366, 982 P.2d 229 (1999)

From 1958 to 1988, Vandenberg operated an automobile dealership on property leased from the Boyds. When Vandenberg vacated the premises, the Boyds removed three underground tanks. Testing revealed that the surrounding soils were contaminated.

Boyd sued Vandenberg for breach of contract, bad faith, nuisance, negligence, waste, trespass, strict liability, equitable indemnity, and declaratory and injunctive relief. Boyd alleged that Vandenberg installed the tanks that were the source of the contamination.

Vandenberg tendered to six insurers. Only U.S. Fidelity and Guarantee (USF&G) Insurance agreed to defend. During judicially supervised settlement proceedings, Vandenberg, Boyd, and USF&G agreed to settle all of Boyd's claims, except those based on breach of lease, and to arbitrate the breach of lease claims.

The arbitrator found that the contamination was caused by Vandenberg's installation of the tanks and awarded more than \$4 million in damages. The arbitrator further indicated that the discharge was not sudden and accidental. After the trial court affirmed the arbitration award, the insurers refused to pay the judgment.

Vandenberg sued the insurers for breach of contract and bad faith. The insurers filed motions for summary adjudication on the ground that the arbitration award was solely for breach of contract, and contractual damages are not covered. The trial court granted the motions, but the California Court of Appeal reversed. The insurers sought review by the California Supreme Court.

The California Supreme Court affirmed the court of appeal, holding that contractual damages can be covered. The court rejected the *ex contractu/ex delicto* distinction used by the lower courts to find noncoverage. Such a distinction cannot be derived from the policy language "legally obligated to pay" because this phrase simply refers to any obligation that is binding and enforceable under the law, whether pursuant to contract or tort liability. The coverage determination instead must be made by analyzing the nature of the

injury and the risk that caused the injury, in light of the particular provisions of the policy.

**THE COURT CONCLUDED THAT THE INSURERS COULD NOT AVOID COVERAGE SOLELY ON THE GROUNDS THAT THE DAMAGES WERE ASSESSED ON A CONTRACTUAL THEORY.**

*Note:* In so holding, the California Supreme Court reversed a long line of lower court decisions that found no coverage for damages arising from contract:

- ◆ *Bernstein v. Consolidated Am. Ins. Co.*, 43 Cal. Rptr. 2d 817 (Cal. App. 1995)
- ◆ *Fireman's Fund Ins. Co. v. City of Turlock*, 216 Cal. Rptr. 796 (Cal. App. 1985)
- ◆ *Fragomeno v. Insurance Co. of the West*, 255 Cal. Rptr. 111 (Cal. App. 1989)
- ◆ *Insurance Co. of the West v. Haralambos Beverage Co.*, 241 Cal. Rptr. 427 (Cal. App. 1987)
- ◆ *International Surplus Lines Ins. Co. v. Devonshire Coverage Corp.*, 155 Cal. Rptr. 870 (Cal. App. 1979)
- ◆ *Old Republic Ins. Co. v. Superior Ct.*, 77 Cal. Rptr. 2d 642 (Cal. App. 1998)
- ◆ *Wilmington Liquid Bulk Terminals, Inc. v. Somerset Marine Inc.*, 61 Cal. Rptr. 2d 727 (Cal. App. 1997)

*Read the implications.*

## 47. *Waller v. Truck Ins. Exch., Inc.*, 11 Cal. 4th 1, 44 Cal. Rptr. 2d 370, 900 P.2d 619 (1995)

Waller, Marmac, Inc., and other codefendants brought an action against their commercial general liability (CGL) insurer for breach of contract and implied covenant of good faith and fair dealing arising from its refusal to defend an action brought by another shareholder who was also an insured. The California Supreme Court granted review to decide whether a CGL insurer is required to defend a third-party action that seeks incidental emotional distress damages caused by the insured's noncovered economic or business torts. The court held, among other things, that the policy did not cover physical or emotional distress, lost reputation, or humiliation resulting from noncovered economic loss because there was no potential for coverage. And, if there is no potential for coverage and hence no duty to defend, the court held, there can be no action for breach of implied covenant of good faith and fair dealing.

Amey sued Marmac, Waller, and the four Marmac officers under 11 causes of action. The first amended complaint included allegations that Marmac's board of directors was "guilty of or have knowingly countenanced acts of persistent and pervasive fraud, mismanagement or abuse of authority and persistent unfairness toward Amey," and that they excluded "Amey from any voice in the management [of Marmac]" to deprive him of a controlling block of stock in the corporation and in order to "gain a controlling interest in and to freeze Amey, a minority shareholder, out of the corporation." Amey also accused the management of Marmac of "self-dealing in voting themselves substantial increases in salary, and causing [Marmac] to enter into an unreasonable or sham contract of employment with [Waller]."

Amey also accused Waller of disregarding and breaching his fiduciary duties to Amey, failing:

*to exercise good faith and due care so as to avoid unfairness to [Amey] by entering into a transaction to dispose of his dominant or control block of stock in [Marmac] without the slightest regard to the wishes and interests, and without prior knowledge of [Amey], and for the purpose of gaining an unfair advantage in the sale or transfer of said controlling block of shares.*

Amey's tenth cause of action alleged intentional infliction of emotional distress against Waller and the Marmac officers, and claimed that because of

their conduct, Amey “suffered humiliation, mental anguish, and emotional and physical distress.” Amey alleged that as fiduciaries, Waller and the Marmac officers’ conduct leading up to the involuntary dissolution and wrongful termination as alleged in the complaint “was outrageous, went beyond all reasonable bounds of decency, was intentional and malicious and was done for the purpose of causing [Amey] to suffer humiliation, mental anguish, and emotional and physical distress.”

Waller and the other defendants tendered the claim to Truck Insurance Exchange (T.I.E.) and its claim adjuster, Farmers. T.I.E. concluded that the CGL policy did not provide coverage under the allegations of the Amey complaint because:

- ◆ Amey’s complaint did not state an occurrence because Amey was not claiming bodily injury or property damage, and any economic injuries he suffered were expected or intended from the standpoint of the insureds.
- ◆ The policy endorsement listed Amey as a named insured, and the policy expressly excluded coverage for liability to named insureds.
- ◆ Amey was a Marmac employee, and the policy excluded coverage for bodily injury suffered by Marmac employees arising out of and in the course of employment.

The court held that there was no duty to defend in this context because the reasonable expectations of the parties when they entered into a contract for commercial general liability (CGL) insurance could not have included a duty to defend this lawsuit, for such policies are not intended to cover economic losses, and because the damages alleged in Amey’s complaint flowed from intangible property losses that could not be considered covered occurrences under the CGL policy. Likewise, the derivative emotional distress damages sought by Amey were not covered because they flowed from the same noncovered acts.

The California Court of Appeal had focused on the fact that Amey’s complaint alleged emotional and physical distress flowing from a noncovered economic loss, and found no duty to defend the underlying lawsuit because the “gravamen” of the complaint was economic loss. It found the damages for emotional and physical distress were derivative of and inseparable from Amey’s allegations of intentional and business torts, allegations that could not, by themselves, give rise to coverage under a CGL policy.

The California Supreme Court agreed with the California Court of Appeal, stating that the CGL policy provides coverage for “occurrences” that cause bodily



injury or tangible property losses, but was never intended to cover emotional distress damages that flow from a noncovered “occurrence,” and the parties could not reasonably have expected that coverage would be expanded merely because a claim of emotional or physical distress is alleged as a result of the economic loss. Accordingly, T.I.E. owed no duty to defend the Amey lawsuit.

Finding that T.I.E. owed no duty to defend the Amey action, the California Court of Appeal concluded that because there was no contractual liability on the part of T.I.E., plaintiffs could not assert a valid bad faith claim. The supreme court held that:

**IF THERE IS NO *POTENTIAL* FOR COVERAGE AND, HENCE, NO DUTY TO DEFEND UNDER THE TERMS OF THE POLICY, THERE CAN BE NO ACTION FOR BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING BECAUSE THE COVENANT IS BASED ON THE CONTRACTUAL RELATIONSHIP BETWEEN THE INSURED AND THE INSURER, AND A BAD FAITH CLAIM CANNOT BE MAINTAINED UNLESS POLICY BENEFITS ARE DUE.**

The court held that the covenant is implied as a supplement to the express contractual covenants, to prevent a contracting party from engaging in conduct that frustrates the other party’s rights to the benefits of the agreement.

In what is essentially dictum, the court noted that “delayed payment based on inadequate or tardy investigations, oppressive conduct by claims adjusters seeking to reduce the amounts legitimately payable and numerous other tactics may breach the implied covenant because” they frustrate the insured’s right to receive the benefits of the contract in “prompt compensation for losses.” But, without that contractual right, the implied covenant has nothing upon which to act as a supplement, and “should not be endowed with an existence independent of its contractual underpinnings.”

Accordingly, in California, if an insurance policy provides no potential basis for coverage, the insurer is under no duty to defend an action against the insured, and does not breach the implied covenant of good faith and fair dealing by failing to do so.

*Read the [implications](#).*

## 48. *Waste Mgmt., Inc., v. International Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 579 N.E.2d 322 (1991)

In this case, the insurers sought production of defense counsel's files from two underlying matters in which the policyholder was a defendant. The Illinois Supreme Court held that neither the attorney-client privilege nor the work product doctrine barred such discovery.

The court in *Waste Mgmt.* first held that the policyholder had to produce its defense counsel's files from the underlying litigation to comply with the cooperation clause in the insurance policy. While a cooperation clause is often included in an insurance policy to protect the insurer's interests by preventing collusion between the insured and the injured party, the *Waste Mgmt.* decision expanded the duty to cooperate in insurance coverage cases in three respects. First, the court stated that "even were the express words, 'duty to cooperate' omitted from the contract, such a duty could reasonably be inferred based merely on principles of fairness and good faith." Second, the court applied the duty to cooperate even though the insurance company was not involved in the defense of the underlying litigation. While the insurers in *Waste Mgmt.* had no duty to defend and indeed refused to defend the policyholder, the court relied on "the principles applied in duty-to-defend cases to define the scope of the duty of cooperation." The court stated that:

**THE INSURER-INDEMNIFIER IS NO LESS INTERESTED OR ENTITLED TO PROTECT ITS FINANCIAL INTERESTS AND TO MINIMIZE UNWARRANTED LIABILITY CLAIMS THAN IF IT WERE ACTUALLY PARTICIPATING IN OR PROVIDING THE DEFENSE.**

The court stated that the duty to cooperate did not end with the termination of the underlying lawsuit, but continued as long as the policyholder sought to enforce its terms.

The court in *Waste Mgmt.* also held that the attorney-client privilege was unavailable to the insured because of the common interest doctrine. Under this doctrine, when an attorney represents two different parties who

have a common interest, communications by one party to the attorney are not necessarily privileged *vis-à-vis* the other party. The court held that:

*Both insurers and insureds had a common interest either in defeating or settling the claim against insureds in the [underlying] litigation ... and therefore that the communication by insureds with defense counsel was of a kind reasonably calculated to protect or to further those common interests.*

The court expanded the common interest doctrine in several aspects. First, while the doctrine is mainly applied when an attorney is retained by two or more parties, underlying defense counsel in *Waste Mgmt.* was neither retained by nor in direct communication with the insurer. According to the court, counsel for the insured did, in a way, represent the insurers because the insurer was ultimately liable for payments if the plaintiffs in the underlying litigation received some damages. The court also allowed the discovery of files created in one of the underlying suits, even though the policyholder only sought recovery of the costs of a separate suit. The court considered that the insurer was entitled to those files as well because it had an interest in any potential recovery for contribution from the underlying plaintiffs. Lastly, the court made clear that the common interest doctrine does not cease to apply once the parties become adverse.

Some courts have held that, by bringing a coverage action, the policyholder “impliedly waives the attorney-client privilege when he places a claim or defense at issue, and the document or information in question has a direct bearing on that claim or defense.” *Metro Wastewater Reclamation v. Continental Cas. Co.*, 142 F.R.D. 471 (D. Colo. 1992). The court in *Waste Mgmt.* found it unnecessary to address the “at issue” doctrine because it had already held against the attorney-client privilege on grounds of the cooperation clause and the common interest doctrine. However, the court implicitly supported the idea that the files were “at issue” by stating that “it is the very conduct of defense counsel in the underlying litigation which is the basis of insurers’ declaratory judgment action and its defense to insureds’ declaratory judgment action.”

The *Waste Mgmt.* court also found the work product doctrine to be inapplicable due to the common interest doctrine and the “at issue” exception. It held that where:

*in the underlying litigation, an attorney represents the common interests of two or more clients whose relationship subsequently becomes adverse,*

*and, in a subsequent action, the work product of the attorney is at issue, [the work product doctrine] is not available to bar discovery by one of the original parties.*

In addition, the court determined that the work product of the insured's defense counsel might be dispositive of issues presented in the action, contained relevant information not obtainable elsewhere, and therefore was discoverable work product.

The court made it clear that privileged attorney-client and work product documents from the underlying litigation would maintain their privileged status *vis-à-vis* the insured's opponents in the underlying litigation. The court also stressed attorney-client communications and work product generated in preparation for the pending coverage action were entitled to protection and need not be produced to the insurers.

*Read the [implications](#).*

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## 49. *White v. Western Title Ins. Co.*, 40 Cal. 3d 870, 221 Cal. Rptr. 509 (1985)

*White* is a first-party coverage case wherein the insurer's bad faith had a direct impact on the policyholders' own property value. In *White*, the policyholders had obtained preliminary title reports and title insurance policies from Western Title when they purchased 84 acres of riverfront land. Three years before the sale to the plaintiffs, the sellers of the land had conveyed an easement to drill wells, build and maintain a pipeline, and pump water from beneath the land to a community mutual water corporation. The easement deed had been recorded, but at the time of the purchase, the buyers knew nothing of the easement, and the reports and policies did not mention the easement.

The policyholders discovered the easement when the community water corporation notified them of its intention to implement the easement. The policyholders made claim to Western Title under the title policies for \$62,947 in damages, based on an appraisal of the diminished value of the land. Western Title "rejected" the claim under a policy exclusion for "loss or damage ... [arising] by reason of ... water rights, claims or title to water." The policyholders then filed suit against Western Title for breach of contract (on the title insurance policies) and negligence (in preparing the preliminary title reports).

Western Title moved for summary judgment on the policy exclusion, and the motion was denied. Then Western Title got its own damage appraisal, which came in at \$2,000, and offered to settle the case for \$3,000 (the "first offer"). The policyholders rejected the first offer. Western Title subsequently served a written offer to compromise for \$5,000 pursuant to Code of Civil Procedure Section 998 (which fixes some costs for the parties if the offer is rejected, depending on whether the case is ultimately worth more or less than the amount offered). The policyholders rejected the Section 998 offer and amended the complaint to allege breach of the covenant of good faith and fair dealing.

The trial court bifurcated the issues for trial between the breach of contract and negligence issues, and the bad faith issue. Liability for breach of contract and negligence was bench tried, and the trial found against Western Title on the issue of liability. Western Title then showed the \$2,000 appraisal to the policyholders and filed a new "offer to compromise" the entire case under Section 998 for \$15,000. Again, the policyholders rejected the offer.

The case went to jury trial on the remaining issues. The jury found actual damages of \$8,400 for the breach of contract claim. In the “bad faith” phase of the case, the policyholders planned to present evidence of Western Title’s conduct during the whole course of litigation, including introducing evidence of the settlement offers. The trial court admitted evidence of the first and the second offer, but excluded evidence of the third offer. The jury returned a verdict against Western Title on the covenant of good faith and fair dealing, awarding the plaintiff compensatory damages of \$20,000 but declining to impose punitive damages.

On appeal, Western Title urged that an adversarial position was created by the litigation, and that any insurer is handicapped in defending itself if post-suit actions are discoverable and admissible in evidence. Also, the attorney who prepared the case for trial would be barred from trying the case because he or she would be a critical witness to the insurer’s good faith during the pretrial period.

The California Supreme Court rejected Western Title’s position “as a matter of principle,” and held that the insurer’s duty of good faith and fair dealing, like the rest of its contractual duties, extends and continues throughout the coverage litigation.

*It could not reasonably be argued under such circumstances either that the insurer no longer owes any contractual duties to the insured, or that it need not perform those duties fairly and in good faith.*

40 Cal. 3d at 886.

The court reasoned that policyholders would find it difficult to prove pre-litigation conduct unreasonable if it could not present evidence of the insurer’s conduct during the later period by way of contrast. Thus, according to the majority, the insurer’s post-filing conduct could be relevant and admissible to determine the good faith of the insurer’s previous conduct.

A minority of the court warned that the *White* decision “cavalierly hobbled” the rights of insurers to effectively defend themselves. Justice Malcolm M. Lucas, dissenting from the bad faith judgment, stated that:

*Scylla and Charybdis had nothing on my colleagues for making life difficult—if not impossible. An insurer who refuses to pay its insured on a disputed claim is now not only at risk that its refusal will subject it to damages for breach of the covenant of good faith and fair dealing, but must also be conscious that any aspect of its conduct*

*during litigation of the original claim of coverage may be used as significant evidence in an ensuing breach of good faith action.*

Justice Lucas went on to postulate about the likely consequences of such a rule:

CONFRONTED WITH SUCH EVIDENCE AND UNFAMILIAR WITH THE VAGARIES OF LITIGATION[,] THE JURY WILL, I SUBMIT, IN ALL LIKELIHOOD REGARD ANY SETTLEMENT ATTEMPTS AS PREJUDGMENT ADMISSION OF LIABILITY, AND STANDARD DEFENSE TACTICS AS INDICATIONS OF A LACK OF GOOD FAITH.

The consequences foreseen by the minority have not occurred. But the case still is good law and has been embraced in other jurisdictions.

*Read the implications.*

## 50. *Zurich Ins. Co. v. Raymark Ind. Inc.*, 514 N.E.2d 150 (Ill. 1987)

Similar to the holding in *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981), the court here held that any commercial general liability (CGL) policy in effect whenever one or more of the following occurred was triggered in connection with asbestos bodily injury claims:

1. the claimant was exposed to asbestos fibers;
2. the plaintiff exhibited symptoms of asbestos-related sickness; and/or
3. the plaintiff's asbestos-related disease manifested itself such that it could have been diagnosed by a medical professional.

The *Zurich* court rejected the insured's contention that bodily injury occurred at all times between the time of exposure and the time when the disease manifested itself, even during periods of nonexposure and, as such, declined to apply the "continuous" trigger adopted by the *Keene* court on the basis that the record "establishes that asbestos-related disease may or may not progress during periods of nonexposure."

The court based its "triple trigger" theory on the fact that the lungs are physically damaged when asbestos fibers are ingested; the disease occurs only when it becomes manifest; and a person may be "sick" prior to the point that a disease manifests itself.

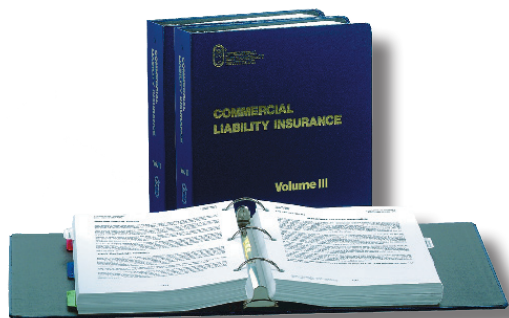
The *Zurich* court based its "triple trigger" on the insuring agreement of the CGL policy that stated, in relevant part: "[t]he [insurance] company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of ... bodily injury ... caused by an occurrence...." The policies defined "bodily injury" to mean "bodily injury, sickness or disease...."

Upon considering medical evidence, the *Zurich* court ruled that, for asbestos claims, "bodily injury" occurs: (1) at or shortly after inhalation; (2) when the disease manifests itself; and (3) if an individual "'suffers from a disordered, weakened or unsound condition' which has not yet progressed to the point of impairment characteristic of 'disease,' may be classified as having a 'sickness,' which would also trigger coverage under the policies." The court based this trigger theory on the fact that the lungs are physically damaged when asbestos fibers are ingested; the concept that disease occurs only when it becomes manifest; and the concept that a person may be "sick" prior to the point that a disease manifests itself.

*Read the [implications](#).*



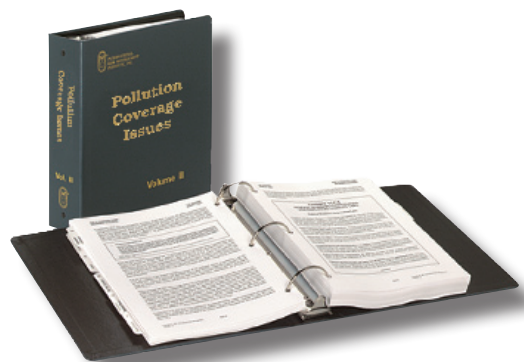
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