

## PERSPECTIVES

# EXPOSURE TRIGGERS AND ALLOCATION METHODS: LEARNING LESSONS FROM PRIOR COURT RULINGS

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### ABSTRACT

This study provides a review of some of the major court rulings that have shaped and continue to shape the commercial general liability (CGL) market. The evolution of the concepts of “triggers” and allocations systems is examined to gain a perspective on the way in which courts reinterpret contract language to apply to new and emerging exposures. A review of the issues impacting the CGL provides valuable insights into the way court rulings can create a significant impact in the insurance market. A stream of court decisions provides the backdrop for today’s challenges, including the reemergence of asbestos claims. The study also fills a gap in the literature related to the crisis in the CGL marketplace and changes in the pricing, regulation, and solvency of insurers operating in those lines. As old risks continue to evolve and new risks emerge, courts have begun to reinterpret liability contracts in much the same way as they reinterpreted contracts with regard to pollution and products in the 1970s and 1980s. Recent rulings related to asbestos and environmental liability underscore the importance of these issues in today’s marketplace. By reviewing these events related to the CGL policy, insurers, insureds, and regulators may gain a new perspective on the importance of developing a clear standard wording that will be consistently interpreted in light of new exposures.

### INTRODUCTION

For over three decades, the wording of the commercial general liability (CGL) policy has been at the center of a number of legal disputes and conceptual difficulties arising from the nature of the events triggering the coverage. Since the mid 1980s, the insurance industry has utilized two CGL insurance policies. The evolution of those two forms and

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their application to a series of unexpected coverage issues has been an ongoing saga at the epicenter of such issues as asbestos, Agent Orange, and toxic substances.

Clearly, the judicial system has shaped the products and services of the insurance industry. The evolution of the coverage forms, the interpretation of policy wording, and the allocation of losses among multiple insurers, provide a perspective on the way in which the law and the insurance industry are related to one another. Over the years, the courts have reinterpreted the policy wording to apply to new settings insurers did not foresee and/or did not intend for the policy to cover. Recent rulings related to asbestos and environmental exposures highlight the fact that the interpretation of CGL contracts is still an important issue facing both insurers and insureds (e.g., McLeod, 2003).

This article explores the impact of court rulings on policy interpretation by providing a historical perspective on legal issues impacting the development of the CGL and its interpretation by the courts. First, the article provides a brief review of the events surrounding the creation of the claims-made policy form. The article then focuses on the debate over what defines an "occurrence" or "trigger." Additionally, various systems of allocating losses among insurance contracts and insureds are discussed. The significance of these changed rulings for the current market place, as well as the academic literature, is discussed. Finally, public policy implications for the general insurance market are reviewed.

This article contributes to the prior literature in several ways. First, by tracing the various interpretations of the CGL policy with respect to latent and continuous injury claims, we hope to find patterns in the court rulings with respect to policy interpretation. These patterns provide important lessons for insurers and regulators, as both old and new policy forms are interpreted in light of emerging exposures. Secondly, these rulings help to better understand the evolution of the CGL marketplace, as insurers have adapted underwriting guidelines, price, and coverage forms to deal with the courts' interpretations. Finally, these issues, while significantly impacting the CGL market, have not been controlled for in prior empirical and theoretical papers related to changes in the liability market. The likely reason for this omission is that it would be difficult or impossible to incorporate the different trigger theories and allocation systems in the models. An understanding of these issues helps to explain some of the abnormalities found in the insurance marketplace as the insurers struggled to adjust to the changing legal environment and emergence of new risks.

## **BACKGROUND OF THE CGL POLICY AND THE CHANGE TO "CLAIMS-MADE" POLICIES**

### Introduction of the Claims-Made Policy Form

Commercial General Liability insurance is usually written on standard policy forms developed by the ISO (Insurance Services Office). Carriers may modify ISO wording, especially in large commercial policies which are subject to negotiation.<sup>1</sup> In 1985, probably in response to the growing threat of asbestos and other products liability litigation, ISO filed two proposed new policy forms for CGL insurance, substantially modifying

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<sup>1</sup> ISO is a licensed ratings service and advisory organization in all 50 states, preparing standardized policy forms and filing them with state insurance departments.

previous coverages.<sup>2</sup> One form is a “claims-made” form where coverage is triggered by claims made during the policy period. The second form is an “occurrence-based” policy form in which coverage is triggered by injury during the policy period caused by an occurrence.

With the occurrence form, insurers may be exposed to so-called “long-tail” risks that are discovered or manifested long after the policy period. “Occurrence” forms had been in use for decades. The original policy wording simply did not envision the kind of long-tail environmental dangers and hazards that became more and more commonplace with complex manufacturing processes, environmental pollution, and increasing sophisticated medical and ecological knowledge. The purpose of the “claims-made” policy was to limit long-tail liability from newly developing claims, particularly asbestos claims.

There was a great deal of controversy surrounding the introduction of these claims-made forms. In March 1988, following the fairly widespread adoption of the two forms, seven states filed complaints, each containing eight federal claims under the federal antitrust laws. In June, ten additional states filed complaints. Various private plaintiffs joined, and in total, 19 states were represented in the litigation.

The antitrust-based suit charged Hartford, CIGNA, Allstate, and Aetna with engaging in a concerted effort to block adoption of the new forms within ISO. The complaints alleged that the four defendants, ISO, various reinsurers, and Lloyd’s of London with committing a series of acts in furtherance of a conspiracy to boycott the new forms, including clandestine meetings and overt and covert agreements in restraint of trade. The case proceeded to the U.S. Supreme Court on the issue of the validity of several defenses based on McCarran-Ferguson Act immunities raised by the defendants.

The U.S. Supreme Court effectively held (1) that insurers do not lose their McCarran-Ferguson Act immunity merely by acting in concert with nonexempt entities (in this case foreign insurers); (2) that international committee does not require American courts to refuse to hear the specific case, since there was no conflict with the law of any other nation; and (3) that the term “boycott” as used in the McCarran-Ferguson Act has a very narrow and specific meaning inapplicable to this case. The end result has been that since the mid 1980s, claims-made CGL policies have come into wider use, including terms and conditions favored by Hartford and the other insurers.<sup>3</sup>

Thus, the insurers and reinsurers, through careful lobbying of ISO, were able to alter the original wording proposed for the claims-made contracts. The new policy wording also contained several other changes favorable to the insurance industry, such as a retroactive date for claims made and the absolute pollution exclusion. The result was that some components of the insurance industry, namely certain large reinsurers and

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<sup>2</sup> Anderson (1987) explains that the proposed changes by ISO were largely influenced by developments in the asbestos area. The precedents set in the asbestos litigation also have an impact on other tort cases related to DES, the Dalkon Shield, and hazardous waste claims.

<sup>3</sup> See generally *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), again renamed *Hartford Fire Insurance Company v. California*, 509 U.S. 764, 113 S. Ct. 2891, 125 L. Ed. 2d 612 (1993). The case provides an interesting discussion of how changes in policy forms are made and the alleged pressures on ISO that help to create new policy forms.

large property insurance carriers, were able to influence ISO to adopt favorable “claims-made” policy wording and other advantageous changes, and successfully defend those changes against antitrust actions through the highest court.

The approval of the new policy language did not end the debate surrounding the policy wording. A new set of controversies arose surrounding the interpretation of contract language by various courts throughout the country. These controversies generally involved injuries and damages that are slow to manifest and/or are progressive in nature. As noted in the 1995 decision in *Stonewall Insurance Company v. Asbestos Claims Management Corporation*,<sup>4</sup>

... [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 . . . [H]owever 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 existence of a latent injury or progressive injury has created two sets of problems that need to be addressed. First, it has led to the issue of defining the term “occurrence.” Second, it has led to the problem of allocating losses between multiple insurers, all of whom may have had policies in effect during the time between the time of the injury and the filing of the claim.

### **THE DEBATE OVER POLICY “TRIGGERS”**

While the policies do not refer to the term “trigger,” that label has been given 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 100 or so words in the coverage clause have “spawned a bewildering plethora of authority interpreting their meaning.”<sup>5</sup>

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 arises from a specific, determinable incident. However, 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 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.<sup>6</sup>

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).<sup>7</sup> The theory selected by the

<sup>4</sup> 73 F.3d 1178 (2nd Cir., 1995), 1186-87, and note 3.

<sup>5</sup> *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).

<sup>6</sup> *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.

<sup>7</sup> *Id.* See also *Owens-Illinois, supra*, p. 980.

courts has a dramatic impact on both the size of recovery and the insurers responsible for the judgment. This impacts the insurers' loss ratios, financial solvency, and future pricing. Since most insurers would argue that the policy was not intended to respond in the manner dictated by the courts, this requires considerable adjustment in the CGL market. Additionally, an understanding of the theories is necessary to better grasp the problems of "stacking" and allocating losses across different insurance policies, insurers, and insureds over time.

### The Exposure Trigger Theory

The *exposure theory* holds that the policy is triggered on the date which the injury-producing agent first contacts the body. This is simple and straightforward, provided that the insurer in place at the time of exposure shoulders responsibility for the resulting injury. Even if the disease lies latent for many years, as in the case of asbestosis, the carrier at the time must bear the loss. This theory works well for the insured and injured party if there was indeed insurance at the time of exposure and that insurer remains solvent. From the standpoint of the insurer, however, this theory does not permit the insurer to "close the books" on injuries or exposures, perhaps ever. The leading case espousing the so-called exposure theory was the 1980 case of *Insurance Company of North America v. Forty-Eight Insulations, Inc.*<sup>8</sup>

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.<sup>9</sup>

Thus, for firms that find it difficult to obtain coverage at a reasonable level due to worries about potential products liability after the first claims are filed, this method still provides some form of coverage for future litigation. However, if the insurer at the time of the first exposure is insolvent, or if the firm did not have coverage during that period, then the exposure theory would not provide adequate coverage.

### The Manifestation Trigger Theory

Another method aimed at maximizing coverage for some insureds is the *manifestation theory*. With this theory, the occurrence does not occur until the disease manifests itself. A major case involving this theory is *Eagle-Pitcher Industries v. Liberty Mutual Insurance Co.*, a 1982 federal decision.<sup>10</sup> This rule, like the exposure theory, depends on the existence of a solvent insurer on a specific date. 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

<sup>8</sup> 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).

<sup>9</sup> Owens-Illinois, *supra*, p. 980.

<sup>10</sup> 682 F. 2d 12 (1st Cir., 1982), *cert. denied* 460 U.S. 1028, 103 S. Ct. 1279, 75 L. Ed. 2d 500 (1983).

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 were not yet manifested.”<sup>11</sup> The term “manifestation” is itself ambiguous and must be interpreted in the light of specific injuries in specific cases.

### **THE CONTINUOUS TRIGGER THEORY**

While the exposure theory and the *manifestation theory* depend on the existence of a solvent insurer at a specific point in time, the *continuous trigger theory* does not. The principal case related to the *continuous trigger theory* is *Keene Corp. v. Insurance Co. of North America*, decided in 1981.<sup>12</sup> 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.”<sup>13</sup> This rule appears to provide the greatest chance for there to be at least some coverage for an injury. However, 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 Trigger 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.<sup>14</sup> Under that theory, the time of injury is subject to actual proof and reasonable inferences—ordinarily medical or expert testimony.<sup>15</sup> 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.*,<sup>16</sup> decided in 1987. There seems to be little support or rationale for this decision.

#### Conclusions Regarding Policy “Triggers”

The courts’ decisions most often rely on the presumption of maximizing coverage. But, as one court noted, “[a] rule of law premised on nothing more than the result-oriented

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<sup>11</sup> Owens-Illinois, note 11, p. 981.

<sup>12</sup> 667 F. 2d 1034 (D.C. Cir. 1981), *cert. denied* 455 U.S. 1007, 102 S.Ct. 1644, 71 L.Ed. 2d 875 (1982).

<sup>13</sup> Owens-Illinois, p. 981.

<sup>14</sup> 565 F. Supp. 1485 (S.D. N.Y. 1983), *aff’d as modified*, 748 F. 2d 760 (2d. Cir. 1984).

<sup>15</sup> 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).

<sup>16</sup> 118 Ill. 2d 23, 112 Ill. Dec. 684, 695, 514 N.E. 2d. 150, 161 (1987).

goal of maximizing coverage has been described as “judicial legislation.”<sup>17</sup> Fairness to the insurer, or to nonclaims-making insureds who might pay higher premiums, is not considered. The decisions seem remarkably consistent only insofar as they attempt to find a theory that will compensate the injured party. But, in fairness to courts and insureds, we should acknowledge the difficulties facing courts with respect to continuous or latent injury claims.

As a result of this ongoing 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 or emerging exposures, in ways not thought of by insurers and/or regulators, with a direct impact on the buyers, claimants, insureds, and insurers. In this case, the benefits to the claimants and the insurers are significant in terms of the insurance settlements. However, the potential gains to the insured were potentially offset by potential difficulties in obtaining future coverage at a reasonable price. The insurers clearly had to deal with large scale and potentially unforeseen losses.

### **SCOPE OF COVERAGE AND THE PROBLEM OF STACKING**

Based on the various trigger theories outlined above, several insurance policies and/or periods of self-insurance may be triggered by a single claim. The allocation question relates to the method a court will choose to allocate damages between triggered policies and/or periods of self-insurance. 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. Depending on the jurisdiction and prior rulings, the system of allocating the loss among policy periods and/or insurers can vary between a “joint and several liability,” “time on risk,” or “coverage provided” system. While their systems vary, just as with the establishment of a trigger, the theme of maximizing coverage to the insured is consistent. The issue of what is fair to the insurer and thus to the nonclaims-filing policyholders rarely enters into determinations.

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

The allocation ruling most favorable to policyholders is found in *Keene Co. v. Insurance Co. of North America*, sometimes called a *joint and several* liability approach.<sup>18</sup> 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.”<sup>19</sup> Other cases supporting this position include *J.H. France Refractories Co. v. Allstate Insurance Co.*,<sup>20</sup> *Acands, Inc. v. Aetna Casualty & Surety Co.*,<sup>21</sup> and *Sandoz, Inc. v. Employer’s Liability Assurance Corp.*<sup>22</sup>

*Keene* uses a conceptual model of a pleated accordion surrounding the entire occurrence, representing the time span from exposure to manifestation. The *Keene* court solves the

<sup>17</sup> American Home Products, *supra*, 565 F. Supp. at 1512.

<sup>18</sup> 667 F. 2d 1034 (D.C. Cir., 1981); *cert den.* 455 U.S. 1007, 102 S. Ct. 1644, 71 L.Ed. 2d 875 (1982).

<sup>19</sup> *Id.*, cited in Owens-Illinois, p. 986.

<sup>20</sup> 534 Pa. 29, 626 A. 2d 502, 508 (1993).

<sup>21</sup> 764 F. 2d 968, 974 (3rd Cir., 1985).

<sup>22</sup> 554 F. Supp. 257, 266 (D.N.J. 1983).

problem of indivisible injury by collapsing the injuries in the accordion into a single year. The court explains 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, as 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 200 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 200 claimants to different insurers.<sup>23</sup> The *Keene* court appeared to be concerned with equating the insurers’ liability with other losses. In *Owens-Illinois*, the court surmised that the *Keene* court’s holding was that one policy’s limits apply to each *claim* of injury.<sup>24</sup>

#### 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 risk” when using a multi-year trigger theory. In *Insurance Co. of North America v. Forty-Eight Insulations Inc.*, the court concluded that a reasonable means of allocating defense costs among triggered policies was based on the number of years of exposure.<sup>25</sup> Other courts such as the *Uniroyal v. Home Ins. Co.* have used similar formulae.<sup>26</sup> 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.<sup>27</sup>

<sup>23</sup> Wm. R. Hickman and Mary R. DeYoung, Allocation of Environmental Cleanup Liability Between Successive Insurers, 17 N. Ky. L.Rev. 291, 301 (1990).

<sup>24</sup> 986 A. 2d at 986.

<sup>25</sup> 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 as 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).

<sup>26</sup> 707 F. Supp. 1368 (E.D. N.Y., 1988).

<sup>27</sup> *Id.* at p. 1392.

With regard to allocation, there is no great difference in principle between the “*joint and several liability*” and the “*time on risk*” approaches. Using either method, allocation will exist among insurance companies on the risk. Additionally, with either method, the use of the multi-year trigger will not end the litigation. The principal difference between “*joint and several liability*” and the “*time on risk*” approaches is in their treatment of self insurance.<sup>28</sup>

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

*Owens-Illinois* also was unable to find the answer to allocation in the language of the policies. 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.<sup>29</sup> 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.

In *Owens-Illinois*, the court essentially allocated the losses among the carriers on the basis of the extent of risk assumed; i.e., proration on the basis of policy limits, multiplied by years of coverage (time-on-risk).<sup>30</sup> The court also found that it was reasonable to require the insured to contribute on the same basis during periods of self-insurance or noninsurance.

The *Owens-Illinois* case has been cited as “the leading opinion in the field, and surely one of the best reasoned.”<sup>31</sup> However, 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 the insured” rule should not be applied to those periods, on the grounds that they were not “bargained away,” but insurance for asbestos exposures was simply not available during the insurance crisis of the mid 1980s.<sup>32</sup>

#### Allocation of the Duty to Defend

In addition to allocating the losses, the courts also have devised systems to allocate defense costs. *Insurance Co. of North America v. Forty-Eight Insulations* is clearly the leading case on the allocations of the duty to defend. 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. While it is obvious that the duty to defend is broader than the duty to pay judgments, the issues are intertwined and were so treated by the court.

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.

<sup>28</sup> *Owens-Illinois*, 650 A. 2d at 989.

<sup>29</sup> *Id.*, p. 993.

<sup>30</sup> See also *Armstrong World Industries*, *supra*, 26 Cal. Rptr. 2d at 57.

<sup>31</sup> *Stonewall Ins. Co. v. Asbestos Claim Management*, 73 F. 3d 1178 (2d Cir., 1995).

<sup>32</sup> *Id.*, p. 1203.

... To the extent that the manufacturer was uninsured, it [also] has to bear its pro-rata share of the costs of defense.<sup>33</sup>

### Stacking

The *Forty-Eight* court also addressed the issues of stacking. From 1955 through 1977, *Forty-Eight* held twelve different insurance policies issued by five different companies. Eleven of these policies had aggregate limits of \$300,000 to \$500,000 per occurrence, and one had an aggregate limit of \$1,000,000. The combined aggregate 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:

[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.<sup>34</sup>

The court affirmed the judgment of the district court.

### Conclusions on Allocation Systems

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. However, as with the definitions of "occurrence," the theme of maximizing coverage seems to apply in the case of allocation systems as well.

### **THE RELATIONSHIP OF COURT RULINGS TO THE MARKETPLACE AND THE PRIOR LITERATURE**

The array of court rulings has continued in waves for many years. Recently, a New York court ruled that each claimant's exposure to asbestos in GE turbine engines is a separate occurrence under the firm's insurance program. As a result of this ruling, the firm's excess policies written between 1965 and 1985 will only be triggered in the event that individual occurrences exceed the primary limits of \$5 million. GE's primary insurance company during the period is insolvent, leaving GE exposed for the claims (McLeod, 2003).

During the 1990s, rating agencies such as Standard and Poor's and A.M. Best, have stated that the industry is under reserved for these exposures (Lenckus, 1995; Sclafane, 1998, 2000). Recently, a study by Fitch Ratings suggested that the insurance industry was under

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<sup>33</sup> 633 F. 2d at 1224.

<sup>34</sup> Id. at p. 1226, court's note 28.

reserved for asbestos by up to \$35 billion at the end of 2001 (Buckley, 2003). A portion of these findings can be explained by the trigger theories and allocation systems that call on “old” policies to respond to current claims as well as the emergence of new classes of claimants.

Given the long-tailed nature of the asbestos exposure and uncertainty over triggers and allocations methods, insurers have been forced to revise their loss reserves related to asbestos and environmental reserves. The NAIC estimates that asbestos related loss reserves rose from \$40.8 billion in 2000 to \$58.5 billion in 2002 (Brostoff, 2003). Colquitt, Hoyt, and McCullough (2003) investigate the impact of increases in asbestos and environmental reserves on shareholder wealth. Even though the market is aware of overall under reserving by insurers, the study finds that in most cases, announcements of reserve increases that relate to increases in asbestos and environmental losses are associated with a decrease in stock price. Interesting, the study does find that the increased reporting standards related to asbestos and environmental reserves implemented by the NAIC in 1995 do provide added information to the market and thereby a reduction in the overall impact on stock prices after the implementation of the reporting requirement.

In the financial economic literature, a great deal of attention has been placed on issues surrounding underwriting cycles and the factors that impacted the actions of insurers during the CGL crisis in the 1980s (e.g., Cummins and Danzon, 1997; Harrington and Danzon, 1994; Harrington and Niehaus, 2000; Lai et al., 2000; Niehaus and Terry, 1993). As part of their study, Cummins and Danzon (1997) explore the potentially different impact of “old” liabilities, such as those from policies from which no new premium is collected and the impact of “new” liabilities from present policies. While they find that price is inversely related to loss shocks, they find that price is less sensitive to loss shocks from “old” liabilities than to changes in capital from other sources. This shows that while not as significant as some shocks to the firm, large losses from prior periods still impact today’s insured and thus the current cost of general liability insurance. Niehaus and Terry (1993) also find support for the hypothesis that past losses affect premiums. This issue is especially pertinent in light of the asbestos exposures and rulings discussed in this article.

Lai et al. (2000) note that, in responding to the crisis, “insurers modified liability insurance policy forms in order to reduce both expected values and risks.” Insurers utilized a variety of strategies, including the adoption of claims-made policies in some areas of liability insurance. Many brokers and agents suggest that claims-made policies are not preferred by most insureds. While often less expensive in the first years of coverage with a carrier, insureds still prefer the tail coverage available with occurrence-based policy forms. Table 1 shows the industry levels for premiums earned and losses incurred for the claims-made and occurrence coverage forms in the other liability line in recent years. In 2001, claims-made policies accounted for approximately 36 percent of the premium earned in the “other liability” insurance category, which contains the CGL.<sup>35</sup> Claims-made policies accounted for only 30 percent of the losses incurred during the same

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<sup>35</sup> 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. For this reason, one must be very cautious with inferences concerning the extent to which occurrence-based CGL coverage is used.

**TABLE 1**

Summary of Yearly Premium and Loss Data (Other Liability Policies)

**Panel 1: Yearly Average Premiums Earned**

Year	Other Occurrence	Other Claims Made	Percentage Claims Made
1995	\$11,283,387,811.00	\$5,103,610,901.00	31.14
1996	\$11,040,347,822.00	\$5,841,183,795.00	34.60
1997	\$11,742,368,336.00	\$5,664,420,514.00	32.54
1998	\$11,278,565,043.00	\$5,990,022,617.00	34.69
1999	\$11,101,635,345.00	\$5,802,652,750.00	34.33
2000	\$11,045,925,423.00	\$6,818,895,791.00	38.17
2001	\$13,416,883,113.00	\$7,683,292,085.00	36.41

**Panel 2: Yearly Average Losses**

Year	Occurrence	Claims Made	Percentage Claims Made
1995	\$10,416,089,211.00	\$2,636,980,899.00	20.20
1996	\$8,539,446,119.00	\$2,934,755,660.00	25.58
1997	\$8,108,263,481.00	\$2,408,207,438.00	22.90
1998	\$8,143,861,666.00	\$2,838,461,596.00	25.85
1999	\$6,813,358,811.00	\$2,326,709,410.00	25.46
2000	\$7,913,867,717.00	\$3,198,893,534.00	28.79
2001	\$10,761,375,109.00	\$4,560,437,573.00	29.76

**Panel 3: Yearly Average Loss Ratios**

Year	Occurrence	Claims Made
1995	0.92	0.52
1996	0.77	0.50
1997	0.69	0.43
1998	0.72	0.47
1999	0.61	0.40
2000	0.72	0.47
2001	0.80	0.59

policy year. Panel 3 of Table 1 illustrates that the loss ratios for the claims-made policies consistently have lower loss ratios than the occurrence based policies. This provides initial evidence that the claims-made form does seem to be allowing insurers to contain the level of losses. This also provides initial support for the idea that the rulings discussed throughout the article have increased the loss ratio for occurrence policies. As the

**TABLE 2**

Summary of Yearly Premium and Loss Data (Products Liability Policies)

**Panel 1: Yearly Average Premiums Earned**

Year	Other Occurrence	Other Claims Made	Percentage Claims Made
1995	\$1,571,656,416.00	\$217,771,069.00	12.17
1996	\$1,574,442,160.00	\$243,367,592.00	13.39
1997	\$1,471,040,006.00	\$262,626,051.00	15.15
1998	\$1,475,914,658.00	\$165,633,385.00	10.09
1999	\$1,440,417,585.00	\$144,220,062.00	9.10
2000	\$1,513,885,532.00	\$151,643,631.00	9.10
2001	\$1,822,922,616.00	\$156,863,158.00	7.92

**Panel 2: Yearly Average Losses**

Year	Occurrence	Claims Made	Percentage Claims Made
1995	\$1,826,931,326.00	\$128,435,673.00	6.57
1996	\$1,601,577,504.00	\$212,721,645.00	11.72
1997	\$1,121,589,967.00	\$117,963,928.00	9.52
1998	\$1,182,773,186.00	\$121,416,700.00	9.31
1999	\$1,416,979,189.00	\$115,953,502.00	7.56
2000	\$1,202,812,097.00	\$84,047,509.00	6.53
2001	\$2,120,277,537.00	\$136,644,701.00	6.05

**Panel 3: Yearly Average Loss Ratios**

Year	Occurrence	Claims Made
1995	1.16	0.59
1996	1.02	0.87
1997	0.76	0.45
1998	0.80	0.73
1999	0.98	0.80
2000	0.79	0.55
2001	1.16	0.87

insurance market hardens, it is likely that insurers and reinsurers will look to claims-made policies as a means of controlling cost and reducing their loss ratios.

As a point of reference, Table 2 contains premium and loss data for products liability based on the claims-made and occurrence forms. In this line of business, the claims-made market accounted for just less than 8 percent of the premium volume in 2001 and only

about 6 percent of the total losses incurred. As with the other liability line, the loss ratios for claims-made forms in products liability are consistently lower than the occurrence forms.<sup>36</sup>

### **CONCLUSIONS AND PUBLIC POLICY IMPLICATIONS**

Justice Holmes's axiomatic comment that "hard cases make bad law" is perhaps no better exemplified than in the variety of legal results surrounding the CGL policy. The addition of claims-made policies to the insurance marketplace, the debates over policy triggers, and the emergence of numerous allocations systems have created a dynamic and fluid environment for insureds and insurers alike in the CGL marketplace. These matters continue to drive legal actions because of the retroactive nature of occurrence insurance. In March 2003, the Supreme Court ruled that workers suffering from asbestosis can recover damages for mental anguish caused by fear of developing asbestos-related cancer. In the same ruling, the justices agreed that the railroad can be held responsible for all asbestosis related damages, even if other parties contributed to the alleged negligence (Hofmann, 2003). This ruling appears to further expand the scope of liability related to asbestos claims.

The asbestos lawsuits have had an enormous impact on the country. Lawsuits related to this exposure have driven 67 companies to bankruptcy and approximately 8,400 firms to court (Steuber et al., 2003). The results range from lost jobs, depletion of 401(k) accounts, and slow settlement. Senator Hatch has promised asbestos reform this year. The bill, sponsored by Senator Nickles would set medical standard for who could sue, among other things. Senator Hatch also would like to see two trust funds established. One fund would be financed by asbestos firms and the other financed by insurers (Steuber et al., 2003).

In light of these recent events, this discussion of the CGL policy, and the court rulings that interpreted the policy with respect to the emerging latent injury class of liability risks, provide a basis to better understand the potential impact of contemporary rulings. The events in the CGL market call for a concerted effort by legislators, 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 interests 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, a new CGL form is making its way into the system. This form includes new language that prevents coverage for bodily injury and property damage known to the insured prior to the policy period. What effect this new language will have remains for the courts to determine and, of course, its effect will be limited to claims arising from occurrences going forward. Hundreds of thousands of claims remain to be settled on the basis of the old forms.

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<sup>36</sup> By contrast, claims-made policies account for between 65 and 71 percent of the medical malpractice premiums earned. Because of the significant difference in the medical malpractice line, the results related to this line are not presented in detail. The results are available from the authors upon request.

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