

**Excess Insurance, Umbrella Insurance
And Multi-Insurer Coverage Programs**

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And Multi-Insurer Coverage Programs**

Section 1

Multi-Insurer Coverage Programs

1.1 Introduction

Businesses frequently purchase insurance from multiple insurers. There are many reasons why businesses do so. For example, insurers are commonly unwilling to issue policies beyond a certain size. If a policyholder seeks more insurance than any insurer it would consider offers then it must make more than one insurer part of the coverage program.

There are also sound reasons why a policyholder might prefer to source coverage from multiple carriers even if the entire coverage were available from a single insurer. For example, the policyholder may wish to diversify its exposure to credit risk of any one individual insurer. Pricing may be more favorable if the coverage is divided among many insurers. The insured may wish to have certain features apply to part of the coverage program but not all. Or the insured may wish to establish or maintain business relationships with key insurers.

Accordingly, multi-insurer programs are commonplace in the commercial insurance landscape, and a variety of structures have emerged to satisfy the requirements of insurers and insured. This article discusses excess and umbrella coverage, which are the building-blocks of such structures, and sets out some of the principal legal issues they raise. The discussion in Sections 1-5 is confined to the issues that arise for a group of policies covering the same single policy period. Sections 6-8 describe issues relating to groups of policies covering multiple policy periods, including the issues of allocation and exhaustion that arise from claims that trigger multiple years of primary and excess policies.

1.2 Insurance Policies Are Bilateral, Not Multilateral, Agreements

Insurance policies are almost always bilateral contracts between a single insurer and the insured. Even when there are multiple insureds under a single policy, the character of most insurance policies remains bilateral. Thus, in procuring a multi-insurer coverage program, a policyholder ought to be wary of the ways that gaps and inconsistencies can occur when an insurance broker is assembling a complex, multiple-insurer (and often multiple-layer) program. Seldom if ever do two insurers jointly issue a policy in which each vouches that the whole coverage will be available to the policyholder, regardless of the conduct of the other insurer and regardless of all policy contingencies.

That policies of insurance are bilateral does not mean they all operate independently. Quite the opposite is true. For example, excess and umbrella policies, as described below, necessarily refer to other policies – at a minimum, the underlying coverage – and are contingent in some way on the provisions of that underlying coverage.

Section 2

Primary, Excess and Umbrella Coverage

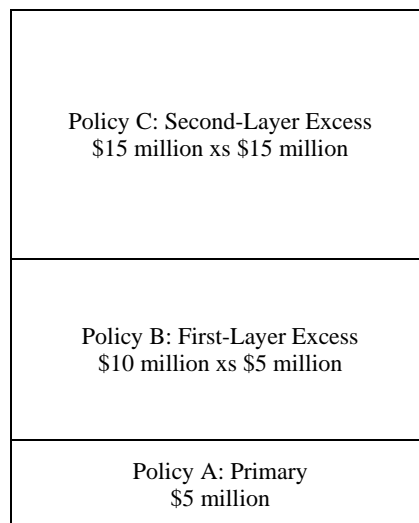
2.1 Primary and Excess Coverage

A primary policy typically pays the “first dollar” of covered claims – often subject to a deductible amount that the insurer bills back to the policyholder – or frequently applying only after the policyholder has paid a specified amount, which is also known as self-insured retention (“SIR”).

In a typical multi-insurer coverage program within a single policy period, the policyholder purchases a primary policy for the period and then adds other policies in “excess” of the primary – that is, policies that begin to provide coverage after a

predetermined amount of coverage has been paid by the primary coverage (and other underlying coverage, if applicable).¹

For example, a policyholder might obtain a \$5 million primary policy (Policy A), a first-layer excess policy with limits \$10 million excess of \$5 million (Policy B), and a second-layer excess policy with limits \$15 million excess of \$15 million (Policy C). Such a multi-layer structure would be depicted by the following simple diagram:



A single claim of \$3 million would be covered entirely by the Policy A. If the claim were instead for \$12 million, \$5 million would be paid from Policy A and \$7 million from Policy B. A claim of \$40 million would be larger than the total available coverage, so in theory a total of only \$30 million would be paid,

¹ See, e.g., *Am. Home Assur. Co. v. Republic Ins. Co.*, 984 F.2d 76, 77 (2d Cir. 1993).

\$5 million from Policy A, \$10 million from Policy B, and \$15 million from Policy C.

The terms “underlying” and “excess” are commonly used to describe the relationships of the policies in such a structure in the following manner: Policies B and C are termed excess to Policy A; Policy A is described as underlying B and Policy C is excess to Policy B; and Policies A and B both constitute coverage underlying Policy C.

Excess coverage is a product available in virtually all lines of commercial insurance: commercial general liability (“CGL”), directors and officers (“D&O”), errors and omissions (“E&O”), first-party property, business interruption, aviation, etc.

There is no requirement or expectation that every policy in a multi-layer insurance program be issued by a distinct carrier. In larger programs, it is not unusual for a particular carrier (or group of affiliated carriers) to participate in two or more layers.

2.2 Umbrella Coverage

An umbrella policy (sometimes called a catastrophe policy) is a type of stand-alone excess policy that provides CGL coverage and that also offers broader scope of coverage than the primary.

While the precise coverage afforded by any policy can only be determined by reference to the policy terms, there are three selling points typical of umbrella coverage, two of which distinguish it from other excess coverage. First, like an excess CGL policy, an umbrella policy provides additional amounts of CGL coverage when the primary CGL coverage becomes exhausted. Second, unlike a CGL excess policy, umbrella coverage also provides additional limits in excess of policies offering other lines of coverage, such as auto, theft and employers liability. Third, unlike other excess coverage, umbrella policies serve as primary coverage both outside the scope of the primary

coverage(s) and within scope but after underlying limits have been exhausted.²

It bears pointing out that the titles of policies can be misleading, and it is the terms of a policy rather than its name that determine whether it is properly deemed primary, excess, or umbrella coverage.

2.3 Excess Coverage: “Following Form”

For the purpose of consistency of coverage among layers, excess policies frequently adopt the coverage provisions of the underlying coverage,— a practice referred to as “following form.” For example, such a policy might provide as follows:

Except as may be otherwise provided by the terms and conditions of this policy, the insurance afforded by this policy shall follow the insuring agreements and is subject to the same warranties, terms, definitions, conditions and exclusions, except as to any renewal agreement, as are contained in the Underlying Insurance specified in the Declarations on the effective date of this policy.

Upper-layer excess policies may be written to follow the form of either a primary policy or a lower-level excess policy. Under either approach, an upper-layer excess policy’s identification of the followed policy may be unclear or ambiguous. Any ambiguity has the potential to be useful to the policyholder, which may seek to have the excess policy follow the most favorable of the candidate underlying forms.³

² See, e.g., *Commercial Union Ins. Co. v. Walbrook Ins. Co.*, 7 F.3d 1047, 1053 (1st Cir. 1993); *Coleman Co. v. Cal. Union Ins. Co.*, 960 F.2d 1529, 1530 n.1 (10th Cir. 1992).

³ 44A Am. Jur. 2d Insurance § 1755 (2008) (explaining role of excess coverage).

Occasionally, upper-layer following-form policies are drafted so that all of the underlying coverage, both primary and excess, acts to restrict the coverage provided by the upper-layer excess policy. In such a case the scope of coverage can be subject to all conditions, exclusions, and restrictions appearing in any of the underlying insurance – in other words, claim-by-claim, the policy can be construed to be as narrow as the narrowest underlying policy.

2.4 Excess Coverage: “Stand-Alone” Forms

Excess policies frequently set forth their insuring agreements, definitions, exclusions, conditions and other terms without incorporating any of the elements of underlying coverage. The scope of coverage of such a “stand-alone” policy may be ascertained from the four corners of the policy itself. This is in contrast to following-form policies, which are intended to be read in connection with their respective underlying “followed” policies.

2.5 Ultimate Net Loss

The insuring clause of many excess CGL policies is phrased in terms of “ultimate net loss.”⁴ This distinctive phrase does not have a single agreed-upon definition. To illustrate the potential issues raised by the term, a representative definition is as follows:

“[U]ltimate net loss” means the sums paid as damages in settlement of a claim or in satisfaction of a judgment for which the insured is legally liable after making deductions for all other recoveries [and] salvages and other insurances (whether recoverable or not) other than the underlying insurance and excess insurance purchased specifically to

⁴ Often, however, the insuring clauses of such policies are instead couched in terms of “loss” or “damages,” but the insurance policy defines that term to have essentially the same meaning as “ultimate net loss.”

be in excess of this policy and also includes investigation, adjustment, appraisal, appeal and defense costs paid or incurred by the insured with respect to damages covered hereunder. . . .

The deduction for “other recoveries” and “salvages” appears to refer to potential recoveries made by the underlying plaintiff relating to damaged property or to subrogation recoveries.

The exclusion of “other insurances (whether recoverable or not) other than the underlying insurance and excess insurance purchased specifically to be in excess of this policy” purports to reduce ultimate net loss by some imputed value of the insured’s coverage claims, whether or not recoverable, pursuant to insurance policies that are from a different policy period or otherwise outside the tower of primary and excess policies to which the subject policy belongs.

The inclusion of the costs of defense in the definition of ultimate net loss is representative of many policies but not universal. In addition, it is not unusual for a policy to exclude defense costs from its definition of ultimate net loss but nevertheless reimburse defense costs and not make that obligation subject to the policy limits.⁵ As usual, it is the policy language as a whole that must be read to make that determination, not the definition of ultimate net loss alone.

Although not illustrated in the language quoted above, the definition of ultimate net loss in an excess policy may also

⁵ For example, there are policies that define ultimate net loss to exclude defense costs, but that cover both defense and indemnity costs. The insurer would pay on behalf of (or reimburse) the insured for both indemnity and defense costs, but policy limit would only be reduced by ultimate net loss (i.e., indemnity costs). Such a policy, therefore, would reimburse defense “in addition to limits.” See Section 5.2 *infra*.

expressly exclude regulatory fines, penalties, punitive damages or other types of expense or loss.

2.6 Excess Policies: Narrowing of Coverage With Additional Terms and Conditions

The sample “following form” language set forth in Section 2.3 expressly provides that provisions in the excess policy control in case of a conflict with the “Underlying Insurance” that is to be followed. Such conflicting provisions might include, most obviously, the declarations, but also could include terms that narrow or expand the underlying scope of coverage, or narrow some and expand other aspects of the underlying coverage.

The presence of additional terms, conditions and exclusions in an excess policy (Policy X) could also affect a policy excess to it (Policy Y), as long as Policy Y follows form (i.e., adopts the underlying policy’s terms and conditions) to either Policy X alone or is narrowed by the coverage of two or more policies, including Policy X.

Thus, it can be critically important to read all terms of every excess policy that might be implicated by a claim. In some instances the highest-layer excess policies have coverage as narrow as the narrowest of all the underlying policies.

Narrowing the scope of upper-level excess coverage can sometimes be advantageous to policyholders. For example, policyholders often elect to restrict upper layers of D&O insurance to personal coverage for the directors and officers only, but not the corporation – a type of coverage termed “Side A Only” coverage.⁶

⁶ “Side A” is a reference to the promise to provide D&O coverage to individual directors only in instances in which the corporation cannot or will not hold the directors harmless. Many D&O policies include coverage for Side A claims as well as for Side B (corporate reimbursement) and Side C (corporate securities claims), but some provide Side A coverage only.

Such coverage effectively reserves policy limits for the directors and officers that cannot be eroded by the needs of the corporation, regardless of the cost of the corporation's defense or resolution of the claims against it.

Section 3

Other Notable Types of Excess Coverage

3.1 Difference-in-Conditions Coverage

A difference-in-conditions ("DIC") policy is a form of stand-alone excess that drops down and serves as primary when there is any difference in policy conditions or coverage scope between the DIC policy and the underlying, or when the underlying is exhausted. Typically, a DIC policy will provide coverage for a limited risk that the primary insurer is unwilling to bear (such as coverage for investigations that may not qualify as civil complaints or other covered claims in the underlying). Such policies also are frequently used in D&O coverage programs. For example, one insurer's DIC form policy, in addition to providing Side A Only excess and umbrella coverage, provides coverage for claims not paid by the underlying D&O insurance in the event that:

[T]he insurer(s) of the Underlying Insurance (i) wrongfully refuses to indemnify the Insureds as required under the terms of the Underlying Insurance; or (ii) is financially unable to indemnify the Insureds; or (iii) rescinds the Underlying Insurance

3.2 Quota Share Policies

Sometimes a layer of excess coverage for a given policy period is divided among two or more insurers with proportional sharing of claims among the participating insurers, in an arrangement known as "quota share participation." For example, the second excess layer of the hypothetical policy structure illustrated in Section 2.1, \$15 million excess of \$15 million, might be subdivided into three quota share policies with individual limits of \$3 million, \$5 million and \$7 million, depicted as follows:

Policy C1 \$3M part of \$15M xs \$15M	Policy C2 \$5M part of \$15M xs \$15M	Policy C3 \$7M part of \$15M xs \$15M
Policy B \$10 million xs \$5 million		
Policy A \$5 million primary		

Claims applied to the second-layer excess would be paid simultaneously by Policies C1, C2, and C3 in proportion to their respective limits – i.e., 20% by Policy C1, 33.33% by Policy C2, and 46.67% by Policy C3.

Section 4

Exhaustion of Underlying Policies and Attachment of Excess Policies

4.1 Basic Principles

A central issue in many excess coverage matters is the determination of when (i.e., with which dollar) the excess policy “attaches,” i.e., begins to reimburse loss and/or defense costs and/or assume the defense of a claim. Because an excess policy attaches when a predetermined amount is payable by the underlying coverage, this issue is bound up with the exhaustion of the limits of the underlying coverage. When a claim or a portion of a claim is ineligible for payment by any of the underlying

policies due to exhaustion of the underlying limits, the excess policy will attach and the claim will be payable by that policy.⁷

In the case of umbrella coverage, the picture is complicated because some of the coverage is excess to the underlying insurance (i.e., applies only when the underlying primary policy has paid its limits) but other coverage is dollar-one (albeit typically subject to exhaustion of an SIR specified in the policy). In the case of a claim for which the umbrella coverage is primary, there are no underlying limits to exhaust, other than any applicable SIR. Otherwise, the claim would fall within the scope of the underlying coverage, the limits of which would need to be exhausted before the umbrella would attach.

The limits of liability of the underlying coverage may be exhausted by the insured's payment of judgments or settlements (commonly called "indemnity" payments), by payment of defense costs, or by payment of both, as may be provided in the policy language of the underlying coverage.

The two main types of policy limits, per-occurrence limits and aggregate limits, are described below.

4.2 Per-Occurrence Policy Limits

A per-occurrence limit represents the maximum payable from a policy with respect to one or more claims constituting a single occurrence.⁸ Thus, if a policyholder incurs losses due to one or more claims under a single occurrence, once the total amount of the losses equals or exceeds the per-occurrence limit, no additional

⁷ 44A Am. Jur. 2d Insurance § 1755 (2008) (explaining role of excess coverage).

⁸ A typical definition of "occurrence" in a CGL policy is an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.

amounts are payable from the policy for claims constituting that occurrence.

The amount of any per-occurrence limit often depends on the type of claim. For example, a CGL policy might provide for one limit to apply to personal injury occurrences and another to property damage occurrences. The limit is typically specified in the declarations page of the policy.

That said, if the policyholder suffers losses from two claims that constitute separate occurrences, the per-occurrence limit serves to limit the potential recovery from each claim, but not the policyholder's overall recovery. In the absence of an aggregate policy limit (as discussed in the following Section), a policyholder has a potentially unlimited recovery from a policy with a per-occurrence limit. This is true even for a policy with a low per-occurrence limit, in cases involving numerous claims constituting separate occurrences.

To illustrate these points, assume that a policy is governed by the law of a state that provides that all product liability claims against an insured for personal injury allegedly arising from exposure to asbestos-containing products manufactured by the insured constitute a single occurrence. Suppose that such an insured entered settlements of two asbestos personal injury claims, one for \$900,000 one for \$600,000, that were payable by a CGL primary policy with no deductible and a \$1 million per-occurrence limit for personal injury claims. Under these circumstances, all of the first claim and \$100,000 of the second claim would be payable by the primary coverage, for a total recovery from that policy of \$1,000,000. The unreimbursed balance of \$500,000 would apply to the excess policy (if any).

On the other hand, if the two claims were deemed separate occurrences (as might be the case, for example, if one claim were for asbestos-related personal injury and the other were for asbestos-related property damage), then the entire amount of both claims would be recoverable under the primary policy for a total recovery from that insurer of \$1,500,000. Moreover, the per-occurrence limit would not be exhausted by either claim, so there

would be the potential for further recovery from that primary policy both for personal injury and property damage claims.

4.3 Aggregate Policy Limits

An aggregate policy limit, in contrast, serves to restrict recoveries aggregated over multiple occurrences and claims. While some aggregate limits (typically in excess policies) apply to all claims covered by a policy, it is common at the primary or umbrella layer for an aggregate limit to relate to a restricted class of claims only. For example, aggregate limits might apply to the products liability and completed operations coverage of a CGL policy, or to its premises/operations coverage, but not necessarily to all claims overall.

Returning to the example of Section 4.1, if the policy were in addition subject to an aggregate limit of \$1,500,000 for the product liability coverage (or “hazard” as it is often termed), then a \$900,000 personal injury and a \$600,000 property damage claim would exhaust the product liability coverage of the policy entirely, although coverage would remain for non-product liability claims.

4.4 Climbing the Policy Tower

In a tower of coverage for a single policy period, the application of claims to insurance commences with the bottom and proceeds to the top. The process starts with the primary policy at the bottom of the tower, continuing with the first-layer excess policy once the primary is exhausted for the purposes of the claim under consideration, and then working up to higher layers of excess coverage. The ascent continues policy by policy, as each successive policy is exhausted by the application of claims, and to the extent that additional excess coverage exists.

In the case of a single large claim that exhausts one or more policy limits, the climbing of the policy tower may occur in a single step.

In the case of many smaller claims that accumulate to exhaust coverage (whether due to exhaustion of aggregate limits, or because the claims all fall within one occurrence and thereby

exhaust a per-occurrence limit), the policy tower is climbed gradually, over time, sometimes likened to the filling of a bathtub or the climbing of a ladder.⁹

4.5 Settlement of Underlying for Less Than Full Policy Limits

Policyholders seeking to settle losses that exhaust the entire coverage of one or more of their insurers often are asked by an insurer to settle for less than full policy limits. Such a proposition may seem appealing to the insured as a way of avoiding the expense, delay and risk of coverage litigation. The choice may also be justified in the case that the insurer is a weak long-term credit risk, but is solvent enough to currently fund a settlement.

Most courts have held that excess policies are obligated to provide coverage so long as the applicable underlying amount has been paid by either the underlying insurers or the insured, following the widely-cited decision in *Zeig v. Massachusetts Bonding & Ins. Co.*, 23 F.2d 665, 666 (2d Cir. 1928).

Thus, if an insured settles an \$8 million coverage claim for \$4 million with the issuer of a \$5 million primary policy, the first-layer excess policy would be triggered for \$3 million (\$8 million less \$4 million paid by the primary insurer, and less \$1 million retained by the policyholder to exhaust the primary limit.)

⁹ In at least one instance, a court permitted a policyholder to exhaust an underlying layer in year 1 and then access the excess policy at the next layer in year 2, and so on. The court referred to this as the “hopscotch” method. *Kaiser Aluminum & Chem. Corp. v. Certain Underwriters at Lloyd*, No. 312415, Decision on Group IIA Trial Issues at 9 (Cal. Super. Ct., San Francisco, June 13, 2003); *Kaiser Aluminum & Chem. Corp. v. Certain Underwriters at Lloyd*, No. 312415, Decision on Group IIB Trial Issues at 5 (Cal. Super. Ct., San Francisco, Feb. 20, 2004).

Policyholders who are considering such settlements should be mindful of a potential risk created by two recent poorly reasoned coverage decisions in Michigan and California.¹⁰ In these cases, based on specific language in the excess coverage, the courts held that a policyholder had forfeited all coverage under its excess policies because the policyholder had made a settlement with its primary insurer under which the primary insurer paid less than the full limit of its policy. In particular, in one case the excess policy at issue provided that:

In the event of the depletion of the limit(s) of liability of the “Underlying Insurance” solely as a result of actual payment of loss thereunder by the applicable insurers, this Policy shall...continue to apply to loss as excess¹¹

In response to these decisions, many policyholders have sought, and many carriers have issued, endorsements to their policies that specifically eliminate this particular risk. In some instances insurers have revised their basic policy forms, or issued standard endorsements, to ensure recognition of payment of loss by either the policyholder or the underlying insurer as sufficient to reduce limits of the underlying coverage.

4.6 Insolvent Underlying Coverage

A common question that arises in the context of insureds that are facing an insolvent primary or lower-layer excess carrier is whether, given the inability of the insolvent carrier to defend or indemnify losses, the insurer(s) excess to the insolvent insurer are obliged to “drop down” to the underlying layer and assume the obligations of the insolvent insurer in that insurer’s place.

¹⁰ See *Qualcomm, Inc. v. Certain Underwriters at Lloyd’s, London*, 73 Cal. Rptr.3d 770 (Cal. Ct. App. 2008); *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019 (E.D. Mich. 2007).

¹¹ *Comerica*, 498 F. Supp. 2d at 1022.

The answer to this question depends heavily on the drafting of the policy provisions implicating the solvent excess coverage.¹² In one leading case, the excess policy provided that the excess carrier would be liable for “ultimate net loss in excess of...the *amount recoverable* under the underlying insurance as set out in the schedule of the underlying insurance.”¹³ There the California Supreme Court held that the excess coverage dropped down in place of the policy of the insolvent carrier, reasoning that the phrase “amount recoverable” was ambiguous and accordingly would be construed in favor of the policyholder.¹⁴ In another leading case, the U.S. Court of Appeals for the Fifth Circuit went even further in finding that such a usage of “amount recoverable” was unambiguous and that plainly no amount was recoverable from an insolvent underlying carrier:

We have interpreted the term “recoverable” to mean the amount *actually recoverable* from the underlying policies....[W]e found that under Louisiana law, “[w]hen an excess insurer used the term ‘collectible’ or ‘recoverable’ it is agreeing to ‘drop down’ in the event that the primary coverage becomes uncollectible or unrecoverable”; we concluded that the language of the policy at issue, “other valid and collectible insurance,” provided drop-down coverage when the primary insurer became insolvent. Hence, our case law dictates that “recoverable” does not even fall within the category of

¹² Of course, DIC coverage is expressly designed to drop down in the case of underlying insolvency. *See* Section 3.1 *supra*.

¹³ *Reserve Ins. Co. v. Pisciotto*, 640 P.2d 764, 770 (Cal. 1982) (en banc) (emphasis added).

¹⁴ *Id.* at 815.

ambiguous terms; its meaning is fixed in favor of the insured.¹⁵

There are various ways, however, that excess carriers may draft their policies unambiguously so as not to drop down in the case of underlying insolvency. One typical approach is to include a “Maintenance of Underlying Insurance” clause requiring the insured to maintain full policy limits of the underlying coverage, except for any reduction due to claims, and providing that “[f]ailure of the...insured to comply [with the maintenance requirement] shall not invalidate this policy but in the event of such failure, the company shall be liable only [to] the extent that it would have been liable had the...insured complied therewith.”¹⁶ Some policies also expressly provide that they do not drop down in the event of insolvency and that the insured expressly agrees to self-insure in the event of any underlying insurer insolvency.¹⁷

Section 5

Duty of Defense and Indemnification of Defense Costs

5.1 Defense Obligations of Excess Policies

In the case of liability insurance policies, the primary insurer’s duty to defend is a core feature for the policyholder. Upon notice of a claim, the policyholder tenders defense to the insurer, which will conduct the defense in cooperation with the

¹⁵ *Sifers v. Gen. Marine Catering Co.*, 892 F.2d 386, 401 (5th Cir. 1990), quoting *Mission Nat’l Ins. Co. v. Duke Transp. Co.*, 792 F.2d 550, 553 (5th Cir. 1986).

¹⁶ *Hartford Accident & Indem. v. Chi. Hous. Auth.*, 12 F.3d 92, 95 n.2 (7th Cir. 1993); see also *Molina v. U.S. Fire Ins. Co.*, 574 F.2d 1176, 1177-78 (4th Cir. 1978) (additional requirement in policy that the insured maintain “collectible” underlying insurance).

¹⁷ See, e.g., *Huggins v. Gerry Lane Enters., Inc.*, 950 So. 2d 750 (La. Ct. App. 2006).

insured, generally using counsel of the insurer's choosing. For some lines of liability coverage, such as D&O insurance, the policyholder almost always directs its own defense and is reimbursed for certain defense costs by the insurer. Accordingly, depending on the line of coverage, primary liability policies may obligate the insurer to either conduct the defense of claims or reimburse the insured's defense costs. Of course, if the insurer wrongly denies coverage under a duty-to-defend policy and the policyholder conducts its own defense, the costs of that defense ultimately will be recoverable.¹⁸

Upon the exhaustion of primary coverage, the provision of a defense or reimbursement of defense costs by the excess insurer is no less crucial to the policyholder. For lines of coverage that characteristically provide for defense reimbursement, such as D&O, the cost of defense of claims often overshadows the costs of settlement. Consequently, reimbursement of defense costs under excess coverage policies is the general rule for such lines of coverage.

Among excess CGL policies, defense coverage characteristics are not uniform. For example, such policies may expressly provide for the insurer to defend, to reimburse defense costs, or –(occasionally)– to have no duty whatsoever with respect to the defense of claims. Many umbrella policy forms place the duty to defend on the insurer for claims in which the umbrella serves as primary coverage, and require the insured to conduct the defense when the umbrella serves as excess.

5.2 Common Provisions Regarding Defense in Excess CGL Policies

Frequently, ambiguous provisions in excess CGL policies relating to the defense of claims provoke a coverage dispute.

¹⁸ 44 Am. Jur. 2d Insurance § 1407 (2008).

The first principle regarding the resolution of such disputes to keep in mind is that any limitation on the insurer's duty to defend or reimburse defense costs must be explicit in order to be effective.¹⁹ For example, the U.S. Court of Appeals for the Ninth Circuit has ruled that the following common provision granting the insurer the right to associate itself with the insured's defense was not sufficient in and of itself to exempt the insurer from reimbursement of the insured's defense costs:

The insured shall be responsible for the investigation, settlement or defense of any claim made...which no underlying insurer is obligated to defend....The company shall have the right and shall be given the opportunity to associate with the insured or its underlying insurers, or both, in the defense and control of any claim...which involves or appears reasonably likely to involve the company.²⁰

Similarly, conditions in excess policies to the effect that the insurer shall not be obligated to assume charge of the investigation, settlement, or defense of any claim against the insured have been interpreted as *not* exonerating the insurer from the duty to reimburse defense costs.²¹

Excess follow-form policies that are otherwise silent regarding defense will of course be governed by the defense provision of the followed underlying policy or policies.

¹⁹ See, e.g., *Interstate Fire & Cas. Co. v. Stuntman, Inc.*, 861 F.2d 203, 206 (9th Cir. 1988) (under California law, exclusion of defense coverage "must be conspicuous, plain and clear" and "[t]he law imposes an implied obligation to defend where it is not expressly and clearly omitted from the particular risk").

²⁰ *Id.* at 205-06.

²¹ See, e.g., *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995), *modified on other grounds and reh'g denied*, 85 F.3d 49 (2d Cir. 1996).

Where the excess insurer's defense obligation is to reimburse the insured's costs, such costs will either erode the applicable policy limit or be paid without impact on the remaining policy limits, depending on the particular policy language at issue. Which treatment applies for any given policy can be an intricate determination in the circumstance (which is not unusual) of unclear policy provisions. The proper reading may be dependent upon, among other things, whether ultimate net loss includes defense costs and whether policy limits are expressly stated to be eroded only by damages or ultimate net loss.²²

Section 6

Which Policy Periods Are Triggered by a Claim

The previous Sections have concentrated on a discussion of the issues that can arise with regard to a group of policies covering the same single policy period. But how does one determine which policy period or periods are implicated by a given claim?²³ Personal injuries or property damage might implicate a single policy period if one only looks to a specific event as constituting the trigger. Such an event might be one which is characterized as having caused the injuries or damage. Alternatively, one might look to a point in time when the injury or damage first manifested or was first discovered.²⁴

²² See related discussion in Section 2.5 *supra*.

²³ This issue arises with particular significance in the context of "occurrence-based" insurance policies, in which coverage is triggered based upon when the relevant accident or injury is said to have occurred. See *supra* note 8. Only the policies in force on the relevant date or range of dates are implicated.

²⁴ Such theories are commonly referred to as "single point" triggers.

In the case of asbestos-related personal injury claims or claims for property damage stemming from the disposal of hazardous waste, for example, there may well be some lag between the time when an individual is exposed to the toxic substance and when the injury or damage is first discovered or manifests itself.²⁵ However, personal injuries or property damage may instead be thought to implicate multiple policy periods if one characterizes such injuries or damage as developing over a period of time or on some sort of continuing basis. In response to varied conceptualizations of when and how insured harm occurred, courts have developed varying approaches to resolving the question of whether a given policy period has been triggered.

As its name implies, the “exposure-only” trigger theory implicates coverage only under the policies in effect at the time when the individual or his property was exposed to the toxic substance at issue.²⁶ In the case of an asbestos-related personal injury claim, for example, only those policies in effect on the date(s) when the individual was exposed to the asbestos would be implicated under the exposure-only trigger theory.

In contrast, the “manifestation-only” trigger theory posits that the insured harm transpires only at the point in time that an injury manifests itself or is first detected.²⁷ For example, in the case of asbestos-related personal injury, only those policies in effect on the date(s) when the individual claimant first realizes he

²⁵ One result of this lag time between initial exposure and manifestation of injury is that claims often are not filed immediately after initial exposure. These are commonly referred to as “long tail claims.”

²⁶ See, e.g., *Shook & Fletcher Asbestos Settlement Trust v. Safety Nat’l Cas. Corp.*, 909 A.2d 125, 128 (Del. 2006); *Ins. Co. of N. Am. v. Forty-Eight Insulations*, 633 F.2d 1212, 1223 (6th Cir. 1980), *aff’d on reh’g*, 657 F.2d 814 (6th Cir. 1981).

²⁷ See, e.g., *Eagle-Picher Indus. v. Liberty Mut. Ins. Co.*, 682 F.2d 12, 19 (1st Cir. 1982).

or she has suffered that injury would be implicated under a manifestation-only trigger theory.

Yet another single point trigger methodology is the “injury-in-fact” approach, which seeks to determine – and requires proof of – the precise point(s) in time at which the individual or his property actually suffered the injury in question (however that may be defined).²⁸ This approach usually requires claimant-by-claimant medical evidence and does not lend itself to quick or easy determinations of trigger dates. For instance, a growing body of medical evidence indicates that the onset of asbestos-related disease sometimes does not commence until several years after exposure – a period that also varies from person to person.

In recent years, however, one theory in particular has gained widespread acceptance, particularly for coverage claims arising from toxic tort liability such as asbestos-related personal injury and environmental remediation liability matters. This theory implicates every insurance policy on the risk from the beginning of the exposure period and “continuing” through the entire progression of the injurious process until the injury or damage manifests or is first detected.²⁹ With regard to asbestos-related personal injuries, then, every policy in effect from the time the individual was first exposed through the time he was diagnosed or first discovered the injury would provide coverage.

In the event that such a continuing injury is found to trigger liability over multiple policy periods, the question then becomes how liability should be allocated among the insurers providing coverage for those policy periods, a point to which we turn in the next Section.

²⁸ See, e.g., *Am. Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 565 F. Supp. 1485, 1498-99 (S.D.N.Y. 1983), *aff'd*, 748 F.2d 760 (2d Cir. 1984).

²⁹ See, e.g., *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1045-46 (D.C. Cir. 1981).

Section 7

Horizontal Allocation Principles for Claims Triggering Multiple Policy Periods

7.1 Allocation Methodologies

In essence, allocation theories seek to determine how to divide up liability among implicated policies when more than one policy period is triggered by a loss. The issues that arise in such situations are numerous and varied, but two basic principles lie at the heart of the question: the “all sums” approach and the “pro rata” approach.

Under the all sums approach,³⁰ an insured may allocate some or all of its liability into a single policy period of the insured’s choosing. It may also select other policy periods into which to allocate additional liability. Under this approach, there need not be allocation of loss to uninsured or under-insured policy periods, and it is therefore considered the most favorable approach for the insured.³¹

Consider the following example: under a continuous trigger theory, a claimant is subject to a \$10 million liability for an asbestos-related personal injury triggering policies over the course of five years, thereby implicating five annual periods of insurance coverage. The coverage in each of years one to four totals \$5 million, with a \$5 million policy in year five subject to an SIR of \$2 million (for a total aggregate policy limit of \$25 million). Pursuant to the all sums approach, liability could be allocated in a

³⁰ This approach is alternatively referred to as the “pick and choose” approach.

³¹ While the all sums approach allows the insured to choose the triggered policy or policies in the first instance, the insurer(s) whose policy or policies are selected typically may then seek reallocation or contribution from the other insurers whose policies are also implicated under the continuous trigger theory.

variety of ways: the policyholder could avoid the SIR in year 5 and nevertheless achieve 100% recovery by electing to recover, for example, \$5 million each in years one and two, or \$2.5 million in each of years 1 through 4. Under either allocation, as well as many other possible allocations that might be elected by the policyholder, the insured will receive the full amount of its claim.

Courts employing all sums methodology principally rely on explicit policy language of the following sort: “The company will pay on behalf of the insured *all sums* which the insured shall become legally obligated to pay” (emphasis added). Such courts typically point to both the affirmative grant of all sums coverage in addition to the absence of any policy language specifically directing pro-ration to the insured.³² Further support for the all sums approach is drawn from the principle of construction that insurance policies should be construed so as to effect their dominant purpose of providing indemnity to the insured and avoiding forfeitures.³³ Many courts also point to the doctrine of *contra preferentem*, explaining that standard policy language is at least ambiguous with regard to allocation and that any such ambiguity should be construed in favor of the insured.³⁴

³² See, e.g., *Keene*, 667 F.2d at 1048 (“[E]ach policy has a built-in trigger of coverage. Once triggered, each policy covers [the insured’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 insured’s] entire liability once they are triggered. That interpretation is based on the terms of the policies themselves.”).

³³ See, e.g., *id.* at 1041. A related consideration is that this approach is thought to protect the reasonable expectations held by the insured when entering into the contract of insurance. See, e.g., *Am. Nat’l Fire Ins. Co. v. B&L Trucking & Constr. Co.*, 951 P.2d 250, 256 (Wash. 1998).

³⁴ See, e.g., *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481, 492 n.30 (Del. 2001).

The pro rata approach has two principal variations: pro rata by “time on the risk” and pro rata “by limits.” As a general matter, the pro rata by time on the risk approach divides the insured’s loss proportionally among all insurers whose policies are implicated according to the portion of the loss that occurred during the time each policy was in place.³⁵ The pro rata by limits approach divides total liability into shares across the triggered periods with greater weight assigned to years in which the insured purchased greater amounts of coverage.³⁶ The weight is equal to the proportion the policy limits of a given policy bear to the total policy limits of all triggered policies.³⁷ Under many circumstances, such as those illustrated in the example below, the pro-rata by limits method can prove advantageous for the policyholder.

In contrast, the pro rata by time on risk approach can be more favorable to insurers, as it typically reduces their overall liability by requiring the insured to contribute for periods in which

³⁵ See, e.g., *Pub. Serv. Co. of Colo. v. Wallis & Cos.*, 986 P.2d 924, 940 (Colo. 1999) (“[T]he...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,” and “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.”); *Stonewall*, 73 F.3d at 1203-04.

³⁶ See, e.g., *Owens-Ill., Inc. v. United Ins. Co.*, 650 A.2d 974, 993-95 (N.J. 1994).

³⁷ Under some circumstances, an allocation may be made to an uninsured period, if the policyholder elected not to obtain coverage and the court can determine an amount of coverage that ought to have been procured. Similarly, allocation can be made to an underinsured period based on an attributed “full” amount of coverage that the policyholder should have or could have purchased.

they did not purchase insurance or other gaps in coverage are present.³⁸

Again consider the example of a \$10 million asbestos-related personal injury liability, this time allocated over four consecutive annual policy periods with policy limits \$1 million, \$1 million, \$8 million and \$10 million. Under a pro rata by time on the risk approach, the four year spread period would dictate an allocation of \$2.5 million for each of the four years. However, policy limits of \$1 million in each of the first two policy periods would preclude recovery of \$3 million of the entire \$10 million claim (i.e., a shortfall of coverage in the amount of \$1.5 million for each of two years). In other words, the policyholder could recover \$7 million but not more.

In contrast, an insured would receive a full reimbursement of its \$10 million claim under the pro rata by limits approach. Given the total aggregate policy limit of \$20 million, years one and two would each account for 5% of the total limits (\$million divided by \$20 million), year three would account for 8/20 or 40% of the total limits (\$8 million divided by \$20 million) and 50% would be attributed to year four (\$10 million divided by \$20 million). Thus, the \$10 million claim would be allocated \$0.5 million each to years one and two, \$4 million to year three and \$5 million to year four. Because in each case the allocation is an amount that is less than policy limits, a full recovery is possible.

³⁸ Pro rata by limits is considered somewhat more favorable to the insured than pro rata by time on the risk, as the former approach requires the insured to bear a portion of the loss only with respect to policy periods in which it did not purchase insurance or purchased an insufficient amount. *See id.* at 995 (“When periods of no insurance reflect a decision by an [insured] 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.”).

Courts employing pro rata methodology also purport to rely on specific policy language, such as the following:

The 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 or property damage *to which this insurance applies*, caused by an occurrence.... *This insurance applies only to bodily injury or property damage which occurs during the policy period.* (Emphasis added.)

Despite the inclusion of all sums terminology in the policy language, courts adopting this approach emphasize the limitation of coverage to injury or damage that occurs during the policy period.³⁹ Such courts typically also stress concerns relating to fairness, equity, and public policy.⁴⁰

7.2 Horizontal Allocation When One Insurer is Insolvent

A situation faced not infrequently in coverage situations is how to allocate liability when an implicated insurer has become insolvent. The answer is straightforward when examined through

³⁹ See, e.g., *Publ. Serv. Co.*, 986 P.2d at 939.

⁴⁰ See, e.g., *Stonewall*, 73 F.3d at 1204 (explaining that equity requires the insured to accept a proportionate share of the risk for periods in which it elected to assume risk by “declining to purchase available insurance or by purchasing what turned out to be an insufficient amount); *Owens-Ill.*, 650 A.2d at 992 (expressing concern that adoption of an all sums approach would create incentives for policyholders to make irresponsible decisions about purchasing insurance by not forcing them to internalize the proper level of insurance costs, thereby interrupting the pass-through of such costs to the greater economic market). Other courts criticize this aspect of the pro rata approach as relying too heavily on principles of imagined fairness and not enough on actual policy language. See, e.g., *Aerojet-Gen. Corp. v. Transp. Indem. Co.*, 948 P.2d 909, 930 (Cal. 1997).

the lens of the all sums approach – the insured simply directs the liability to another insurer whose policy is also implicated.

Under a pro rata approach, however, the insured generally will bear the portion of the loss that otherwise would have been assigned to the insolvent insurer. Consider once again our hypothetical \$10 million asbestos-related personal injury claim triggering four consecutive annual policy periods with limits \$1 million, \$1 million, \$8 million and \$10 million, but now assume that the \$10 million policy in year four was issued by an insolvent insurer. Using a pro rata by time on the risk approach, the policyholder would recover only \$4.5 million of its \$10 million claim.⁴¹ Using a pro rata by limits approach, the calculation of the policyholder’s recovery would depend on whether any allocation is to be made to year four. If no such allocation is required, then the policyholder’s recovery would be the full \$10 million.⁴² If allocation were extended to all four years, for example on the theory that the policyholder alone was assuming the risk of insurer insolvency, the insurance recovery would be \$5 million.⁴³

⁴¹ \$2.5 million would be allocated to each of the four triggered years. In years one and two, there would be a \$1.5 million shortfall each year due to policy limits of only \$1 million; there would be no shortfall in year three, and in year four there would be a full \$2.5 million shortfall due to the insurer insolvency.

⁴² The \$10 million loss would be allocated pro rata by limits over three policies (\$1 million, \$1 million and \$8 million), resulting in 100% recovery.

⁴³ The \$10 million loss in this case would be allocated among policy periods with limits \$1 million, \$1 million, \$8 million and \$10 million, resulting in an allocation of \$0.5 million, \$0.5 million, \$4 million and \$5 million, as with the example in Section 7.1. However, the allocation of \$5 million to the year four policy would not be recoverable due to the insurer insolvency, so only \$5 million could be recovered.

Section 8

Exhaustion of Underlying Insurance for Multi-Year Coverage Programs

Another issue that can arise in situations where progressive injuries occur over multiple policy periods involves the interplay between the attachment of excess policies and the doctrine of exhaustion.⁴⁴ If liability is triggered over the course of several years, for which dates do the excess policies attach? Under the “vertical exhaustion” doctrine,⁴⁵ once a primary policy is exhausted, any remaining coverage obligation shifts upward to the excess policy at the next layer of insurance within the same policy period.⁴⁶ Thus, each excess policy in a triggered year must contribute to the insured’s indemnification once its particular underlying coverage is exhausted, even if other triggered primary policies covering other policy periods have not yet contributed to indemnification. Courts applying vertical exhaustion often rely on a variety of public policy concerns in doing so.⁴⁷

⁴⁴ See generally Section 4 *supra*.

⁴⁵ Also commonly referred to as “exhaustion by years” or “spiking.”

⁴⁶ See, e.g., *Carter-Wallace, Inc. v. Admiral Ins. Co.*, 712 A.2d 1116, 1124 (N.J. 1998).

⁴⁷ See *id.* (explaining that the vertical exhaustion “approach makes efficient use of available resources because it neither minimizes nor maximizes the liability of either primary or excess insurance, thereby promoting cost efficiency by spreading costs,” that it “promotes ‘simple justice’...by respecting the distinction between primary and excess insurance while not permitting excess insurers unfairly to avoid coverage in long-term continuous-trigger cases,” and “introduce[s] a degree of certainty and predictability into the complex world of environmental insurance litigation in continuous-trigger cases”).

In contrast, the “horizontal exhaustion” doctrine⁴⁸ requires each layer of coverage – across multiple policy periods – to indemnify the insured to the full extent of its respective policy limits before requiring any contribution from any excess policy. Perhaps unsurprisingly, excess carriers tend to favor application of this doctrine because their policies are triggered only after the limits of all triggered primary policies have been exhausted. Courts applying horizontal exhaustion typically rely on the absence of language in the “other insurance” provisions of the excess policy stating that the policy is excess over a particular, specific primary policy and will be triggered when that discrete policy is exhausted.⁴⁹ These courts also embrace horizontal exhaustion as a method of preventing the insured from “effectively manipul[at]ing the source of its recovery.”⁵⁰ Such courts conclude that if insureds are permitted to recover from excess policies upon the exhaustion of a single primary policy, this would allow the insured to seek indemnification from its excess insurers rather than from either itself as a primary self-insurer or from insolvent insurers in other triggered policy periods, “blur[ring] the distinction between primary and excess insurance, and...allow[ing] certain primary insurers to escape unscathed when they would otherwise bear the initial burden of providing indemnification.”⁵¹

⁴⁸ Also commonly referred to as “exhaustion by layers.”

⁴⁹ See, e.g., *Mayor & City Council v. Utica Mut. Ins. Co.*, 802 A.2d 1070, 1105 (Md. Ct. Spec. App. 2002); *Padilla Constr. Co. v. Transp. Ins. Co.*, 58 Cal. Rptr. 3d 807, 809 (Cal. Ct. App. 2007).

⁵⁰ *U.S. Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d 1226, 1262 (Ill. App. Ct. 1994).

⁵¹ *Id.*