Filed 6/22/16 Goulds Pumps v. Travelers Casualty and Surety Co. CA2/5

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

GOULDS PUMPS, INC., Plaintiff and Respondent, v. TRAVELERS CASUALTY AND SURETY COMPANY, Defendant and Appellant.	B255439 (Los Angeles County Super. Ct. No. BC290354)

APPEAL from a judgment of the Superior Court of Los Angeles County, Emilie H. Elias, Judge. Affirmed.

Dentons US, Ronald D. Kent and Susan M. Walker; McCloskey, Waring & Waisman and Sonia S. Waisman for Defendant and Appellant.

Morgan, Lewis & Bockius, Paul A. Zevnik, Michel Y. Horton and David S. Cox for Plaintiff and Respondent.

I. INTRODUCTION

Defendant, Travelers Casualty and Surety Company, appeals from a judgment entered in an insurance coverage case after a court trial. The trial court found that defendant's excess policies provided occurrence based coverage for certain asbestos-related losses incurred by plaintiff, Goulds Pumps, Inc. We affirm the judgment.

II. THE PLEADINGS

The initial complaint was filed on February 13, 2003. At issue are allegations appearing in the fifth and sixth amended complaints' eleventh causes of action which were filed on July 24 and September 28, 2012, respectively. The sixth amended complaint was filed during the court trial. According to the eleventh causes of action, defendant issued policies to plaintiff providing $50 million in excess coverage insurance. The eleventh causes of action make allegations concerning two policies issued by defendant. Paragraph 216 of the eleventh cause of action in the sixth amended complaint seek a declaration of rights as to defendant's policy Nos. 45XN54WCA and 45XN60WCA. Policy No. 45XN54WCA provided $25 million in products liability excess coverage from January 1, 1981, through January 1, 1982. Policy No. 45XN60WCA provided plaintiff $25 million in products liability excess coverage from January 1, 1982, through January 1, 1983. Plaintiff seeks declarations, among other things, that: defendant's two policies were triggered by bodily and personal injuries sustained between January 1, 1981, and January 1, 1983; the reimbursement duty was triggered once Utica Mutual Insurance Company paid $25 million for asbestos-related losses whether in a single or series of underlying lawsuits; the underlying suits invoked the "products hazard" portion of defendant's policies; the Utica Mutual Insurance Company policies are "underlying insurance" and subject to aggregate limits of liability; defendant's policies "follow form" to those of Utica Mutual Insurance Company; defendant's policies are governed in material part by those of Utica Mutual Insurance

Company; defendant is bound by claims decisions made in applying the Utica Mutual Insurance Company policies; defendant has received timely notice of the claims in the underlying suits; there is no defense to defendant's coverage responsibilities; and defendant must pay plaintiff $50 million with respect to the underlying litigation. The eleventh causes of action's prayers for relief seek declarations of rights and duties concerning the foregoing issues.

There are two affirmative defenses that are pertinent to the present case. The twelfth affirmative defense states, "As an excess insurer, and under the terms of the Travelers/Goulds Policies and some or all of the Travelers/ITT Policies, Travelers Casualty has no duty to indemnify Plaintiffs (or any entity seeking coverage under such policies) for any costs or expense in connection with the investigation or defense of claims or suits, or interest on any judgment which accrues after entry of the judgment." Further, the fourteenth affirmative defense states, "As an excess insurer, and under the terms of the Travelers Casualty Policies, Travelers Casualty has no duty to indemnify Plaintiffs (or any entity seeking coverage under the Travelers Casualty Policies) unless and until the excess level of the Travelers Casualty Policies, or any of them, is reached as result of damages paid for covered claims on account of any one accident or occurrence."

III. THE POLICIES

Plaintiff's coverage claims are based on primary, umbrella and excess policies issued by Utica Mutual Insurance and The Aetna Casualty and Surety Companies. The Aetna Casualty and Surety Company is defendant's predecessor. For 1981 and 1982, plaintiff purchased a primary layer of coverage from Utica Mutual Insurance Company. In addition, for the same two years, plaintiff purchased umbrella policies from Utica Mutual Insurance Company. Finally, plaintiff purchased excess policies from defendant. We now detail the relevant policy provisions and liability limits.

To begin with, from 1979 through 1981, plaintiff purchased primary comprehensive general liability policies from Utica Mutual Insurance Company. The policies were all assigned policy No. GLA25439. For the policy periods from January 1, 1979, through January 1, 1982, the limits of liability for bodily injury were $500,000 for each occurrence. However, the limits of liability section for the policy providing coverage between January 1, 1979, and January 1, 1982, contains the following aggregate limitation on bodily injury liability: "$,000." The January 1, 1982, through January 1, 1983 primary policies provide for personal injury limits of liability of $500,000 for each occurrence and $500,000 aggregate for bodily injury liability. As will be noted, the absence of an aggregate limit in the January 1, 1979 through January 1, 1982 policy periods is an issue of consequence in this litigation.

The pertinent coverage language in the three Utica Mutual Insurance Company primary policies is as follows: "The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of [¶] A. bodily injury . . . to which this insurance applies caused by an occurrence, and the company shall have the right and duty to defend any suit against the insured seeking damages on account of such bodily injury . . . , even if any of the allegations of the suit are groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient, but the company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company's liability has been exhausted by payment of judgments or settlements." The term "occurrence" is defined as follow, "'[O]ccurrence means an accident, including continuous or repeated exposure to conditions, which results in bodily injury . . . neither expected nor intended from the standpoint of the insured [.]"

In addition to the primary policies, Utica Mutual Insurance Company issued commercial umbrella liability policies for each of the policy years at issue. The occurrence limit is $25 million. The aggregate limit is $25 million. The underlying coverage insurance is identified as Utica Mutual insurance Company policy No. GLA25439, the underlying primary policies described above.

Defendant identifies two excess policies that are at issue. The policies were issued by The Aetna Casualty and Surety Company. The first policy was in effect from January 1, 1981, to January 1, 1982, and is policy No. 45XN54WCA. The second policy was in effect from January 1, 1982, through January 1, 1983, and is policy No. 45XN60WCA. Both policies are entitled, "Excess Overlayer Indemnity Policy." Section 1 of the two policies identifies the limits of liability. The limits of liability for each of defendants' two policies or $25 million for each occurrence. In addition, section 1 of the two policies states each underlying policy has a $25 million aggregate annual limit of liability.

The indemnification language at issue is set forth in section 2 of the policies as follows: "[Defendant] will indemnify the INSURED against EXCESS NET LOSS arising out of an accident or occurrence during the policy period, subject to the limits of liability stated in Section 1. and to all of the terms of this policy. [¶] 'INSURED' means any person or organization who qualifies as an Insured under the terms of the Controlling Underlying Insurance. [¶] 'EXCESS NET LOSS' means that part of the total of all sums which the INSURED becomes legally obligated to pay or has paid, as damages on account of any one accident or occurrence, and which would be covered by the terms of the Controlling Underlying Insurance, if written without any limit of liability, less realized recoveries and salvages, which is in excess of any self-insured retention and the total of the applicable limits of liability of all policies described in Section 3. Schedule of Underlying Insurance; whether or not such policies are in force. [¶] Loss shall not include any costs or expense in connection with the investigation or defense of claims or suits, or interest on any judgment which accrues after entry of the judgment."

Section 3 of defendant's two excess policies identifies the underlying insurance policies. Defendant's two excess policies identify unspecified Utica Mutual Insurance Company umbrella liability policies. When referring to the underlying insurance policies, defendant's two excess policies use the terminology "TBD." The parties do not dispute that the Utica Mutual Insurance Company policies assigned policy No. GLA25439 are the underlying insurance subject to defendant's two excess policies. Defendant's two excess policies identify both the individual occurrence and aggregate

liability limits in the underlying Utica Mutual Insurance Company umbrella policies. Defendant's two excess policies specify the underlying Utica Mutual Insurance Company umbrella policies each have $25 million coverage for each occurrence with a $25 million aggregate liability limit.

IV. ISSUES PRESENTED BY THE PARTIES AND THE STATEMENT OF DECISION

Prior to trial, the parties agreed there were five specific coverage issues to be decided. The five specific coverage issues were whether: the 1977-1982 Utica Mutual Insurance Company primary policies issued to plaintiff were subject to aggregate limits; defendant's policies attached upon losses exceeding the underlying Utica Mutual Insurance Company policies' aggregate limits; defendant's policies, to be triggered, required exposure to asbestos or merely bodily injury during the policy period; the payment of defense costs eroded the aggregate limits of the Utica Mutual Insurance Company umbrella policies; and under the pro rata allocation method, plaintiff has properly allocated uninsured and underinsured periods. As to this final issue concerning pro rata allocation, the trial court also decided the following issues, whether: plaintiff should be allocated a pro rata share of asbestos liabilities for the years 1933 to 1955; plaintiff should be allocated a pro rata share of asbestos liabilities for 1955 through 1981; and plaintiff should be allocated a pro rata share of asbestos liabilities for the years following 1985. The trial court found as follows as to these issues: the 1977-1982 Utica Mutual Insurance Company primary policies are subject to aggregate limits; defendant's excess policies attach upon losses exceeding the Utica Mutual Insurance Company policies' aggregate limits; defendant's policies were triggered by bodily injury rather than *mere exposure to asbestos* during the policy periods; and the payment of defense costs did not count in determining exhaustion of the aggregate limits of the Utica Mutual Insurance Company umbrella policies. As to the fifth coverage issue, the trial court found as follows: plaintiff was allocated $25,000 per year from 1933 to 1955 for

payments to asbestos claimants; for the time frame between 1955 through 1981, plaintiff was not allocated any pro rata share for payments to asbestos claimants; and no pro rata share of costs for payments to asbestos claimants was allocated to plaintiff for the post-1985 time period.

Defendant appealed after the filing of the final statement of decision. Typically, a final statement of decision cannot be the basis of an appeal. (*Allen v. American Honda Motor Co.* (2007) 40 Cal.4th 894, 901; *In re Marriage of Campi* (2013) 212 Cal.App.4th 1565, 1570-1571.) An appeal may proceed if a filed and signed final statement of decision constitutes the trial court's final decision on the merits. We asked the parties to address the question of whether there was an appealable determination. (*Allen v. American Honda Motor Co., supra,* 40 Cal.4th at p. 901; *In re Marriage of Campi, supra,* 212 Cal.App.4th at pp. 1570-1571.) Both sides have expressly indicated in writing that the signed and filed statement is decision does just that--finally resolves the dispute on its merits. Hence, upon remittitur issuance, no further proceedings are to occur in the trial court except in connection with costs on appeal. This opinion brings this dispute to a complete and final resolution.

V. DISCUSSION

A. Forfeiture

Plaintiff argues that defendant failed to comply with its obligations to set forth all of the material evidence. As a result, plaintiff argues that defendant has forfeited all of its sufficiency of the evidence contentions. We agree with the entirety of plaintiff's argument. Defendant's briefing omits virtually all of the evidence which is adverse to its positions. Once a reader has a handle on the facts of the case, the legal issues are not difficult. But defendant has failed comply with its duty to fairly set forth the significant evidence. (Cal. Rules of Court, rule 8.204(a)(2)(C); *Singh v. Lipworth* (2014) 227 Cal.App.4th 813, 817.) Defendant's reply brief provides no justification for declining to

find forfeiture because of the opening brief's incomplete and selective recitation of the evidence. Thus, all sufficiency of the evidence contentions have been forfeited. (*Forman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 881; *Duarte Nursery, Inc. v. Cal. Grape Rootstock Improvement Com.* (2015) 239 Cal.App.4th 1000, 1016.) Our discussion that follows is merely an alternative ground for affirming the judgment.

B. Attachment Point Contention

1. Trial court's interpretation

Defendant argues that the trial court failed to enforce the policies' language for when its excess duties are triggered. For clarity's purpose, we begin with the trial court's analysis of the basis of defendant's contention. Defendant does not quarrel with the manner in which the trial court articulated the issue. The trial court identified the issue as being whether defendant's policies attach upon a loss exceeding the underlying policies aggregate limits. The trial court posited the issue as follows: "The parties' dispute concerns the 'EXCESS NET LOSS' definition. The issue is whether the words 'on account of any one accident or occurrence' and 'applicable limits' means [defendant's policies] attach when there is an exhaustion of either the 'EACH OCCURRENCE' limits or the 'AGGREGATE' limits [] or only when there is exhaustion of the 'EACH OCCURRENCE' limits []." Thus, this is the dispute which we must decide—when exhaustion occurs.

The trial court explained that defendant's argument was that exhaustion occurs only when the policies' "each occurrence" limit has been exhausted. By contrast, plaintiff argued that defendants' policies attach when there is exhaustion of either the "each occurrence" limits or the "aggregate" limits. The trial court accepted plaintiff's argument as the more persuasive analysis of the language of the policies. The trial court explained that the policy language was ambiguous under New York law because it was susceptible to more than one reasonable interpretation. An insurance agreement is

ambiguous and subject to construction if it is susceptible to more than one reasonable interpretation. (*Selective Ins. Co. of America v. County of Rensselaer* (N.Y. 2016) 47 N.E.3d 458, 461; *Universal American Corp. v. Nat. Union Fire Ins. Co. of Pittsburgh, Pa.* (N.Y. 2015) 37 N.E.3d 78, 80; *White v. Continental Casualty Co.* (N.Y. 2007) 878 N.E.2d 1019, 1021.) Further, under New York law, any ambiguity must be resolved in the insured's favor. (*Selective Ins. Co. of America v. County of Rensselaer*, *supra*, 47 N.E.3d at p. 461; *White v. Continental Casualty. Co.*, *supra*, 878 N.E.2d at p. 1021.) Moreover, under New York law, the test for evaluating whether an insurance contract is ambiguous focuses on the average insured's reasonable expectations after reading the policy and employing common speech. (*Universal American Corp. v. Nat. Union Fire Ins. Co. of Pittsburgh, Pa.*, *supra*, 37 N.E.3d at p. 81; *Mostow v. State Farm Ins. Companies* (N.Y. 1996) 668 N.E.2d 392, 394.)

The trial court was persuaded that an average reasonable insured "reading the policy and employing common speech" would interpret the policy language as argued by plaintiff. According to the trial court, "It conveys the more common[]sense reading given that the 'EXCESS NET LOSS' definition uses 'limits,' a pluralized word, and directs the reader to the Schedule of Underlying Insurance, which identifies two kinds of 'applicable' umbrella policy limits - an 'EACH OCCURRENCE' limit and an 'AGGREGATE' limit, not just an 'EACH OCCURRENCE' limit." And, according to the trial court, defendant did not use clear and unambiguous language in the excess net loss definition to exclude coverage for losses exceeding the aggregate limit. Under New York law, an insurer which seeks to exclude coverage must do so in clear and unmistakable language. And any exclusions, under New York law, are given a strict and narrow interpretation. (*Federal Ins. Co. v. International Business Machines Corp.* (N.Y. 2012) 965 N.E.2d 934, 938; *Pioneer Tower Owners Assn. v. State Farm Fire & Cas. Co.* (N.Y. 2009) 908 N.E.2d 875, 877.)

Further, the trial court relied on the following evidence to resolve any ambiguity in the policies' language. Barry Bradshaw, plaintiff's former general counsel, testified he was concerned about and desired to purchase coverage for losses in excess of an

aggregate limit. Mr. Bradshaw testified: "If we reached the aggregate limit, and I wanted to have coverage in excess of the aggregate limit. [¶] . . . If the aggregate was 500,000 and there was a claim for $500,000, that would take it out. [¶] Or if there were three claims for 200-, 133-- or -- or whatever number, would take it up, so when they added it up, the total of the claims could wipe it out too." Mr. Bradshaw conveyed these expectations to the broker who secured the coverage from Utica Mutual Insurance Company. (The same broker secured coverage provided by defendant's excess policies.)

Moreover, one of defendant's training bulletins, which was used to train its employees, explained there were two types of catastrophic losses. One such loss would be an individual incident while the other would be a depletion of an aggregate limit. According to defendant's training bulletin, one of the aggregate exposures involved asbestos claims. Defendant's training Bulletin No. 801 states in part: "Excess Liability placements are used by an account to obtain high limits of coverage for possible catastrophic losses. Such catastrophic losses can be of the individual type or can be caused by the depletion of an aggregate limit. An example of an individual catastrophic loss would be an occurrence such as a hotel fire where numerous people suffer injury. Aggregate exposures will be represented by product losses arising out of such areas as . . . asbestosis . . . *that is subject to an aggregate limit in the umbrella*." (Italics added.) Also, James Britt, a former employee of The Aetna Casualty and Surety Company, testified that Bulletin No. 801 was used to train employees. The training involved what is now the defendant's excess policies.

Dennis Connolly testified as to a meeting of the leadership of The Aetna Casualty and Surety Company. The meeting was held at the insurer's Hartford, Connecticut headquarters. After a thorough discussion of the issues, the company's president, William Bailey, concluded that the policies at issue would attach once the aggregate limits were exhausted.

Additionally, the trial court noted that defendant had not asserted its current interpretation of the trigger limits prior to 2009. Defendant's initial letters in response to plaintiff's claims did not assert that its coverage only attached when the "excess net loss"

resulted from a single occurrence. And there was evidence that The Aetna Casualty and Surety Company inserted an "Asbestos Exclusion" in some other policies during the 1980s. The exclusion stated, "[A]sbestos loss will not count towards the exhaustion of an underlying product aggregates before [the policy at issue] responds." And Stephen Sennott, a career employee of defendant, gave evasive answers to questions directed at why it was necessary for an asbestos exclusion to be inserted in defendant's excess policies. When pressed for an answer, Mr. Sennott claimed, "I'm not really sure what the intent of this was."

2. The trial court's analysis was correct

We agree with the trial court's assessment. There is ambiguity in the language of the policies as to when defendant's duties are triggered. We reach this conclusion based upon the totality of the extraneous evidence; not merely the testimony of a single witness or content of a document. In the face of ambiguity in the insurance policy language, defendant's contention that extraneous evidence is not reviewed under New York law is meritless. (*State v. Home Indem. Co.* (N.Y. 1985) 486 N.E.2d 827, 829; *Campanile v. State Farm Gen. Ins. Co.* (N.Y.App. 1990) 161 A.D.2d 1052, 1054; see *In re Prudential Lines Inc.* (2d Cir. 1998) 158 F.3d 65, 77; *American Home Products Corp. V. Liberty Mutual. Ins. Co.* (S.D.N.Y. 1983) 565 F.Supp. 1485, 1500; *Hartford Accident & Indemnity Co. v. Wesolowski* (N.Y. 1973) 305 N.E.2d 907, 909.) As the trial court's foregoing analysis demonstrates, defendant's excess duties were triggered when either the occurrence or aggregate limits were exceeded under New York law. We need not address the parties' remaining contentions.

C. Pro Rata Risk Arguments

1. Overview

Defendant argues the trial court violated New York law in allocating financial responsibility for the payment of asbestos claims. In defendant's view, the trial court failed to impose greater financial responsibility on plaintiff to pay asbestos claims as mandated by New York law. Defendant argues, "The trial court applied an allocation methodology contrary to pro rata time-on risk principles as established by New York law." According to defendant, there are three separate time periods. First, between 1933 and 1954, according to defendant, plaintiff could have purchased more coverage. Second, between 1955 and 1985, plaintiff purchased liability insurance but in amounts which were exhausted. Third, after 1985, plaintiff purchased liability insurance but it included asbestos exclusions. Defendant argues: "As of 1933-1954, the [t]rial [c]ourt allocated some liability to [plaintiff], but capped that allocation at $25,000 in the aggregate per year. Its rationale was that [defendant] bears the unprecedented burden to show there was more coverage than $25,000 in the aggregate per year 'generally available' to [plaintiff] during that period and that [defendant] did not do so. [] Likewise, for 1955-1985, the [t]rial [c]ourt placed the same unprecedented burden on [defendant], concluded [defendant] failed to meet it and allocated nothing to [plaintiff] for this period. [] With respect to post-1985, the [t]rial [c]ourt adopted an 'unavailability' exception to pro rata allocation for this period when it concluded insurance coverage for asbestos liabilities was not generally available. [] These are errors under New York law." We conclude no reversible error occurred.

2. The development of New York law concerning pro rata allocation of insurance indemnification principles

a. coverage duties in cases involving asbestosis

We begin by explaining the development of New York law concerning an insurer's duties to provide coverage in cases involving progressive diseases such as asbestosis. In *American Home Products Corp. v. Liberty Mutual Ins. Co*, *supra*, 565 F.Supp. at pages 1489-1497, the insured, which was provided coverage under a comprehensive general liability policy, sold pharmaceuticals. The insured was sued in products liability suits and sought a determination its comprehensive general liability policies provided both defense and indemnification duties. (*Id.* at pp. 1488-1489.) The district court discussed the meaning of an occurrence clause in an insurance coverage case. As a general rule, the district court held: "Thus, an occurrence of 'personal injury, sickness, or disease' is read to mean any point in time at which a finder of fact determines that the effects of exposure to a drug actually resulted in a diagnosable and compensable injury. Depending upon the facts of each case, the drug involved, the period and intensity of exposure, and the person affected, an injury may occur in this sense upon exposure, at some point in time after exposure but before manifestation of the injury, and at manifestation. This construction is supported by the policy's language and background, the intentions and expectations of the parties, and considerations of practicability and fairness. It provides liberal protection to the insured, without doing violence to the principle—long a part of the law of New York—that insurance policies are contracts under which insureds obtain all the protection for which they may reasonably be said to have paid, but not more." (*Id.* at p. 1489.) As we will note, on appeal, the "diagnosable and compensable" language in the foregoing paragraph was disapproved by the Second Circuit panel. (*American Home Products Corp. v. Liberty Mutual Ins. Co.* (2d Cir. 1984) 748 F.2d 760, 764-766.)

The district court then analyzed these broad insurance coverage principles in the context of a progressive disease: "The plain meaning of the 'occurrence' clause is no secret to the parties. Courts and writers have recognized that 'occurrence' is most logically construed to include only those injuries, sicknesses, or diseases that are proved to have existed during coverage. For example, in [*Ins. Co. of North America v.*] *Forty-Eight Insulations*[*, Inc.* (6th Cir. 1980) 633 F.2d 1212, 1217, footnote omitted] the Sixth Circuit stated: [¶] ['']In each case where a plaintiff sues an asbestos manufacturer, a hearing could be held to determine at what point the build-up of asbestos in the plaintiff's lungs resulted in the body's defenses being overwhelmed. At that point, asbestosis could truly be said to "occur". From then on, all companies which insured the manufacturer would be treated as being "on the risk".['']" (*American Home Products Corp. v. Liberty Mutual. Ins. Co.*, *supra*, 565 F.Supp. at p. 1497.) The Sixth Circuit's *Ins. Co. of North America* decision cited in the foregoing quotation arose from asbestos suits. (*Ins. Co. of North America v. Forty-Eight Insulations, Inc.*, *supra*, 633 F.2d at p. 1213.)

The district court summed up its assessment of New York insurance coverage law thusly: "The most basic demand of the policy language is that to establish Liberty's liability the insured must prove that an 'occurrence'—injury, sickness, or disease—arose during the policy period. The plain language demands that the insured prove the cause of the occurrence (accident or exposure), the result (injury, sickness, or disease), and that the result occurred during the policy period. An exposure that does not result in injury during coverage would not satisfy the policy's terms. On the other hand, a real but undiscovered injury, proved in retrospect to have existed at the relevant time, would establish coverage, irrespective of the time the injury became manifest." (*American Home Products Corp. v. Liberty Mutual. Ins. Co.*, *supra*, 565 F.Supp. at p. 1497.)

The Second Circuit affirmed virtually all of the district court's analysis: "We agree with the district court's conclusion, substantially for the reasons stated in its opinion, that the trigger-of-coverage clause unambiguously provides for coverage based upon the occurrence during the policy period of an injury in fact. We reject only so much of the court's decision as holds that 'injury in fact' means an injury that was

'diagnosable' or 'compensable' during the policy period." (*American Home Products Corp. v. Liberty Mutual Ins. Co.*, *supra*, 748 F.2d at p. 764; see *Stonewall Ins. v. Asbestos Claims Management Corp.* (2d Cir. 1995) 73 F.3d 1178, 1194; *Continental Casualty v. Rapid-American* (N.Y. 1993) 609 N.E.2d 506, 511 [applying "injury-in-fact" test].) The Second Circuit panel, paraphrasing the district court, held: "To paraphrase the district court's analysis rejecting the manifestation theory, 'a real but undiscovered injury, proved in retrospect to have existed at the relevant time, would establish coverage, irrespective of the time the injury became [diagnosable].' 565 F.Supp. at 1497." (*American Home Products Corp. v. Liberty Mutual Ins. Co.*, *supra*, 748 F.2d at p. 766; see *Stonewall Ins. v. Asbestos Claims Management Corp.*, *supra*, 73 F.3d at p. 1194.)

The Second Circuit panel otherwise rejected the insurer's argument that coverage only applies once the disease manifests itself: "The provision that the policies give coverage for occurrences that cause injury, read with the provision that the policies apply only to 'personal injury, sickness or disease . . . which occurs during the policy period,' clearly supports the court's conclusion that coverage is triggered by injury in fact. Liberty's construction of 'injury' as 'manifestation of injury' is inconsistent with this language. Some types of injury to the body occur prior to the appearance of any symptoms; thus, the manifestation of the injury may well occur after the injury itself. There is no language in the policies that purports to limit coverage only to injuries that become apparent during the policy period, regardless of when the injury actually occurred. Therefore, we agree with the district court that Liberty's manifestation interpretation is not reasonable." (*American Home Products Corp. v. Liberty Mutual Ins.Co.*, *supra*, 748 F.2d at p. 764.) The foregoing Second Circuit discussion is recognized as accurately synthesizing New York law on triggering coverage in the case of progressive disease. (*Uniroyal, Inc. v. Home Ins. Co.* (E.D.N.Y. 1988) 707 F.Supp. 1368, 1388.) Also, the foregoing New York injury in fact rules apply generally to both primary and excess insurers in asbestosis cases. (See *Stonewall Ins. v. Asbestos Claims Management Corp.*, *supra*, 73 F.3d at p. 1194.)

b. pro rata allocation of risk and financial responsibility

These insurance coverage issues arising in the context of progressive diseases have an additional complexity when there are periods where the insured has no coverage, is underinsured or is covered. There are two types of relevant liability in an insurance coverage context—joint and several liability or, in the alternative, individual liability. New York law, in our situation, imposes potential individual and proportionate liability on a carrier issuing a comprehensive general liability policy. (*Consolidated Edison Co. of N.Y., Inc. v. Allstate Ins. Co.* (N.Y. 2002) 774 N.E.2d 687, 694-695 (*Consolidated Edison*); see *Ins. Co. of North America v. Forty-Eight Insulation, Inc.*, *supra*, 633 F.2d at p. 1225.)

Further, when multiple policies apply in the context of asbestos-like gradual diseases, New York law provides that each carrier's liability is allocated. The manner in which financial responsibility of each carrier apportioned is referred to under New York law as pro rata allocation. (*Consolidated Edison*, *supra*, 774 N.E.2d at p. 695.) Each insurer is liable for its pro rata share of the insured's financial losses paying and defending asbestos claims. (*Ins. Co. of North America v. Forty-Eight Insulations, Inc.*, *supra*, 633 F.3d at p. 1225.) The New York Court of Appeals explained: "Proration of liability among the insurers acknowledges the fact that there is uncertainty as to what actually transpired during any particular policy [citation]." (*Consolidated Edison*, *supra*, 774 N.E.2d at p. 695 citing *Sybron Transition Corp. v. Security Ins. Of Hartford* (7th Cir. 2001) 258 F.3d 595, 602.) The reason New York courts reject joint and several liability but opt instead for an individualized pro rata duty to indemnify was explained by the Court of Appeals: "The Court observed that joint and several allocation is particularly inappropriate where 'it is impossible to determine the extent of the . . . damage that is the result of an occurrence in a particular policy period' because it 'presupposes [an] ability to pin an accident to a particular policy period' [Citations.]" (*Roman Catholic Diocese of Brooklyn v. Nat. Union Fire Ins. Co. of Pittsburgh, Pa.* (N.Y. 2013) 991 N.E.2d 666, 676, quoting *Consolidated Edison*, *supra*, 774 N.E.2d at pp. 694-695.) Using a pro rata

allocation as New York courts do in this context is based on principles of equity and policy rather than contract language. (*E.R. Squibb & Sons, Inc. v. Lloyd's & Companies* (2nd Cir. 2001) 241 F.3d 154, 171, fn. 9; *In re Prudential Lines Inc., supra*, 158 F.3d at p. 85.)

Although not entirely pertinent to the remaining issues in this case, courts applying New York law have approved the use of the so-called "time-on-the-risk" method of allocating risk. In *Consolidated Edison*, *supra*, 774 N.E.2d at page 695, an asbestos case, the Court of Appeals held: "[T]he trial court was presented with the 'time-on-the-risk' method as an alternative to Con Edison's 'joint-and-several' approach. The court applied 'time on the risk' and thus dismissed claims against policies that would not be reached under Con Edison's highest estimate of damages. That was not error." New York's time-on-the-risk theory was described in a Second Circuit opinion, "The [pro rata] was determined by multiplying the judgment or settlement by a fraction that has as its denominator the entire number of years of the claimant's injury, and as its numerator the number of years within that period when the policy was in effect." (*Stonewall Ins. v. Asbestos Claims Management Corp.*, *supra*, 73 F.3d at p. 1202; see *Olin Corp. v. Ins. Co. of North America* (2000) 221 F.3d 307, 327 (*Olin Corp.*); *Keyspan Gas East Corp. v. Munich Reinsurance America, Inc.* (N.Y.App. 2014) 998 N.Y.S.2d 781, 785; *Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.* (N.Y.App. 2006) 822 N.Y.S.2d 30, 32-33.) Courts have held that the "time-on-the-risk" method of allocating risk applies both to indemnification and defense costs. (*Towns v. Northern Security Ins. Co.* (Vt. 2008) 964 A.2d 1150, 1166-1167.)

A comparatively simple example of the "time-on-the-risk" allocation was explained in *Serio v. Public Service Mutual Ins. Co.* (N.Y.App. 2003) 759 N.Y.S.2d 110 at pages 111-115. *Serio* involved a settlement by two successive insurers and a claim based upon exposure to lead paint. (*Id.* at pp. 111-112) One of the insurers had provided coverage for two of the years when potential exposure occurred. (*Id.* at p. 111) The other insurer only provided coverage for a single year. (*Ibid.*) The appellate division described the issue before it: "[W]e address a matter of great importance concerning the

apportionment of liability between successive insurers for losses caused by a child's exposure to lead paint. Where the exposure occurred over a period of three years, and where the two insurers covered that loss, respectively, during consecutive periods of two and one years, we hold that each insurer shall bear a share of liability for the purpose of funding their negotiated settlement with the injured parties, directly proportionate to each insurer's time on the risk." (*Id*. at p. 111.) The appellate division held that each insurer was thus responsible for paying a proportional share of the loss which arose during their respective policy periods. (*Id*. at p. 116.) One insurer paid for two thirds of the settlement while the other paid for one third of the settlement. (*Ibid.*)

New York has adopted a special rule for apportioning or prorating claims when an insured has no insurance or is under-insured. The Second Circuit described how New York law treats an insured who fails to purchase insurance or is underinsured when conducting pro rata allocation of responsibility for asbestos claims: "The District Court had ruled, on motion for summary judgment, that the obligations of all triggered policies were to be prorated based upon the policies' respective triggered time periods with one significant qualification. That qualification, referred to as the 'proration-to-the-insured approach,' required the insured to bear a pro rata share of payment obligations for any periods in which the insured had no insurance, either because it did not purchase insurance or because the insurance it purchased had been consumed by prior payments. In effect, the insured was treated for uninsured periods as if it was an insurer that had issued an insurance policy to itself, and it was included in the allocation formula in the same way as the other insurers. [Fn. Omitted.]" (*Stonewall Ins. v. Asbestos Claims Management Corp*. (2d Cir. 1996) 85 F.3d 49, 50; accord, *Stonewall Ins. v. Asbestos Claims Management, supra*, 73 F.3d at p. 1194; *Ins. Co. of North America v. Forty-Eight Insulations, Inc., supra*, 633 F.2d at p. 1225.) A Second Circuit panel described the effect of New York's proration to the insured rules of allocating responsibility to a insured who purchases no or insufficient insurance: "Allocation also forces an insured to absorb the losses for periods when it self-insured and can prevent it from benefiting from coverage for injuries that took place when it was paid no premiums. [Citations.]" (*Olin*

Corp., supra, 221 F.3d at p. 323; see *Towns v. Northern Security Ins. Co., supra,* 964 A.2d at p. 1167.)

Proration-to-the insured principles do not apply when coverage for a risk is *unavailable*. (*Olin Corp., supra,* 221 F.3d at p. 325; *Stonewall Ins. v. Asbestos Claims Management Corp., supra,* 85 F.3d at p. 50; *Stonewall Ins. v. Asbestos Claims Management Corp., supra,* 73 F.3d at p. 1194.) In *Olin Corp.*, the Second Circuit panel described a situation where comprehensive general liability coverage was unavailable for gradual pollution damages. The Second Circuit panel explained why, when allocating financial responsibility, the unavailability of insurance differs from when an insured chooses not to purchase a policy or is underinsured: "The district court found that beginning in 1971, 'for all practical purposes, Olin could not obtain general comprehensive liability [insurance] without a pollution exclusion [clause].' [*Olin Corp. v. Ins. Co. of North America* (S.D.N.Y. 1997) 986 F.Supp. 841,] 844. Coverage for gradual pollution damage to property therefore could not thereafter be obtained through the purchase of a CGL policy. *See id.* [¶] An insured assumes a share of the risk 'either by declining to purchase available insurance or by purchasing what turn[s] out to be an insufficient amount of insurance.' *Stonewall,* 73 F.3d at 1204. For Olin to have decided to 'assume or retain [the] risk,' there had to have been an opportunity for it to obtain some form of generally available insurance for this sort of risk. Otherwise the decision to 'go bare' was not made by Olin; it was imposed on Olin by the marketplace." (*Olin Corp., supra,* 221 F.3d at p. 325.)

If a policy's benefits are modified to exclude coverage for a particular risk, the policyholder cannot avoid proration to the insured if other available policies are not purchased. (*Olin Corp., supra,* 221 F.3d at p. 326.) Citing its prior discussion in *Stonewall Ins. v. Asbestos Claims Management Corp., supra,* 73 F.3d at page 1203 concerning the failure to purchase any or sufficient insurance, the Second Circuit panel explained: "We did not suggest that the relevant inquiry was limited to whether an insured was able to continue obtaining coverage for the particular risk in the same policy type, without an exclusion. If coverage under one type of policy becomes unavailable by

exclusion, and the insurance customer can but does not buy the excluded coverage separately or in another policy type, it follows that the customer has opted to self-insure." (*Olin Corp. v. Insurance Co. of North America*, *supra*, 221 F.3d at p. 326.) In *Olin Corp. v. Ins. Co. of North America*, *supra*, 986 F.Supp at page 844 the district court found that other insurance was available to cover the risk at issue. The Court of Appeals distinguished the case before another panel in *Stonewall Ins.* discussion about prorating to the insured when insurance to cover a risk was unavailable: "We agree with the district court that its findings as to the general availability of insurance that would have covered the risk at issue here and Olin's failure to obtain it were all that was necessary to allocate the uninsured years to Olin. There was no need to analyze whether Olin subjectively elected to forego insurance and self-insure. [¶] *Stonewall*, we think, stands for that proposition. While the opinion does use the term 'elected,' the touchstone of our analysis was availability, not election. *See Stonewall,* 73 F.3d at 1204 (referring to district court's application of proration 'to years when asbestos liability insurance was no longer available'). And we said that 'periods of no insurance reflect a decision by an actor to assume or retain a risk' when it 'is reasonable' to 'expect the risk-bearer to share in the allocation,' comparing such periods 'to periods when coverage for a risk is *not available*.' *Id.* at 1203 (emphasis added and internal quotation marks omitted) (quoting *Owens–Illinois*[, *Inc. v. United Ins. Co.* (N.J. 1994)] 650 A.2d [974,] 995)" (*Olin Corp.*, *supra,* 221 F.3d at p. 325.)

3. Standard of review

It bears emphasis that New York jurisprudence regarding prorated allocation of losses involves the application of equitable principles. (*E.R. Squibb & Sons, Inc. v. Lloyd's & Companies*, *supra,* 241 F.3d at p. 172, fn. 9; *In re Prudential Lines Inc*., *supra,* 158 F.3d at p. 85.) Under New York law, a trial court's application of equitable principles is reviewed for an abuse of discretion. (*Holterman v. Holterman* (N.Y. 2004) 814 N.E.2d 765, 769; *Rosemont Enters v. Irving* (N.Y. 1977) 361 N.E.2d 1040, 1041; see *Peabody Essex Museum, Inc. v. U.S. Fire Ins. Co.* (2015) 802 F.3d 39, 47 ['We review . .

. for an abuse of discretion the court's . . . selection of the allocation method."]; *Boston Gas Co. v. Century Indemnity Co.* (1st Cir. 2013) 708 F.3d 254, 259 [in coverage action, abuse of discretion standard of review applies to determination that insurer's limited time on the risk had the effect of reducing its share of the damages to less than 15 percent].) Thus, we will evaluate the trial court's allocation rulings for an abuse of discretion.

4. The trial court's ruling concerning the 1933-1954 and 1955-1985 periods

Defendant argues that the trial court committed error by "[c]apping" the proration to the insured for the years 1933-1985. On appeal, the parties have divided this time frame into two separate periods; 1933 through 1955 and 1955-1985. The trial court expressly found that defendant failed to present evidence that plaintiff could have purchased insurance during the relevant time frame. The trial court found that defendant failed to present any significant evidence concerning how much more insurance should have been purchased. Further, the trial court expressly found the evidence presented by plaintiff as to the amount of insurance it maintained was credible. For clarity purposes, we will identify the evidence which supports the trial court's decision in connection with the 1933 through 1985 time frame. Then we will briefly discuss why, based on the evidence presented to it, the trial court did not err. From a factual perspective, the principal issue is the availability of insurance to reimburse manufacturers for indemnification and defense costs resulting from asbestos claims from 1933 through 1985.

James Robertson an insurance risk management consultant, testified as to the availability of excess coverage in 1930's and 1940's. Mr. Robertson testified at his deposition, "The concept of exhausting product liability aggregate would have been shocking to policyholders and underwriters in the 1920s and the 1930s." Mr. Robertson testified that during 1920's and 1930's, there was no coverage available in the insurance marketplace that would have provided coverage after exhaustion of an underlying aggregate limit. In the 1980's, the only excess insurance sold by Aetna Casualty and Surety Company was in the format of the policies purchased by plaintiff.

Dennis Connolly an insurance law attorney also testified concerning the availability of insurance in the 1930's and 1940's. Typically, during that time, the limits were quite small with an aggregate generally not exceeding $25,000. Most policies did not include product liability coverage. Mr. Connolly relied upon a study prepared by S.B. Ackerman which indicated that in 1948 the standard limits for product liability were: $5,000 for injury to one person; $10,000 for injury to several persons in one accident; and an aggregate limit of $25,000 for the entire term of the policy. Also, for the years 1933, 1937, 1944 and 1946, Mr. Connolly, after reviewing an analysis prepared by A.M. Best Company , concluded: "[F]or each of these years the product liability insurance being written was a minuscule part of the casualty insurance being written in the United States and actually in London, too."

Mr. Connolly testified that between 1943 to 1960, products liability was not considered universally to be a hazard that warranted insurance coverage. The exception to this general rule were "recognized ultrahazardous risk categories" such as pharmaceutical or aviation product manufacturing. Mr. Connolly also relied upon a study prepared by Randy Fields, a highly regarded insurance historian, concerning the need to secure insurance in the 1950's. In Mr. Fields's study, he surveyed almost 50 percent of the policies purchased during the 1950's. Mr. Fields's conclusion there was only a limited need to purchase products liability coverage was shared by manufacturing concerns and the legal community and insurance industry alike. For example, in the 1940's, the society was not particularly litigious and liability awards were much smaller.

However, potential product liability risks increased with changes in the law over a period of time. Mr. Connolly testified that over time changes in the law increased the risks and therefore the need for insurance by manufacturers such as plaintiff. Mr. Connolly testified the first million dollar verdict did not occur until the mid-1960's. None of the mass tort litigation resembled the modern phenomena. During this time frame, attorney advertising became permissible which enabled lawyers to perform a better job of aggregating victims. It was during the 1960's that umbrella coverage became available in the United States. Yet even during the time period between July 1,

1976, and March 15, 1977, claims involving pumps of all types were insignificant. During that time frame, a survey by the Insurance Services Office indicated that less than 0.7 percent of all closed claims involved pumps. This included pumps of all types. And the number of claims was so insignificant that it was not even registered statistically by the Insurance Services Office staff. According to Mr. Connolly, plaintiff's pumps at the time were neither considered to be a particularly hazardous product nor prone to litigation. Thus, there was no need to purchase a "lot" of insurance.

In addition, Mr. Bradshaw, plaintiff's former general counsel, testified in the 1970's plaintiff had only been sued in "very minor" products liability suit. The dollar amounts at issue in those suits was merely a "few thousand" dollars. During this time period, Mr. Bradshaw had never had to use his umbrella policies in a product liability case. Mr. Bradshaw's intent was to purchase sufficient insurance to cover any potential risk. Mr. Bradshaw received a letter from plaintiff's insurance broker Marsh & McLennan which stated, "Your loss in this line of insurance is unbelievable." The term "unbelievable" in this context meant good or favorable. Plaintiff's losses in 1976 through 1978 were $5,076, $19,905 and $257 respectively.

As a result, Mr. Connolly testified: "[T]he known limits of [plaintiff's] historic products liability insurance coverage for products were reasonable at the time [plaintiff] purchased insurance in light of the types of products [plaintiff] manufactured, [plaintiff's] loss history, [plaintiff's] revenue, and the contemporaneous legal environment." In assessing whether plaintiff purchased sufficient insurance, Mr. Connolly believe the following matters were relevant: the legal environment; social factors; claims arising during a particular period of time; and rules which allow for recovery by tort claimants. Mr. Connolly testified these matters were important, "Because you didn't have to buy a lot of insurance when there wasn't much liability or possibility of liability." Further, Mr. Connolly compared plaintiff's insurance purchases with those of larger corporations. Mr. Connolly testified: "[I]t would not be reasonable to expect that a company whose . . . size just wasn't anywhere near these other companies--it was unreasonable to expect that

they would be purchasing limits that matched these giant companies and that the company was, in fact, buying . . . limits that were approximately equal to its net income."

Mr. Bradshaw testified that in 1985 his client stopped using asbestos-containing products in their pumps. Until then, plaintiff's executives did not believe there was any possibility that the packing and gaskets which contained asbestos could cause injury to anyone. The first time plaintiff was sued in connection with asbestos exposure was in the mid-1980s.

In 1933-1955, defendant argues that it presented evidence that aggregate limits were available for substantially higher amounts during that time period. The trial court concluded that plaintiff in fact should bear a pro rata share for failing to purchase adequate insurance from 1933 to 1955. The trial court set plaintiff's pro rata share for the 1933-1955 time period at $25,000 annually.

As can be noted, there is evidence that products liability claims were not a matter of any consequence prior to the 1950's. There was testimony: in the 1920's and 1930's, it was unheard of to exhaust product liability aggregates; in the same time frame, there is no policy provided coverage after exhaustion of the underlying aggregate limit; in the 1930's and 1940's policy limits were quite small with aggregate limit not exceeding $25,000; most policies did not include product liability coverage; the study conducted by Mr. Ackerman indicated that by 1948 the aggregate limits were $25,000 for the entire term of the policy; throughout the 1930's and 1940's, product liability coverage was a minuscule part of casualty insurance; from 1943 to 1960 product liability was not considered a hazard by the legal community, the insurance industry and manufacturing concerns; and the need for product liability insurance only arose after court decisions and changes in societal attitudes beginning in the mid-1950's. The trial court relied upon Mr. Connolly's testimony that the amount products liability coverage available at a maximum $25,000 in the aggregate. In doing so, the trial court did not violate New York law. Given our conclusion concerning the 1933 to 1955 time frame, we need not address plaintiff's waiver argument.

We now turn to the time period of 1955 through 1981. Defendant argues plaintiff could have purchased more insurance. Defendant argues that another plaintiff in this case purchased more insurance. We agree with plaintiff that there is substantial evidence it purchased more insurance than it needed.

Mr. Bradshaw testified he purchased insurance with an eye to taking care of "any losses that could occur during" the policy period. Mr. Bradshaw testified: "I wanted to be sure that if something happened or a series of something happened, I wanted to be covered. [¶] [O]ur company was a public company. I didn't want to have some unexpected big loss coming up that would mess up the earnings. [¶] If it did, I probably wouldn't have a job, so I was worried about that too." When the insurance purchasing decisions were made, Mr. Bradshaw knew that in the 1970's, plaintiff had only been sued in very minor cases on product liability theories. During that time frame, plaintiff found it necessary to utilize the umbrella policies. Further, plaintiff's loss history, according to Mr. Connolly, was "extremely good" with "very low losses" during the 1970's.

In 1981, Mr. Robertson wrote that prior to that year, it was difficult to convince companies to purchase more than $1 million in umbrella limits. And, as noted, Mr. Connolly testified that plaintiff's insurance purchasing strategies were reasonable in light of: the products it manufactured; its loss history and revenue; and the contemporaneous legal environment. Mr. Connolly took into account the fact that plaintiff's products were "not particularly prone to litigation" of the type that would require a "lot" of insurance. Plaintiff's pumps were considered a "relatively benign product" in Mr. Connolly's view. Further, Mr. Connolly concluded it would be unreasonable to expect plaintiff to secure more insurance when compared with the purchases of larger companies. Finally, as the trial court explained in its statement of decision, there is insufficient evidence as to how much insurance should have been purchased. To sum up: Mr. Bradshaw made purchases with the intention of covering any potential loss; there was testimony that the amount of insurance maintained by plaintiff was sufficient to meet any potential needs; and the evidence is insufficient as to how much more insurance should have been purchased.

Based upon the foregoing, the trial court reasonably declined to prorate any liability to plaintiff between 1955 and 1981 on an underinsured theory.

5. The trial court's refusal to prorate responsibility to plaintiff for post-1985 indemnification and defense costs

The trial court ruled that after 1985, coverage for asbestos claims was unavailable. Since asbestosis coverage was unavailable, the trial court declined to prorate any financial obligation to plaintiff. Defendant reasons argues that the New York Court of Appeals has never upheld an unavailability exception to prorating responsibility to the insured. This contention is meritless.

To begin with, the issue of proration to the insured when a particular type of coverage is unavailable has never been discussed by the New York Court of Appeals. But, as we have previously discussed, federal and state courts when applying proration to the insured jurisprudence as they apply New York law do directly address the issue. And they all hold that if insurance is unavailable, the insured may have no costs prorated to it. (*Olin Corp., supra*, 221 F.3d at p. 326; *Stonewall Ins. v. Asbestos Claims Management Corp., supra,* 85 F.3d at p. 50; *Stonewall Ins. v. Asbestos Claims Management Corp., supra,* 73 F.3d at p. 1204; *Keyspan Gas East Corp. v. Munich Reinsurance America, Inc., supra*, 998 N.Y.S.2d at p. 785.)

The trial court's findings of unavailability of such insurance after 1985 are supported by the record. It is widely recognized that asbestos liability insurance ceased to be available by 1986. (*Sybron Transition Corp. v. Security Ins. of Hartford*, *supra*, 258 F.3d at p. 599; *Stonewall Ins. v. Asbestos Claims Management Corp., supra*, 85 F.3d at p. 50; *Stonewall Ins. v. Asbestos Claims Management Corp., supra,* 73 F3d at pp. 1203-1204; *U.S. Fidelity & Guaranty Co. v. Treadwell Corp.* (S.D.N.Y. 1999) 58 F.Supp.2d 77, 104.) Mr. Robertson was unable to identify a single insurer who would issue asbestos coverage to plaintiff in 1985 given its loss experience. In fact, by the early

1980s, the proliferation of asbestos litigation threatened the financial stability of the insurance markets.

Further, there was testimony from Mr. Connolly that meaningful bodily injury asbestos coverage was unavailable to plaintiff and similarly situated policyholders after 1985. Brian Gagan, a broker who had worked in the insurance profession since 1954 and was retained by defendant to offer opinion testimony, testified: "We had clients who were being sued for asbestos products. So when the coverage would come up for renewal, we would attempt to obtain coverage on some basis. We were uniformly unsuccessful in doing that. The outcome was always the same. We could not find an insurer who could provide coverage for asbestos products." According to Mr. Gagan, he was unable to secure asbestos coverage after the late 1970s. Accordingly, the trial court correctly identified the applicable New York law concerning proration of financial responsibility when an insured could not purchase insurance for a particular risk. Under any standard of appellate review, sufficient evidence supported the trial court's application of the facts to this applicable rule of law.

6. Burden issue

Defendant argues that the trial court improperly required it to prove, for pro rata allocation purposes, whether insurance was available during particular time periods. Defendant has cited no decisions by New York courts which support its contention the burden rested with plaintiff. In any event, there are decisions which indicate in the pro rata allocation context that the burden rests with the insurer. (*Keyspan Gas East Corp. v. Munich Reinsurance America, Inc.*, *supra*, 998 N.Y.S.2d at p. 787; see *Chemical Leaman Tank Lines, Inc. v. Aetna Casualty and Surety Co.* (3d Cir. 1999) 177 F.3d 210, 231.) And, New York law concerning imposing a burden on a party is consistent with the trial court's ruling. In the insurance context, the burden of proof is imposed on the party with the better and easier access to the relevant facts. (*Northville Industries Corp. v. Nat. Union Fire Ins. Co. of Pittsburgh, Pa.* (N.Y. 1997) 679 N.E.2d 1044, 1049; *Consolidated*

Edison, *supra*, 774 N.E.2d at p. 692.) It makes sense that an insurer would have better and easier access to information concerning coverage offered by it and its competitors than would the insured. Also, defendant would be in a better position to assess underinsurance given its role as an insurer. Finally, defendant has failed to demonstrate that had the burden been otherwise placed upon plaintiff that the result would have been any different.

D. Exposure Issue

Defendant argues that the 1977-1983 Utica Mutual Insurance Company umbrella policies required an *exposure* to asbestos occur during the policy periods in order to trigger coverage. Defendant reasons as follows: the Utica Mutual Insurance Company policies provide for indemnity for an occurrence; its excess policies are subject to the same definition for an occurrence; and the term "occurrence" requires exposure or inhalation of asbestos during the policy period. (*In re Liquidation of Midland Ins. Co.* (N.Y. Sup.Ct. 1994) 623 N.Y.S.2d 689, 691-694 (*Midland Ins. Co.*).) The trial court ruled: the controlling case was *Stonewall Ins. v. Asbestos Claims Management Corp.*, *supra*, 73 F.3d at page 1192, footnote 5; there was an ambiguity in the policy language; as a result, it was appropriate to examine extrinsic evidence; the extrinsic evidence, which we shall discuss later, required that an excess policy track the extent of protection provided by underlying policies; and the decision in the case of *Midland Ins. Co.*, *supra*, 623 N.Y.S.2d at pages 691-694 was not a correct statement of New York law.

Defendant's position has no merit. We set forth the relevant New York injury in fact decisional authority in part III(B)(2)(a) of this opinion. New York applies injury in fact analysis which requires the presence of an undiscovered injury during the relevant time frame provided by the policy. Exposure is not the relevant triggering event in all cases. (*Stonewall Ins. v. Asbestos Claims Management Corp.*, *supra*, 73 F.3d at p. 1194; *American Home Products Corp. v. Liberty Mutual Ins. Co.*, *supra*, 748 F.2d at p. 764; *Continental Casualty Co. v. Rapid-American Corp.* (N.Y. 1993) 609 N.E.2d 506, 511.) Somewhat complicating matters is that defendant's excess coverage is determined by the

occurrence language appearing in the underlying Utica Mutual Insurance Company policies. (See *Olin Corp. v. American Home Assurance Co.* (2d Cir. 2012) 704 F.3d 89, 93-94; *J.P. Morgan Securities, Inc. v. Vigilant Ins. Co.* (N.Y. 2013) 992 N.E.2d 1076, 1079.) The trial court applied California law in interpreting the Utica Mutual Insurance Company policies. (*Hurtado v. Superior Court* (1974) 11 Cal.3d 574, 581-582; see *Beech Aircraft Corp. v. Superior Court* (1976) 61 Cal.App.3d 501, 522.) California's injury in fact rules, which only slightly differ from those in New York, do not support a finding that liability is triggered only upon exposure. (See *Stonewall Ins. v. Asbestos Claims Management Corp.*, *supra*, 73 F.3d at p. 1195-1196; *Montrose Chemical Corp. of Cal. v. Admiral Ins. Co.* (1995) 10 Cal.4th 645, 669-685; *U.S. Fidelity & Guaranty Co. v. American Re-Insurance Co.* (N.Y. 2013) 985 N.E.2d 876, 887.) Thus, under either New York or California law, defendant's exposure and trigger contentions have no merit.

Further, the trial court did not err in its line of analysis. The trial court concluded similar language in *Stonewall Ins. v. Asbestos Claims Management Corp.*, *supra*, 73 F.3d at page 1192, footnote 5 had been interpreted to permit the use of extrinsic evidence. In our case, there is evidence that the parties' expectations were the coverage remained the same throughout all the policy levels: Mr. Bradshaw testified the terms and conditions were to be the same throughout the primary, umbrella and excess policies; Mr. Connolly and Mr. Gagan testified the custom and practice in insurance profession was to have uniform layered coverage for insureds; Kristen Martin, senior vice-president at Utica Mutual Insurance Company, testified that her employer interpreted its primary and umbrella policies to apply to injury in fact scenarios; and defendant's own documents (or those of The Aetna Casualty and Surety Companies) indicated that the excess policies provide the same coverage as underlying insurance. We agree with the trial court's analysis concerning the state of the law and the evidence cited in the statement of decision supporting its conclusion. Finally, as noted, the trial court concluded the holding of the case of *Midland Ins. Co.*, *supra*, 623 N.Y.S.2d 689, the decision of only one judge, incorrectly stated New York law. We agree with the trial court that the

Midland Ins. Co. case is inconsistent with the remainder of New York law on the subject of triggers.

Defendant's related contention that the trial court should have made further findings concerning what triggered plaintiff's 1977-1983 Utica Mutual Insurance Company Policies is without merit. The statement of decision contains a lengthy analysis of when the policies were triggered. The request for further trigger findings is nothing more than a disguised effort to relitigate injury in fact issues. Both New York and California apply versions of the injury in fact rule as a trigger. (See *Stonewall Ins. v. Asbestos Claims Management Corp.*, *supra*, 73 F.3d at pp. 1195-1196; *Montrose Chemical Corp. of Cal. v. Admiral Ins. Co.*, *supra*, 10 Cal.4th at pp. 669-685; *U.S. Fidelity & Guaranty Co. v. American Re-Insurance Co.*, *supra*, 985 N.E.2d at p. 887.) Further findings were unnecessary because the statement of decision fairly disclosed the trial court's determinations as to the case's ultimate facts and material issues. (*Muzquiz v. City of Emeryville* (2000) 79 Cal.App.4th 1106, 1126; *Golden Eagle Ins. Co. v. Foremost Ins. Co.* (1993) 20 Cal.App.4th 1372, 1380.)

E. Aggregate Limits in the 1979-1982 Utica Mutual Insurance Company Primary Policies

Defendant argues that the 1979-1982 Utica Mutual Insurance Company primary policies have no product liability aggregate limits. The parties agree that the aggregate limit sections of the 1977 through 1981 Utica Mutual Insurance Company primary policies contain blank spaces. As noted, next to the language "Bodily Injury Liability and Property Damage Liability" the policies identify the aggregate limit thusly: "$,000." The primary policies do specify a $500,000 per occurrence limit. This language appears under the heading, "AMENDMENT--LIMITS OF LIABILITY [¶] (Single Limit) [¶] (Individual Coverage Aggregate Limit)". Thus, defendant argues that the 1977-1982 primary policies have no aggregate limits. To begin with, this contention is

frivolous as it relates to the January 1, 1982 Utica Mutual Insurance Company primary policy. That policy indisputably is subject to a product liability aggregate limit.

As noted, the trial court applied California law when interpreting the Utica Mutual Insurance Company policies. (*Hurtado v. Superior Court, supra,* 11 Cal.3d at pp. 581-582; see *Beech Aircraft Corp. v. Superior Court, supra,* 61 Cal.App.3d at p. 522.) Defendant is not a party to those policies; it merely provides excess coverage. We agree with plaintiff that defendant forfeited the right to argue that New York law controls the interpretation of the Utica Mutual Insurance Company policies. Prior to trial, defendant secured a ruling in response to an in limine motion that *New York law applied to its policies*. Trial commenced on July 30, 2012, and closing arguments were held on August 26, 2013. Testimony was received on a haphazard basis sometimes for a day or two at a time during the more than one year period the case was tried. For more than one year the case was tried on the theory that New York law applied to defendant's policies. After the tentative statement of decision was filed, defendant asserted for the first time that the Utica Mutual Insurance Policies were subject to New York law. Under these circumstances, defendant has forfeited the right to seek the protection of New York law as to the underlying policies. (*People v. Simon* (2001) 25 Cal.4th 1082, 1097-1103; *City of El Monte v. Superior Court* (1994) 29 Cal.App.4th 272, 279-280.) The issue was not presented until after the tentative statement of decision was issued. Thus, the issue of the application of New York law to the Utica Mutual Insurance Company underlying policies was not timely presented to the trial court.

Under California law, the use of secondary evidence was admissible to explain the absence of an aggregate limit in the policies from 1979 through 1982. (*Pacific Gas & Electric Co. v. G. W. Thomas Drayage & Rigging Co.* (1968) 69 Cal.2d 33, 37-39; *Fremont Indemnity Co. v. Fremont General Corp.* (2007) 148 Cal.App.4th 97, 114-115.) There is substantial evidence that the aggregate limit sections in the policies from 1979 through 1982 were left blank by mistake: Mr. Bradshaw, plaintiff's general counsel, testified his client's intention was to purchase policies with aggregate limits; plaintiff's broker, Marsh & McLennan, provided summaries to Mr. Bradshaw which showed

aggregate limits of $500,000; the binders and certificates of insurance issued to plaintiff contained a $500,000 aggregate limit; Marcia Schilling, who processed Utica Mutual Insurance Company primary policies, testified her employer never issued primary policies without aggregate limits; without an aggregate limit, according to Ms. Schilling, there was no way to rate a policy; and when preparing the initial policy form in 1981, Ms. Schilling wrote in the number 500 next to the 3 zeros in the aggregate limit line but a typist neglected to insert it.

Additionally, John A. Griffin, who in 2009 was a Utica Mutual Insurance Company senior vice president, testified his employer did not provide products liability coverage without an aggregate. All Utica Mutual Insurance Company products liability policies contained an aggregate limit. According to Mr. Griffin, it was an industry standard that no insurance company would provide coverage without an aggregate limit in the products liability context. Another Utica Mutual Insurance Company employee, Daniel D. Daly, testified that it was his employer's practice to always include aggregate limits in primary and umbrella policies. In fact, according to Mr. Daly, Utica Mutual Insurance Company never issued a products liability policy without an aggregate limit. Thus, Mr. Daly believe the omission in the policies at issue of an aggregate limit was in error. Ms. Martin described how the primary policies were exhausted, which presupposed the existence of aggregate limits. And both Mr. Connolly and Mr. Gagan testified it was the custom and practice in the insurance industry to impose an aggregate limit. The foregoing is sufficient to resolve the ambiguity resulting from the absence of an indication of an aggregate limit under California law. No serious argument can be made under California law that there was no aggregate in any relevant Utica Mutual Insurance Company policy.

The result is the same under New York law. Under New York law, if there are multiple meanings that can be derived from a contract term, extrinsic evidence may be reviewed to determine the parties intended meanings. In part IV(B)(1) of this opinion, we discussed New York's allowance for the use of extrinsic evidence in the case of ambiguous insurance policy language. The Utica Mutual Insurance Company primary

policies include a form endorsement entitled: "Single Limit [¶] Individual Coverage Aggregate Limit." Above this language in the form are the words, "AMENDMENT—LIMITS OF LIABILITY." The amendment identifies liability "limits" but only the occurrence limit is identified. This internal ambiguity is sufficient to permit the admission of extrinsic evidence. The extrinsic evidence discussed in connection with the application of California law applies equally here. The relevant primary policies had aggregate limits.

F. Remaining Issues

Several other contentions warrant brief comment. First, defendant argues that the trial court erroneously refused to decide whether defense fees and costs count towards reaching the Utica Mutual Insurance Company aggregate limits. This contention is unmeritorious. There is no dispute that defendant's coverage is excess to the protection provided by the Utica Mutual Insurance Company policies. The Utica Mutual Insurance Company policies unequivocally provide only for reimbursement of indemnification costs. Second, defendant makes the following argument: "The [t]rial [c]ourt twice declined to decide what [plaintiff] must prove to treat multiple asbestos injury claims as one occurrence." Third, defendant argues that the trial court incorrectly failed to discuss how the Utica Mutual Insurance Company's policies were triggered in 1977 through 1983. The trial court could reasonably find these issues were not material to the question of when defendant's duty to provide coverage attaches and other materially related issues. The point is that Utica Mutual Insurance Company policies reached their aggregate limits and defendant had a duty to then commence providing coverage. Additionally, the trial court did not abuse its discretion in concluding these matters did not warrant a judicial declaration of rights based on the testimony before it. (Code Civ. Proc., § 1061; *Meyer v. Sprint Spectrum L.P.* (2009) 45 Cal.4th 634, 646-648; *Caldwell v. Gem Packing Co.* (1942) 52 Cal.App.2d 80, 83.) Further, the trial court did not abuse its discretion in concluding the statement of decision discusses all of the material issues raised by the pleadings. (*Muzquiz v. City of Emeryville*, *supra*, 79 Cal.App.4th at p.

1126; *Golden Eagle Ins. Co. v. Foremost Ins. Co.*, *supra*, 20 Cal.App.4th at p. 1380.) None of defendant's omitted findings contentions have any merit.

IV. DISPOSITION

The judgment is affirmed. Plaintiff, Goulds Pumps, Inc., shall recover its costs incurred on appeal from defendant, Travelers Casualty and Surety Company.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

TURNER, P. J.

We concur:

KRIEGLER, J.

KUMAR, J.*

* Judge of the Los Angeles Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.