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Chutes and Ladders: Hurdles in Reaching Your Next Layer of Coverage

Chutes and Ladders: Hurdles in Reaching Your Next Layer of Coverage

Laura Besvinick
Hogan Lovells US LLP
Miami, FL

Rebecca L. Ross
Troutman Sanders LLP
Chicago, IL
ACCESSING YOUR EXCESS COVERAGE
A CHECKLIST OF ISSUES

One of the more complex issues arising in a large exposure case is whether the insured’s settlement with an underlying carrier will impede its rights against excess carriers. While the issue is initially one for policyholders, it directly affects insurers because it so significantly impacts what a policyholder is willing to do. This paper is designed to give you a checklist of issues that may arise and some of the options for dealing with those issues.

I. There Are Many Reasons Why An Insured May Be Willing To Settle For Less Than Full Limits

There are a host of reasons why settlement amounts are often less than policy limits. Those reasons relate both to the uncertainties in claim as well as the potentially applicable policy provisions.

A. The scope of the problem may be in doubt. In many circumstances, a settlement of the insurance coverage may occur prior to the time the insured finally resolves the claim. That routinely happens in environmental cases where the state is demanding a clean-up of a site and the ultimate amount of that clean-up is in doubt. The insured often must begin the clean up responsibilities while it is still determining the scope of the problem. And, even after a remediation scenario is adopted, unforeseen problems may cause the initial estimates to become unreliable. At times, the insured agrees to a settlement with one insurer in order to get money in the door, but later finds that the claim is much larger than originally thought.

B. The responsibility for the claim may be in doubt and/or change. The insured may be challenging its responsibility for a particular claim. It may be claiming that it owes nothing and may agree to an early settlement for less than limits. When liability is
ultimately determined, the insured may find that it is more responsible than it originally thought. Alternatively, the insured may have resolved responsibility only to find out that another responsible party is no longer viable. The insured’s liability may dramatically change if another tortfeasor becomes insolvent.

C. **Claim documentation may be missing.** Policyholders sometimes agree to settle an underlying case for a limited amount of money with the understanding that the claimant is going to receive a check and not have to provide substantial detail concerning its claim. Particularly in cases involving mass settlements, claimants’ counsel often refuse to settle for nuisance value if they have to obtain information from each claimant. An insurer demanding proof of payment and other information justifying settlement may agree to pay a portion of the settlement but not the entire amount.

D. **The terms and conditions of the policy may be disputed.** In lost or missing policy cases, the existence of coverage is at issue. Often the insured relies on standard policy forms, ledgers, letters to and from brokers, insurers or the insured, loss runs, or claims information to prove coverage. Depending on the state and the type of information available, policyholders and insurers often settle these claims with an agreement that limits the amount of coverage the insurer will pay in exchange for an agreement that the policy was issued.

E. **The policy limits may be in doubt.** There is often a disagreement between insurers and policyholders on the amount of the limits. At times, that is a question of whether multiple limits apply (e.g. because the insured argues that each claimant is a separate occurrence). For example, New York deems every person to be a separate occurrence. *See Appalachian Ins. Co v. Gen. Elec. Co.*, 863 N.E.2d 994, 1001 (N.Y. 2007) (“Under
the circumstances, there were unquestionably multiple occurrences and the excess insurers were entitled to a declaration to that effect.”). Illinois generally looks at the cause and finds that multiple claimants can constitute a single occurrence. See U.S. Gypsum Co. v. Admiral Ins. Co., 643 N.E.2d 1226, 1260 (Ill. App. Ct. 1994) (“It would be unwise and without support in case law to determine that each installation of the asbestos containing products constituted a separate occurrence when Gypsum’s liability is predicated on its involvement in the manufacture and sale of the products rather than the installation of the products.”).

(“We hold that the subsequent performance of the parties, industry norms and the premiums paid all strongly suggest that the parties intended for [two multi-year policies] to apply annual-aggregate limits.”); Commercial Union Ins. Co v. Swiss Reinsurance Am. Corp., 413 F.3d 121, 126 (1st Cir. 2005) (citing Benjamin More & Co. v. Aetna Cas. & Sur. Co., 843 A.2d 1094, 1103 (N.J. 2004) (noting that New Jersey courts have suggested that an annualization approach may normally apply to multi-year policies)). When the case law is unsettled, these issues are often compromised with a lower than limits settlement.

G. **Stub Policies.** A similar issue arises with stub policies – policies with more than one year of coverage but less than two. The question is whether there is a single limit, two limits or a pro-rated limit. The historical basis for the policies sometimes answers the question, but other times, the issue is compromised in the settlement.

H. **Treatment of defense costs may affect settlement value.** At times, there are questions concerning how the policies treat defense – within limits or outside of limits. In addition, there are sometimes questions concerning whether the policy even has a defense obligation. If the issues are undecided, parties will often resolve them with settlements that treat defense costs within limits, often raising the specter of a later challenge by an excess carrier.

I. **The insurer may have exclusions which limit coverage.** Policyholders and insurers routinely argue about the meaning of various exclusions. At times, the application of an exclusion will depend on what state’s law applies. Other times, there is a disagreement about the scope of the exclusion and what it was intended to cover. Particularly where the exclusion results in a “winner-take-all” scenario, the issues are often settled in an
agreement under which the insured takes less than full policy limits in exchange for coverage under the policy.

J. **The insurer may threaten insolvency.** The financial viability of an insurer has a direct effect on the willingness of a policyholder to accept less than the full policy limits. Often insurers that are in financial difficulty will agree to settle a claim, but only if the insured agrees to a deep discount off the policy limits. In order to obtain any money from the insurer, the insured often settles for less than policy limits.

K. **The insurer may have other policy defenses.** Issues such as late notice and lack of cooperation will often affect the settlement value of a claim. If an insurer believes that the conditions of the policy have not been followed, it will often refuse to settle without a substantial discount reflecting these coverage defenses.

II. **Burden of Proof in Demonstrating Exhaustion**

In order to access its excess insurance coverage, a policyholder must first demonstrate that it has exhausted its primary insurance coverage. In practice, however, proving exhaustion can be a difficult process. The losses for which an insured seeks coverage can take place over a number of years and may involve claims from a wide array of underlying plaintiffs. The task of accumulating proof of both primary and excess coverage and demonstrating the extent of the covered loss can cause headaches and confusion.

A. **The insured carries the burden of proof.** In most United States jurisdictions, the insured will carry the burden of proof in demonstrating the exhaustion of underlying insurance coverage before it will be able to access excess insurance coverage. See *Northrop Grumman Corp. v. Factory Mut. Ins. Co.*, 805 F.Supp.2d 945, 954 (C.D. Cal. 2011) (citing *Legacy Vulcan Corp. v. Superior Court*, 185 Cal.App.4th 677, 686 (2010);
Qualcomm, Inc. v. Certain Underwriters at Lloyd’s, 161 Cal.App.4th 184, 194 (Cal. 2008)) (“As a general rule, absent a controlling policy provision, in order to trigger excess insurer’s duty to pay, the duty ordinarily lies with the insured to establish proof of a primary policy’s exhaustion.”); Kajima Constr. Serv. v. St. Paul Fire & Marine Ins. Co., 879 N.E.2d 305, 312 (Ill. 2007) (“[H]orizontal exhaustion requires an insured to exhaust all available primary limits before invoking excess coverage.”).

B. Locating information is problematic. Evidentiary issues frequently become the paramount concern in assessing whether or not a primary insurance policy has been exhausted. As an insurer, underwriting documents, claim searches, claim files and loss runs are the first documents to review when attempting to prove-up an exhaustion argument. This documentation, however, has a tendency to get lost in the shuffle when companies transition to new software programs or phase out paper based record keeping systems. Computer crashes, viruses, and negligent employee computer usage can also lead to the destruction or mishandling of critical information.

As an insured, historical accounting records, loss runs and other documents created by a company’s risk management department may contain applicable evidence. Policyholders frequently experience difficulty in locating historical business records due to poor or nonexistent document retention policies. Such documents are also susceptible to destruction due to natural disasters (such as flooding or fires) or a simple relocation of corporate headquarters. If the information is electronically stored, the previously discussed computer related hazards are also a threat to the safety of this information. All parties that could even conceivably become engaged in coverage litigation should draft and implement internal procedures for the production, retention, storage and duplication
of all vital documents. Attorneys and staff should be trained to identify and protect information that could become germane to an insurance coverage dispute.

C. **Getting documents into evidence is often difficult.** Once the information relevant to proving exhaustion has been identified, the admissibility of this evidence becomes the key consideration. Authentication problems, hearsay objections and privilege issues are frequently hurdles to the admissibility of evidence relevant to a resolution of an exhaustion dispute.

i. **Authentication.** As a threshold matter, authentication will be a condition precedent to the admissibility any evidence. See Fed. R. Evid. 901(a). The proponent of a certain piece of evidence must put forth sufficient proof to demonstrate that a document in question is what its proponent claims. In an exhaustion dispute, the underlying claims at issue may have taken place decades prior to the actual evidentiary battle and the individuals that created the documents in question may no longer be available testify as to the authenticity the documents. Alternate means of authentication may be necessary for claim files, loss runs, accounting records or risk management documents. Some litigants have tried to authenticate this information by having an expert witness compare the document in question to a specimen that has already been authenticated. See Fed. R. Evid. 901(b)(3). A loss run could also be authenticated by proffering testimony describing the process by which a loss run is created and demonstrating that the process or computer system used to create a loss run produces accurate results. See Fed. R. Evid. 901(b)(9).
ii. **Hearsay.** A party seeking the admission of evidence to defeat or demonstrate exhaustion may face frequent hearsay objections from the opposition. An insurer, for instance, may seek the admission of its claim files as evidence despite the fact that the documents contain hearsay statements recorded by a deceased claim handler. One way to secure the admissibility of this information would be to argue that the claim files are records of regularly conducted business activities. *See* Fed. R. Evid. 803(6). The insurer would be required to demonstrate that it was the regular practice of the company to create claim files by offering the testimony of a company representative best suited to discuss the creation and maintenance of such records. In a similar, but somewhat divergent scenario, an insurer or insured may seek to prove the nonexistence of a document by demonstrating that it was a regularly kept business record but that it is not included within the reports, records or data routinely recorded and preserved. *See* Fed. R. Evid. 803(7).

iii. **Attorney-Client Privilege and Attorney Work Product.** Insurance coverage disputes almost always involve complex issues associated with the attorney-client privilege and the attorney work product doctrine. In certain jurisdictions, for instance, an insurer may be entitled to discover information created in underlying litigation that would otherwise be protected by the attorney-client privilege due to the “common interest” it shares with its insured. *See, e.g.*, *Waste Mgmt., Inc. v. Int’l Surplus Lines Ins. Co.*, 144 Ill.2d 178, 335-36 (Ill. 1991). Admissibility, however, does not always follow discoverability and excess insurers will not necessarily be allowed the same access as primary insurers. Insurers at the
primary and excess level as well as policyholders should all be aware of the applicable jurisdiction’s law regarding attorney-client privilege and attorney work product doctrine.

D. Proving trigger dates is complicated because information on when injury occurs is not needed in the underlying action. The law firms hired to pursue or defend the underlying litigation rarely develop the factual information necessary for the resolution of an exhaustion dispute. The law firms handling the underlying liability phase of the litigation will have an obligation to establish or defeat liability and to maximize or minimize damages. This process frequently omits critical information relevant to the most germane exhaustion questions such as trigger. For example, in a case involving underlying liability related to the contamination of a municipal water supply, a manufacturing company’s chief executive officer may provide extensive deposition testimony regarding the type of chemicals used at the company’s facility. The timing of any alleged release of the chemicals, however, may not be fully developed by this testimony. This information could become a necessary component of a coverage dispute.

III. How to Determine What Exhausts Limits

A. Does the claim trigger coverage during the insurer’s policy period? The first question to consider is whether the claim at issue “triggers” coverage under the policy. The general rule for determining when an “occurrence”-based policy will respond to a claim is to identify the policy period in which the claimant was actually injured. However, in cases of environment contamination or toxic tort, it may be difficult to pinpoint when injury occurred, and alternative “trigger” tests have developed.
i. **“Injury in Fact.”** Under the “injury in fact” test, the trigger date is the date the claimant was actually injured, even if the injury is not discovered until years later.

ii. **“Exposure.”** Under the “exposure” test, the trigger date is the date of exposure to the injury-producing substance.

iii. **“Manifestation.”** Under the “manifestation” test, the trigger date is the date the injury became reasonable apparent or known to the claimant.

iv. **“Continuous” or “Multiple.”** Under the “continuous” or “multiple” trigger test, all policies on the risk from the date of first exposure to the manifestation of injury are triggered. *See Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981). Significantly, under a continuous trigger approach, the same claim may trigger more than one policy.

B. **Does the “occurrence” limit in a multi-year policy apply to the multi-year policy term, or does it apply annually?** In multi-year policies containing both “per occurrence” and annual “aggregate” policy limits, the question arises whether the “per occurrence” limits also apply on an annual basis. “Federal courts that have considered the issue generally have determined that only one ‘per occurrence’ set of limits is available for a single occurrence under a multi-year insurance contract.” *See Allocation of Losses in Complex Insurance Coverage Claims § 8.2* (collecting cases). However, some courts have reached the opposite conclusion, reasoning that if a policyholder can establish that continuous injury occurred over a multi-year policy period, the policyholder is entitled to annualize the “per occurrence” limits and to recover a separate “per occurrence” limit for each year. *See Chemical Leaman Tank Lines, Inc. v. Aetna*
C. Do the claims constitute a single “occurrence” under the policy or multiple “occurrences”? Where a policy provides separate “per occurrence” and “aggregate” limits, the question arises whether the claims of multiple claimants constitute a single “occurrence” subject to the “per occurrence” limit or multiple “occurrences” subject to the policy’s “aggregate” limit.

D. If the claim triggers coverage under multiple policies, what proportion of the claimant’s damages is allocated to the insurer’s policy period? When more than one insurer’s policy period is triggered, the question arises whether – and, if so, how -- claims for indemnity should be apportioned among the triggered policies. Courts employ four distinct approaches.

i. “Pro Rata by Years.” Under the “pro rata by years” or “time on the risk” approach, each triggered policy bears a share of the total damages proportionate to the number of years on the risk, without regard to the policy’s limits of liability. See Ins. Co. of N. Am. V. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980).

ii. “Pro Rata by Years and Limits.” Under this approach, each policy’s share is based both on the number of years on the risk and the policy’s limits of liability. See Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994). In essence, an insurer’s liability is determined by calculating the aggregate limits of coverage provided by the insurer and comparing this figure to the total exposure assumed.
by all insurers on the risk. This percentage is then applied to the loss to determine the insurer’s share.

iii. “Pro Rata by Exposure.” Under this approach, the court apportions liability to each policy period based on the amount of injury attributable to that policy period. See Uniroyal, Inc. v. Home Ins. Co., 707 F. Supp. 1368 (E.D.N.Y. 1988). This approach is very fact-specific.

iv. “All Sums.” The “all sums” approach allows the policyholder to seek recovery in full under the triggered policy of its choosing. See Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981).

E. Must primary policies covering all potentially applicable policy periods be exhausted before any excess policies may be accessed? When a claim triggers numerous layers of coverage over multiple policy periods, another important question is the order in which the policies will be exhausted. There are two basic approaches: “horizontal exhaustion” or “exhaustion by layers,” and “vertical exhaustion” or “exhaustion by years.”


IV. Strategic Considerations in the Settlement Process

A. Will a settlement for less than policy limits keep the policyholder from reaching the next layer of coverage? Multiple courts have addressed the application of exhaustion clauses in excess policies to circumstances where the insured has entered into below-limits settlements with underlying insurers. The clear consensus from those cases is that when the exhaustion clause in question is clear and unambiguous, it must be enforced as written.


By contrast, those cases which have found that an insured could satisfy an exhaustion clause through below-limits settlements with underlying insurers (with the insured absorbing the resulting coverage gap) have done so because the exhaustion clause in question was ambiguous. For example, a widely-cited 1928 decision on this issue by the Second Circuit, Zeig v. Massachusetts Bonding & Insurance Co., found that an excess policy’s exhaustion clause which required that the underlying primary policy be “exhausted in the payment of claims to the full amount of the expressed limits” was ambiguous and was satisfied by the insured’s below-limits settlement with the primary carrier. 23 F.2d 665, 666 (2d Cir. 1928). However, the court expressly recognized the validity and enforceability of clearly-worded exhaustion clauses, commenting that “the parties could impose such a condition precedent to liability upon the policy, if they chose to do so.” Id. at 666.

A number of courts have found that exhaustion clauses which require the underlying insurers to “have paid or been held liable to pay” their full limits are unambiguous. And those courts have often contrasted the language of the exhaustion clause in question with the language of the Zeig exhaustion clause. For example, in Indian Harbor, the exhaustion clause in an excess policy issued by Swiss Re stated that it attached “only when the Underlying Insurer(s) shall have paid or have been held liable to pay, the full amount of the Underlying Limit(s)....” 2012 N.Y. App. Div. LEXIS 4627, at *8. The Appellate Division of the New York Supreme Court held that the Swiss Re policy’s exhaustion clause was, unlike the Zeig exhaustion clause, unambiguous and
enforceable. *Id.* at *12-13; see also Am. Re-Insurance Co. v. Universal Builders Supply Inc., 532 N.Y.S.2d 712, 714-16 (N.Y. App. Div. 1988) (finding that an exhaustion clause which required the underlying insurers to have paid or have been held liable to pay their full limits was unambiguous and enforceable).

**B. Where the “all sums” approach applies, how are settlement credits calculated?** The “all sums” approach allows the policyholder to seek recovery in full under the triggered policy of its choosing. The selected (“spiked”) insurer must then pursue cross-claims against the other carrier(s) in order to obtain apportionment. Where the other carrier(s) have settled with the policyholder, however, the selected insurer may be barred from pursuing a cross-claim. In that event, the court may grant a set-off or credit to the selected insurer based on the settlements the policyholder has reached with the other carrier(s). There are two different approaches.

i. **“Pro tanto.”** Under the “pro tanto” approach, the selected non-settling insurer gets credit only for the *amounts paid* by the settling carriers, regardless of the policy limits of the settled policies.

ii. **“Pro rata.”** Under the “pro rata” approach, the selected non-settling insurer gets credit for the *policy limits* of the settling carriers, even if the settling carriers paid less than their policy limits.