

**Evolution of the CGL,
Exposure Triggers and Allocation Methods:
More Problems Ahead?**

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Abstract

This study provides a review of major court rulings that have shaped the Commercial General Liability (CGL) market. A review of the issues impacting the CGL provides valuable insights into today's rapidly changing markets. Continuous injuries such as pollution, asbestos and various carcinogens have created difficulty in interpreting the CGL policy language that was originally drafted with much simpler and more definite injuries in mind. Likewise, involvement of numerous insurers on the same risk over time, when overlaid on such continuing injuries, complicates the issues even further. A stream of court decisions provides the backdrop for today's challenges including the reemergence of asbestos claims, the emergence of mold and mildew, the continued development of e-commerce exposures, and claims from the World Trade Center tragedy. As e-commerce risks continue to emerge, courts have begun to reinterpret liability and property contracts much the same as they reinterpreted contracts with regard to pollution and products in the 1970's and 1980's. At this time the insurance industry is facing another flood of asbestos claims presented to the same old CGL policies. The paper also discusses the controversy surrounding the insurance industry's influence in the creation of the ISO forms of the CGL claims-made and occurrence policies and the ruling in the *Hartford Fire* case. The evolution of the concept of "triggers" and allocations systems is also examined. By reviewing these events, insurers, insureds, and regulators can gain a new perspective on the importance of developing a clear standard wording that will be consistently interpreted even in light of future unknown exposures.

Introduction

Since the mid-1980's the insurance industry has utilized two commercial general liability (CGL) insurance policies. While claims-made and occurrence forms have been a part of commercial insurance for over fifteen years, there are several timely lessons that can be learned from the evolution of these policy forms.

Intertwined in the evolution of the policies is the controversy surrounding the issuance of the first claims-made policy form. Through a review of the *Hartford Fire Insurance*¹ case, one can see the dynamics that can impact the development of new coverage forms. Forces in this process were the Insurance Services Offices, Inc. (ISO), which developed the form, both domestic and international reinsurers, consumers, and the courts. These dynamics remain important as new forms of coverage continue to emerge to deal with new categories of liability risks. The development of the CGL policy provides a framework to discuss this process.

By looking at the legal cases surrounding the evolution of the coverage forms, the interpretation of policy wording, and the allocation of losses among multiple insurers, one develops a perspective on the way in which the judicial system has shaped and continues to shape the products and services offered by the insurance industry. This is relevant in light of current court cases surrounding coverage of e-commerce-related issues. Recently, the courts have reinterpreted the policy wording to apply to new settings that the insurers did not foresee and/or did not intend for the policy to cover. This is a familiar refrain looking back over the last three decades.

Along with the issues surrounding claims-made and occurrence coverage forms, the issue of what defines an "occurrence" or "trigger" has been a topic of much debate and interpretation in the courts. The courts' interpretations have impacted the losses for both current and prior

¹ *Hartford Fire Insurance Co. v. California*, 723 F. Supp., 464 (N.D. Cal. 1989, renamed *In Re Insurance Antitrust Litigation*, 938 F. 2d. 919 (9th Cir., 1991, renamed *Hartford Fire Insurance Company v. California*, 509 U.S. 764, 113 S.Ct. 2891, 125 L.Ed. 2d. 612 (1993).

period commercial general liability (CGL) insurance policies. Based on a series of court decisions, several very different interpretations of the term “occurrence” have evolved. These include the exposure theory, the manifestation theory, and the continuous trigger theory, among others. Additionally, various systems of allocating losses among insurance contracts and insureds have emerged. Examples of common allocation systems include the “all sums” approach, “time on risk” method, and “coverage provided” method.

Both claims-made and occurrence forms continue to be sold in the marketplace. In 1999, claims-made policies accounted for approximately 34 percent of the “other liability” market.² However, with the return of a hardening market, the consumer’s choice between claims-made and occurrence forms might be lessened as carriers increase prices and tighten coverage. For this reason, a clearer understanding of the issues surrounding the mechanics of the CGL forms is critical.

This paper provides a historical perspective on legal issues impacting the development of the CGL policy and the interpretation of the policy by the courts. The contributions of the study are twofold. First, the paper creates a better understanding of the key court cases and their impact on CGL coverages and losses. Secondly, the study provides a view of how the courts’ interpretation of policy language can dramatically impact the scope and characteristics of coverage. The remainder of this paper is divided into five sections. The first part is a general background on CGL wordings including background on the change to the claims-made policies. Subsequent sections trace definitions of triggers and allocations systems in context with key court rulings. Finally, the implications of these changed rulings in the current market place are discussed along with public policy implications for the general insurance market.

² Based on the total premiums written in “other liability” insurance as reported by the *National Association of Insurance Commissioner Property-Casualty Database*. The other liability coverage includes several lines of coverage including the CGL policies. Premiums written for CGL claims-made and occurrence policies are not isolated in the *NAIC Database*.

Background of the CGL Policy and the Change to “Claims-Made” Policies

General Background of the CGL Policy

The source of the duty to defend or the duty to indemnify is found in the contractual language of the policy. The interpretation of this wording has been the subject of a great deal of debate. One center of controversy is the courts’ interpretation of contract language with respect to injuries and damages that are slow to manifest and/or progressive in nature. Situations in which the injuries are manifested quickly after the occurrence are not subject to the range of interpretations present when injuries that are slow to manifest and/or progressive in nature. As noted in *Stonewall Insurance Company v. Asbestos Claims Management Corporation*³

...[T]he standard form language of the insurance policies appears to have been drafted in the expectation that it would usually be applied to the ordinary injury where accident and resulting harm take place almost simultaneously, a circumstance normally presenting no difficulty in determining when an injury has occurred. As the case demonstrates, however, substantial issues of interpretation arise where the policies are sought to be applied to injuries of a progressive nature, which may not fully develop or become manifest until years after exposure to the injury-causing substance.

The court commented:

Virtually the same policy language was used even until the 1980s, when insurers were well aware of the fact that asbestos-related claims were being brought against insureds, and that the nature of the injuries and damage involved in these claims was quite different from the types of harms envisioned in the 1950s.

This occurrence problem is closely intertwined with the other issues related to the evolution of the CGL policy. For example, it was a major impetus for the introduction of claims-made policy forms. Additionally, difficulty in dealing with claims that are progressive and/or slow to manifest has led to multiple court rulings that have developed competing theories related to policy triggers and allocation systems.

³ 73 F.3rd 1178 (2nd Cir., 1995), 1186-87, and note 3.

Introduction of the Claims-Made Policy Form

The Insurance Services Office (ISO) provides widely-used wording for the CGL insuring agreement, conditions, and definitions. Carriers may modify ISO wording, especially in large commercial policies, subject to negotiation. Commercial general liability insurance is often written on standard policy forms developed by ISO. In the mid-1980's, ISO was owned by 1400 property and casualty insurers in the U.S. ISO is a licensed ratings service and advisory organization in all 50 states. It prepares standardized policy forms and files them with state insurance departments.

In 1985, probably in response to the growing threat of asbestos and other products liability litigation, the ISO filed two proposed new policy forms for commercial general liability insurance, substantially modifying previous coverages. One form was a claims-made form where coverage is triggered by claims made during the policy period. The second form was an occurrence-based policy where coverage is triggered by injury during the policy period caused by an occurrence. With the occurrence form, insurers are exposed to so-called "long-tail" risks that are discovered or manifest long after the policy period.

There was a great deal of controversy surrounding the introduction of these forms. In 1988, following the fairly widespread adoption of the two forms, 19 states and several private plaintiffs filed complaints under the federal antitrust laws.⁴ The suit charged four major insurers including Hartford with engaging in a concerted effort to block adoption of the new forms within ISO in addition to seeking three other things: a retroactive date for the claims-made form, the addition of an absolute pollution exclusion, and a defense cost cap.⁵

Following lower court actions, the case proceeded to the U.S. Supreme Court regarding the validity of several defenses based on the McCarran-Ferguson Act immunities. The Supreme

⁴ 938 F. 2nd 925.

⁵ 723 F. Supp. 469.

Court effectively held (1) that insurers do not lose their McCarran-Ferguson Act immunity merely by acting in concert with non-exempt entities (in this case foreign insurers);⁶ (2) that international comity does not require American courts to refuse to hear the specific case, since there was no conflict with the law of any other nation;⁷ and (3) that the term “boycott” as used in the McCarran-Ferguson Act has a very narrow and specific meaning, inapplicable to this case.⁸

The result in *Hartford Fire* cleared the way both for the claims-made form and for a narrow reading of the “boycott” section of the McCarran-Ferguson Act. The end result has been that since the mid-1980’s, claims-made CGL policies have come into wider use, including terms and conditions favored by Hartford and the other insurers.

The new CGL policy wording did not resolve all the problems, however. Occurrence-based policies continue to be sold, and others remain effective for many "long-tail" liabilities. Courts continue to deal with claims arising from such "occurrences" many years after the fact.

Debate Over Policy “Triggers”

The creation of claims-made and occurrence-based policies is but one in a series of court related decisions in the CGL area. Another unresolved battle involves a word that does not even appear in the policy language: “trigger.” That term applies to events that determine whether a policy must respond to a particular claim in a given set of circumstances or an “occurrence” (Fram, 1993). These one hundred or so words in the coverage clause have “spawned a bewildering plethora of authority interpreting their meaning.”⁹

⁶ The decision on this point, written by Justice Souter, was unanimous.

⁷ The decision on this point was 5-4. It was written by Justice Souter, joined by Rehnquist, White, Blackmun and Stevens. Justice Scalia wrote a dissent, joined by Thomas, O’Connor and Kenney.

⁸ The decision on this point was also 5-4. Justice Scalia wrote the opinion, joined by O’Connor, Kennedy, Thomas and Rehnquist. Justice Souter dissented, joined by White, Blackmun and Stevens.

⁹ *Owens-Illinois, Inc. v. United Ins. Co.*, 138 N.J. 437, 650 A.2d 974, 979 (S Ct., N.J., 1994), citing *Gottlieb v. Newark Ins. Co.*, 238 N.J. Super, 531, 534 (App. Div. 1990).

Trigger of coverage issues do not arise in most simple negligence cases, such as auto accidents or slip and fall incidents. The date of the injury is obvious and comes from a specific, determinable incident. Substantial difficulty exists with injuries that result from long-term exposure to toxic substances, such as Agent Orange or asbestos. In such instances, the date of first exposure is sometimes not clear, nor is it the date associated with the manifestation of the injury. Setting aside the medical difficulties of proving causation, fixing the date of an injury is crucial to determining which of several insurers must bear liability for an incident.¹⁰

Courts have generally set the time of injury – the trigger – in one of three ways: at the date of exposure, at the date of manifestation, and over the continuous period from exposure to manifestation (the “continuous trigger” rule).¹¹ A basic understanding of these three theories is necessary to better grasp the problems of “stacking” and allocating losses across different insurance policies, insurers, and insureds over time. The theory selected by the courts has a dramatic impact on both the size of recovery and the insurers responsible for the judgment.

Exposure Theory

The leading case espousing the so-called *exposure theory* was the 1980 case of *Insurance Company of North America v. Forty-Eight Insulations, Inc.*¹² That theory holds that the policy is triggered on the date on which the injury-producing agent first contacts the body:

The court in *Forty-Eight* found that the occurrence was the immediate contact of an asbestos fiber with the lungs, even though the disease took some time to develop. The court’s central purpose was to maximize coverage: it chose the exposure theory because the plaintiff was effectively uninsured after 1976, and any other theory would have put the date of occurrence after 1976. In most toxic waste cases, however, when exposure is not discoverable until many years after the fact, the exposure rule will not provide a feasible method for insurers to monitor risks and charge appropriate premiums.¹³

¹⁰ *Uniroyal, Inc. v. Home Insurance Co.* 707 F. Supp. 1368, 1387 (E.D. N.Y., 1988), quoting *Developments in the Law – Toxic Waste Litigation*, 99 Harv. L.Rev. 1458, 1579-81.

¹¹ *Id.* See also *Owens-Illinois*, supra, p. 980.

¹² 633 F. 2d 1212 (6th Cir.1980), *clarified in part* 657 F. 2d 814 (6th Cir.), *cert. denied* 454 U.S. 1109, 102 S.Ct. 686, 70 L.Ed. 2d 650 (1981).

¹³ *Owens-Illinois*, supra, p. 980.

The exposure theory is simple and straightforward, providing that the insurer in place at the time of exposure shoulders responsibility for the entire resulting injury. Even if the disease lies latent for many years, as in the case of asbestosis, the carrier at the time of exposure must bear the loss. This theory works well for the insured and for the injured party if there was indeed insurance at the time of exposure and the insurer remains solvent. From the standpoint of the insurer, this theory does not permit the insurer to “close the books” on injuries or exposures, perhaps ever, as new exposures are developed.

Manifestation Theory

Other courts also have adopted the *manifestation theory*, again for reasons of expedience in maximizing coverage. A major case here is *Eagle-Pitcher Industries v. Liberty Mutual Insurance Co.*¹⁴, decided in 1982, where the First Circuit argued that the injury – again an asbestos-related occurrence – did not “occur” until the disease manifested itself. The Court took note of the *Forty-Eight Insulations* holding, but held that in the peculiar circumstances faced in *Eagle-Pitcher* the manifestation rule would maximize coverage. “In most cases, however, a manifestation rule would reduce coverage: insurers would refuse to write new insurance for the insured when it became apparent that the period of manifestations, and hence a flood of claims, was approaching. The insured would be left without coverage for victims whose diseases had not yet manifested.”¹⁵

The term “manifestation” is itself ambiguous and must be interpreted in the light of specific injuries in specific cases. This rule, like the exposure theory, depends on the existence of a solvent insurer on the date of manifestation. And, as noted, the rule provides an incentive for insurers to not provide coverage in the face of looming manifestation of injury.

¹⁴ 682 F. 2d 12 (1st Cir., 1982), *cert. denied* 460 U.S. 1028, 103 S.Ct. 1279, 75 L.Ed. 2d 500 (1983).

¹⁵ Owens-Illinois, note 11, p. 981.

Continuous Trigger Theory

A third theory is known as the *continuous trigger theory*. The principal case is *Keene Corp. v. Insurance Co. of North America* decided in 1981.¹⁶ The *Keene* court held that because asbestos-related disease develops slowly, the date of the occurrence should be the continuous period from exposure to manifestation. It held all insurers over that period liable, again relying on the principle of maximizing coverage. “Because it avoids the dangers of the manifestation rule, and because it encourages all insurers to monitor the risks and charge appropriate premiums, the continuous trigger rule appears to be the most efficient doctrine for toxic waste cases.”¹⁷

This rule appears to provide the greatest chance for there to be at least some coverage for an injury. It does not depend on the existence of a solvent insurer at any specific point in time. This theory also leads naturally to the issue of allocation between insurers and to the idea of proration of liability between insurers based on time-on-the-risk and policy limits.

Lesser-Known Theories

There are two other lesser-known theories associated with coverage triggers. First, the *injury-in-fact* (or *damages-in-fact*) theory provides that coverage is triggered by a showing of actual injury or damage-producing event. The 1983 decision in *American Home Products Corp. v. Liberty Mutual Ins. Co.* is the main case.¹⁸ Under that theory, coverage is triggered by a “real but undiscovered injury, proved in retrospect to have existed at the relevant time. . . irrespective of the time the injury became manifest.”¹⁹ In other words, the time of injury is subject to actual

¹⁶ 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied* 455 U.S. 1007, 102 S. Ct. 1644, 71 L.Ed. 2d 875 (1982).

¹⁷ Owens-Illinois, p. 981.

¹⁸ 565 F. Supp. 1485 (S.D.N.Y. 1983), *aff'd as modified*, 748 F. 2d 760 (2d. Cir. 1984).

¹⁹ *Id.* At 1497.

proof and reasonable inferences – ordinarily medical or expert testimony.²⁰ The damages may result at any time from exposure forward, at whatever time there is actual injury or damage.

Second, the *double-trigger* theory holds that the injury occurs at the time of exposure AND the time of manifestation, but not necessarily during the intervening period. The main (and perhaps only) case is *Zurich Ins. Co. v. Raymark Industries, Inc.*,²¹ decided in 1987. There seems to be little support or rationale for this decision.

Conclusions Regarding Policy “Triggers”

The literature reveals that the courts’ decisions often rely on the presumed goal of maximizing coverage. “A rule of law premised on nothing more than the result-oriented goal of maximizing coverage has been described as “judicial legislation.”²² Fairness to the insurer or to non claims-making insureds who might pay higher premiums is often not considered. The decisions seem remarkably consistent only insofar as they attempt to find a theory that will compensate the injured party. But as noted in *Owens-Illinois*:

...[O]ur resolution of the issues is necessarily imperfect. Our concepts of legal causation were developed in an age of Newtonian physics, not of molecular biology. Were it possible to know when a toxic substance clicks on a switch that alters irrevocably the composition of the body and before which no change has ‘occurred,’ we might be more confident that occurrence-causing damage had taken place during a particular policy period. The limitations of science in that respect only compound the limitations of law.²³

This serves to highlight the continued difficulty that courts, insurers, and policyholders have in assessing the occurrence of many latent and/or prolonged injuries. As a result of this on-going debate, policyholders and insurers still face coverage issues on many claims. The discussion also highlights the way in which a court can interpret policy wording in light of new

²⁰ See also *Armstrong World Indus. Inc. v. Aetna Casualty & Sur. Co.*, 25 Cal App. 4th 1316, 26 Cal. Rptr. 2d 35, 52 (1993), review granted *sub.nom.* In re Asbestos Ins. Coverage Cases, 27 Cal. Rptr. 2d 488, 866 P.2d 1311 (1994).

²¹ 118 Ill. 2d 23, 112 Ill. Dec. 684, 695, 514 N.E. 2d. 150, 161 (1987).

²² *American Home Products, supra*, 565 F. Supp. At 1512.

²³ 650 A.2d 974 at 985.

or emerging exposures in ways not thought of by insurers and/or regulators. These interpretations have a direct impact on the buyers, claimants, insureds, and insurers.

Scope of Coverage and the Problem of "Stacking"

Based on the trigger theories outlined above, several insurance policies and/or periods of self-insurance may be triggered by a single claim. Often several insurers were used during the time period between exposure and manifestation. In many instances, periods of voluntary and/or involuntary self-insurance also are involved. The allocation question relates to the method a court will choose to allocate damages between triggered policies and/or periods of self-insurance.

The ruling most favorable to policyholders is found in *Keene Co. v. Insurance Co. of North America*.²⁴ That court ruled “that any triggered policy must respond for the entirety of a claim, subject to the effect of ‘other insurance clauses’ and principles of equitable contribution, but without assigning responsibility for a portion of coverage to the policyholder even if it were uninsured or self-insured.”²⁵ Other cases supporting this position include *J.H. France Refractories Co. v. Allstate Insurance Co.*,²⁶ *Acands Inc. v. Aetna Casualty & Surety Co.*,²⁷ and *Sandoz Inc. v. Employer’s Liability Assurance Corp.*²⁸ These cases putatively stand for the proposition that in some cases medical evidence might establish the extent to which injury occurred during a policy period, thus allowing for apportionment of losses. Absent such evidence, these cases support the *Keene* position, which is often referred to as *joint and several liability*, or the *all sums* approach.

²⁴ 667 F.2d 1034 (D. C. Cir., 1981); cert. denied 455 U.S. 1007, 102 S. Ct. 1644, 71 L.Ed.2d 875 (1982).

²⁵ *Id.*, cited in *Owens-Illinois*, p. 986.

²⁶ 534 Pa. 29, 626 A.2d 502, 508 (1993).

²⁷ 764 F.2d 968, 974 (3^d Cir., 1985).

²⁸ 554 F. Supp. 257, 266 (D.N.J. 1983).

Joint and Several Liability (the Keene Approach) or “All Sums” Approach

While sometimes called a *joint and several* liability approach, the *Keene* model is not precisely such.²⁹ *Keene* used a conceptual model of a pleated accordion surrounding the entire occurrence, representing the time span from exposure to manifestation. The *Keene* court solved the problem of indivisible injury by collapsing the injuries in the accordion into a single year:

The principle of indemnity implicit in the policies requires that successive policies cover single asbestos-related injuries. That principle, however, does not require that *Keene* be entitled to “stack” applicable policies’ limits of liability. To the extent possible, we have tried to construe the policies in such a way that the insurers’ contractual obligations for asbestos-related diseases are the same as their obligations for other injuries. *Keene* is entitled to nothing more. Therefore, we hold that only one policy’s limits can apply to each injury. *Keene* may select the policy under which it is to be indemnified.³⁰

The *Keene* court went on to explain that when more than one policy applies to a loss, the “other insurance” provisions of the policy provide a scheme by which the insurer’s liability is to be apportioned. This is a doubtful proposition, since other insurance clauses are designed to settle disputes between insureds and insurer, not between insurers.

It is not clear from *Keene* whether this rule applies to each *claim* of injury or each *cause* of injury. For example, if there are two hundred claimants, all claiming asbestos-related injuries over a lengthy period of time, it is not intuitively clear under *Keene* whether the insured would be forced to choose one single insurer to target (presumably the one with the highest limits that would cover the most claimants) or whether the insured could distribute each of the two hundred claimants to different insurers.³¹ In *Owens-Illinois*, the Court surmised that the *Keene* court’s holding was that one policy’s limits apply to each *claim* of injury.³²

²⁹ Joint and several liability is generally defined as when a creditor may sue one or more of the parties separately or all together at the creditor’s option, and the entire liability may be imposed entirely on one of the parties.

³⁰ 667 F.2d at 1049-50.

³¹ Wm. R. Hickman and Mary R. DeYoung, *Allocation of Environmental Cleanup Liability Between Successive Insurers*, 17 N. Ky. L. Rev. 291, 301 (1990).

³² 986 A.2d at 986.

A subsidiary question under the joint and several liability theory is who is permitted to choose which insurer will be held liable. In applying Pennsylvania law in *Air Products and Chemicals, Inc. v. Hartford Accident and Indemnity Co.*,³³ the district court utilized a joint and several liability scheme but did not permit the policyholder the discretion to select the policies for coverage. That court instead directed that “liability among triggered policies should be apportioned chronologically and seriatim.”³⁴

Pro-rata allocation or “time on risk” method

Several courts have come to a substantially different conclusion with respect to allocation systems, known as *pro-rata* or time on the risk when using a multi-year trigger theory [Steuber, 1994]. The leading case is *Insurance Co. of North America v. Forty-Eight Insulations Inc.*³⁵ In this case, the court concluded that a reasonable means of allocating defense costs among triggered policies was based on the number of years of exposure. Other courts have used similar formulae, such as the *Uniroyal v. Home Ins. Co.*³⁶ a case in which evidence was available to differentiate between the various periods of coverage. In this case, the judge applied a *pro-rata* method under which the loss was allocated to each policy according to the portion of injuries triggering the policy, based on the quantity of toxic substance released during the respective

³³ 707 F. Supp. 762 (E.D. Pa.1989) *aff’d in part, vacated in part*, 25 F.3d 177 (3d Cir.1994).

³⁴ *Id.* at 769, quoting the trial court opinion in *J.H. France Refractories Co. v. Allstate Insurance Co.* The 3rd Circuit in *Air Products* later rejected the lower court’s apportionment scheme in favor of joint and several allocation, permitting the insured to select the policy under which it is to be indemnified.

³⁵ 633 F.2d 1212 (6th Cir., 1980, clarified, 657 F.2d 814 (6th Cir.), *cert.den.* 454 U.S. 1109, 102 S.Ct. 686, 70 L.Ed. 2d 650 (1981). Other courts taking the same approach include *Gulf Chemical & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, 1 F.3d 365, 372 (5th Cir.1993) (apportioning cost of policyholder’s defense among insurers on risk; policyholder must bear its share of defense costs determined by the fraction of time it lacked coverage. Applied Texas law.) *Fireman’s Fund Insurance Cos. V. Ex-Cell-O Corp.*, 685 F. Supp. 621, 626 (E.D. Mich.1987) (holding insurer on risk during period of alleged exposure liable for policyholder’s defense in proportion that period on risk bears to total period of alleged exposure; policyholder must bear pro-rata share of costs for uninsured periods); and *Northern States Power Company v. Fidelity & Casualty Company of N.Y.*, 523 N.W. 2d 657 (Minn., 1994), (allocating damages to insurers in proportion to time on risk; policyholder carrying only excess insurance must assume retained limit with respect to each policy.)

³⁶ 707 F. Supp. 1368 (E.D.N.Y., 1988).

policy periods. Notably, Judge Weinstein rejected the joint and several liability rule of *Keene* for a simple reason:

[B]ecause for one period the manufacturer had had no insurance, and the Keene court viewed its mission as ensuring that the manufacturer received complete indemnity for all its asbestos-related losses. A firm that fails to purchase insurance for a period, however, is self-insuring for all the risk incurred in that period; otherwise it would be receiving coverage for a period for which it paid no premium. Self-insurance is called ‘going bare’ for a reason.³⁷

“Coverage Provided” Method (And Treatment of Self-Insurance)

With regard to allocation, there is no great difference in principle between *Keene* and *Forty-Eight Insulations*. Using either method, allocation will exist among insurance companies on the risk. Using either method, the use of the multi-year trigger will not end the litigation. The principal difference between *Keene* and *Forty-Eight Insulations* is in their treatment of self insurance.”³⁸

Owens-Illinois also was unable to find the answer to allocation in the language of the policies. The Court in that case spent considerable time in reconstructing the drafting history of the occurrence clause in the 1966 CGL policy, and found little help.³⁹ *Owens-Illinois* also found little refuge in the usual principles of interpretation of contracts of insurance. Textbooks describe insurance contracts as *contracts of adhesion* where ambiguities will be construed in favor of the insured. The court said, “*Owens-Illinois* was a sophisticated insured and cannot seek

³⁷ Id. at 1392.

³⁸ *Owens-Illinois*, 650 A.2d at 989.

³⁹ Id. at 990-91. See also Eugene R. Anderson, *History of Disputed Provisions of the 1966 Standard Form Comprehensive General Liability Insurance Policy, Drafting History, Sales History and Historical Review of Commentators in Insurance, Excess, and Reinsurance Coverage Disputes* 1989, at 203, (PLI Litig. & Admin. Practice Course Handbook Series No. 369, 1989), available in WESTLAW, PLI-LIT, Database, *7.

refuge in the doctrine of strict construction by pretending it is the corporate equivalent of the unschooled, average consumer.”⁴⁰

Instead, the *Owens-Illinois* court proposed perhaps the most sophisticated and complex remedy yet devised. The Court first used, as logically necessary in the absence of medical proof, a continuous-trigger theory.⁴¹ The Court then rejected a straight annual progression theory, under which each injury would be divided equally by the number of years since exposure as an inappropriate and inaccurate measure:

The degree of risk transferred or retained in the early years of an enterprise like *Owens-Illinois* obviously was not at all comparable to that sought to be insured in later years. Hence, any allocation should be in proportion to the degree of risks transferred or retained during the years of exposure. We believe that measure of allocation is more consistent with the economic realities of risk retention or risk transfer. That later insurers might need to respond to pre-policy occurrences is not unfair. “These are ‘occurrence’ policies which, by their nature, provide coverage for pre-policy occurrences (acts) which cause injury or damage during the policy period.” (citing other cases.)⁴²

In *Owens-Illinois*, the Court essentially allocated the losses among the carriers on the basis of the extent of the risk assumed; i.e., proration on the basis of policy limits, multiplied by years of coverage (time-on-the-risk).⁴³ The court also found it was reasonable to require the insured to contribute on the same basis during periods of self-insurance or non-insurance:

A fair method of allocation appears to be one that is related to both the time on the risk and the degree of risk assumed. When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods of when coverage for a risk is not available, to expect the risk-bearer to share in the risk is reasonable. Estimating the degree of risk assumed is difficult but not impossible.⁴⁴

The *Owens-Illinois* case has been cited as “the leading opinion in the field, and surely one of the best reasoned.”⁴⁵ The *Stonewall* case is interesting for the additional facts that, after 1985, asbestos insurance was simply not available. In *Stonewall*, the court held that the “proration to

⁴⁰ *Owens-Illinois*, 650 A.2d at 991.

⁴¹ *Id.*, p. 993.

⁴² *Id.*, p. 993.

⁴³ See also *Armstrong World Industries*, *supra*, 26 Cal.Rptr.2d at 57.

⁴⁴ *Owens-Illinois*, p.995.

⁴⁵ *Stonewall Ins. Co. v. Asbestos Claim Management* 73 F. 3d 1178 (2d Cir., 1995).

the insured” rule should NOT be applied to those periods, on the ground that they were not “bargained away,” but insurance for asbestos exposures was simply not available during the insurance crisis of the mid 1980’s.⁴⁶

Allocation of the Duty to Defend

In *Insurance Co. of North America v. Forty-Eight Insulations*, clearly the leading case on the allocations of the duty to defend, the Sixth Circuit, applying an “*Erie-guess*” of what it believed Michigan law would be, was faced with the prototype asbestos case. The case was brought by a manufacturer of asbestos products against five different insurance companies that had insured the plaintiff over many years. Prior to 1955, the plaintiff was self-insured. From 1955 to 1972, the plaintiff was insured by Insurance Company of North America (INA), but with different policies with differing coverage limits. From 1972 to 1975, Affiliated FM Insurance Company provided insurance. From 1975 to 1976, Illinois National was the insurer. In 1976 Travelers Indemnity provided insurance for several months. And from 1976 to the date of suit Liberty Mutual Insurance Company insured the company. The court spent considerable time dealing with the choice of “trigger” and ended by adopting the *exposure theory* thus concluding that bodily injury should include the tissue damage that takes place upon initial inhalation of asbestos. The first issue in the case dealt not with insurance coverage, but with the question of the duty to defend and defense costs. While it is obvious the duty to defend is broader than the duty to pay judgments, the issues are intertwined and were so treated by the court.

The principal issue in the case was the allocation of liability among the insurers, including the issue of allocating the liability to the insured for years of non-insurance. The court’s description of the allocation process is instructive:

⁴⁶ Id., p. 1203.

The district court...adopted the exposure theory for purposes of liability and prorated liability among all of the insurance companies which were on the risk while the injured victim was breathing in asbestos. For those years that Forty-Eight did not have insurance, the district court treated the manufacturer as self-insured and responsible for a pro rata share of the cost of indemnification. Thus, if insurer A provided 3 years of coverage, insurer B an additional 3 years, and the manufacturer was uninsured for the remaining 3 years, liability would be allocated at 1/3 for each of the three concerns.

The district court applied an identical rule apportioning the costs of defending the underlying suits. To the extent that the manufacturer was uninsured, it has to bear its pro-rata share of the costs of defense.⁴⁷

The insured, *Forty-Eight*, agreed that liability should be apportioned as described, but argued that defense costs should not fall on its shoulders at all because the policies provided a duty to defend based on the allegations of the complaint.⁴⁸ The court did not agree, especially where, as here, the defense costs could be readily apportioned based upon the date that the claim arose.⁴⁹ Finally, the court moved on to the issue of allocation of liability:

...[I]n allocating the cost of indemnification under the exposure theory, only contract law is involved. Each insurer is liable for its pro rata share. The insurer's liability is not 'joint and several,' it is individual and proportionate. Accordingly, where an insurer can show that no exposure to asbestos took place during certain years, then that insurer cannot be liable for those years. The reason is simple: no bodily injury *resulting from Forty-Eight's products* (court's emphasis) took place during the years in question...However the burden of disclaiming coverage will be on the insurer for the year or years in question.⁵⁰

Finally, the court made extended comments about the concept of "stacking." From 1955 through 1977, Forty-Eight was covered by twelve different insurance policies issued by five different companies. Eleven of these policies had limits of from \$300,000 to \$500,000 and one had a limit of \$1,000,000. The combined limits of the twelve policies were \$5.6 million. The court noted that if the inhalation of each asbestos fiber was deemed to be a separate 'bodily injury,' this would result in the 'stacking' of liability coverage to produce coverage that is many times \$5.6 million, giving Forty-Eight much more insurance than it paid for:

⁴⁷ 633 F.2d at 1224.

⁴⁸ *Id.*, citing *Maryland Casualty Co. v. Peppers*, 64 Ill.2d 187, 355 N.E. 2d 24 (1976).

⁴⁹ *Id.*

⁵⁰ *Id.*, 1225.

[N]o insurer should be held liable in any one case to indemnify Forty-Eight for judgment liability for more than the highest single yearly amount in a policy that existed during a period of the claimant's exposure for which judgment was obtained. . . .The initial exposure to asbestos fibers in any given year triggers the coverage. However, under the terms of the policies, additional exposure to asbestos fibers is treated as arising out of the same occurrence. Thus, on its face, the liability of each insurer is limited to maximum amount 'per occurrence' provided by each policy. We have no problem with extending the policy language so that each insurer would face no more liability per claim than the maximum limit it wrote during any applicable year of coverage.⁵¹

The court affirmed the judgment of the district court.

Conclusions on Allocation Systems

As seen throughout this discussion, state and federal courts have devised a variety of systems based on the specific elements of losses and applications of the laws of various states. While their systems vary, the theme of maximizing coverage to the insured is consistent. The issue of what is fair to the insurer and thus to the non-claims filing policyholders rarely enters into determinations.

Two further issues appear clear. First, multiple policies can and often are called upon for a single occurrence, in the practice often referred to as "stacking." Second, depending on the jurisdiction and prior rulings, the system of allocating the loss among policy periods and/or insurers can vary between a "time on risk" and "coverage provided" system. As seen in the previous discussions, the courts have implemented a variety of systems. There is currently no single uniform method that provides a definitive ruling for the allocations of long-tailed losses among insurers. Given state primacy over insurance regulation, it is in fact doubtful that such a uniform method would or could be adopted.

⁵¹ Id. at 1226, court's note 28.

The Current Marketplace

Through the process of changing and often seemingly contradictory court rulings, both claims-made and occurrence forms have persisted in the market. Table 1 shows the premium volume for each of the major coverage forms in recent years. In 1999, claims-made policies accounted for approximately 34 percent of the premiums written in the “other liability” insurance category, which contains the CGL.⁵²

Table 4 contains a summary of the losses for the claims-made and occurrence policies in the same time period. Losses reported for the claims-made forms are consistently about 20 percent of the total losses for those lines of business. The results of Table 5 illustrate the ratio of losses to premiums for “other liability” policies. During the period sampled, the loss ratio for the occurrence policies was significantly higher than the loss ratio for the claims-made policies. This furthers the idea that the rulings discussed throughout the paper have increased the loss ratio for occurrence policies. As the insurance market hardens, it is likely that insurers and reinsurers will look to claims-made policies as a means on controlling cost and reducing their combined ratios.

Conclusions and Public Policy Implications

The addition of claims-made policies to the insurance marketplace, the debates over policy triggers, and the emergence of numerous allocation systems have created a dynamic environment for insureds and insurers in the commercial general liability marketplace. While these issues have subsided from the insurance trade press in recent years, they are perhaps more timely than

⁵² The NAIC database does not provide a breakdown of the claims-made and occurrence premiums specifically for the CGL policy. A data source containing this specific information could not be identified. It is interesting to note the average percentage of claims-made insurance for products liability insurance has ranged from 9 to 13 percent during the 1995 – 1999 time period. (See Table 2) By contrast, Table 3 shows that claims-made policies account for between 70 and 74 percent of the medical malpractice policies. For this reason, one must be very cautious with inferences concerning the percentage of occurrence based CGL coverage.

ever with the advent of the cases related to e-commerce, the growing number of so-called second or third generation asbestos and DES claims, toxic mold, long-tail environmental claims, and now the World Trade Center losses.

In a recent Arizona court case, a circuit judge ruled, “a standard property damage and business interruption policy covers losses caused by computer outages.”⁵³ By saying that “‘physical damage’ is not restricted to the physical destruction or harm of computer circuitry but includes loss of access, loss of use and loss of functionality,” the case dramatically broadened the coverage in the policy. While the insurers and reinsurers involved in the case have filed counter suits and appealed the decision, this case could have a dramatic impact on the insurance industry just as latent injury claims had in the CGL markets in the 80’s. Is there a need for a new definition of property damage?

In light of these recent events, a discussion of the CGL policy and the court rulings that interpreted the policy with respect to the emerging latent injury class of liability risks provides a basis to better understand the potential impact of contemporary rulings. The events in the CGL market call for a concerted effort from regulators and insurers to carefully look at the policy wording to see how coverage responds to new and unexpected risks as well as to familiar old ones. In the event of potential ambiguity, new more precise wording should be developed to clarify the intent and scope of the policy. These actions could protect the industry from a barrage of seemingly different court rulings related to future claims while still protecting the interest of insureds. In the post World Trade Center era, these questions are more critical. Massive losses will certainly reduce industry capital and spark an even harder insurance market. At this writing, the latest revisions in the CGL are underway.

⁵³ John Leming, *E-Coverage Alter*, Risk Management, No. 8, 12 – 16, 47 (2000).

TABLE 1

**Yearly Premiums Written For Other Liability Policies
Claims-made vs. Occurrence***

Year	Claims-made	Occurrence	Percentage Claims-made
1995	\$10,190,149,995	\$22,497,663,235	31.17%
1996	\$12,338,239,230	\$22,024,870,003	35.91%
1997	\$11,539,991,786	\$23,661,208,973	32.78%
1998	\$10,665,825,521	\$23,356,202,873	31.35%
1999	\$11,290,147,740	\$22,320,621,865	33.59%

*Values Taken from the *NAIC Property-Liability Database*

TABLE 2

**Yearly Premiums Written For Monoline Products Liability Policies
Claims-made vs. Occurrence***

Year	Claims-made	Occurrence	Percentage Claims-made
1995	\$398,036,412	\$3,072,825,774	11.47%
1996	\$433,540,911	\$3,080,068,564	12.34%
1997	\$439,729,223	\$2,847,822,952	13.38%
1998	\$318,547,914	\$2,664,955,268	10.68%
1999	\$270,610,914	\$2,698,321,199	9.11%

*Values Taken from the *NAIC Property-Liability Database*

TABLE 3

**Yearly Premiums Written For Products Liability Policies
Claims-made vs. Occurrence***

Year	Claims-made	Occurrence	Percentage Claims-made
1995	\$5,308,457,456	\$1,910,821,216	73.53%
1996	\$5,524,646,771	\$2,150,559,029	71.98%
1997	\$5,711,378,326	\$2,192,571,443	72.26%
1998	\$6,041,965,835	\$2,425,323,808	71.36%
1999	\$6,117,778,997	\$2,587,506,820	70.28%

*Values Taken from the NAIC Property-Liability Database

TABLE 4

**Yearly Losses For Other Liability Policies
Claims-made vs. Occurrence***

Year	Claims-made	Occurrence	Percentage Claims-made
1995	17,534,106,181.00	79,489,510,857.00	18.07%
1996	19,174,490,321.00	80,698,669,485.00	19.20%
1997	19,196,170,158.00	81,377,051,090.00	19.09%
1998	20,302,249,187.00	83,870,889,483.00	19.49%
1999	19,763,567,398.00	77,788,224,909.00	20.26%

*Values Taken from the NAIC Property-Liability Database

TABLE 5

**Yearly Ratio of Losses to Premiums
for Other Liability Insurance**

Year	Claims-made	Occurrence
1995	1.72	3.53
1996	1.55	3.66
1997	1.66	3.44
1998	1.90	3.59
1999	1.75	3.49

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