

Occurrence and Claims Made: The Road Behind

and the

Road Ahead

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Introduction

The commercial liability insurance market has undergone dramatic changes in the last half century. The wellspring of change has been largely attributed to the underlying legal climate and its impact upon the products hazard, the emergence of new risks, as well as changes in the commercial general liability (CGL) policy forms. When one of the writers first studied risk and insurance, product liability was characterized as *caveat emptor*: “let the buyer beware” (Elliott and Vaughan, 1972 and Mehr and Cammack, 1976). Product liability suits were not common, and successful litigation was rare. The rule today is more aptly described as *caveat vendor*: “let the seller beware.” Indeed, in many instances, strict liability is the rule, making the seller liable regardless of fault. This shift in legal philosophy has had a dramatic impact on the CGL marketplace.

In many ways, the evolution of the law relating to the interpretation of the CGL policies regarding latent injury claims contributed to serious losses for the insurance industry. Because of the long tail of liability related to the perils covered under these policies, 50-year old contracts are often called upon to pay claims. For example, in 1993, Chubb and CNA agreed to pay \$3 billion to settle claims against Fiberboard. The chairman of CNA pointed out with dismay that two liability policies, written in the 1960s and generating a mere \$20,000 in premiums, would then cost CNA \$2 billion in claims (Schachner, 1993). The debate over asbestos claims is still occurring as insurers continue to increase asbestos and environmental reserves.

Modifications to the occurrence policy forms have occurred over time to try to limit the adverse claims experience related to this type of coverage. For example, the 1986-generation of forms added an aggregate limit that included bodily injury claims for product liability.¹ However, it is common knowledge that in the soft market, underwriters were liberal with reinstatements of aggregates and sometimes even removal of the aggregate. Considering the contemporary scene, with the new generation of asbestos claims as well as DES claims, pollution claims, and a variety of emerging perils, the issues related to product liability coverage are still critical to the insurance industry. Despite the current market conditions, there is no assurance the massive losses seen in the mid-1980s will not recur.

Whether the insurance crisis of the 1980s could happen again is for others to predict. The recent hard market is moderate in comparison. Clearly, other causal factors were

Abstract

While the basic difference between the occurrence and the claims-made forms of the commercial general liability (CGL) policy are well documented, this article takes a look at the evolution of the CGL policy forms, the important legal decisions impacting the policy, as well as the historical trends in the marketplace in order to highlight some important lessons. The article also uses a case study to illustrate the potential financial impact of prior policy limits and policy forms on current claims. The goal of the article is to highlight the importance of the debate over claims-made and occurrence forms and the impact that these forms continue to have on the CGL marketplace both in terms of the impact on the insurance industry's profitability and the level of coverage provided to the insureds.

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present in 1984, but the fact remains that occurrence-based CGL coverage is still common today. This article discusses selected problems inherent in occurrence-based CGL forms and conditions as they relate to product liability. First, the article takes a brief historical look at the CGL marketplace in an effort to analyze the general trends and performance of the product liability market. Second, the article discusses the array of triggers and allocation methods used in latent injury claims to show the impact that various legal decisions have had on policy interpretation and, hence, on the level of insurable losses. This is followed by a discussion of the alternatives to occurrence-based coverage developed in the market. In an effort to illustrate these points in a more concrete manner, a case study related to these issues is included. The case not only provides an illustration of the way these policies are combined over time, but it also illustrates some of the limitations of the alternatives to occurrence-based policy forms. Finally, conclusions and implications related to the product liability market and the use of occurrence-based policies are offered.

While today's commercial general liability policies are significantly different from the policies sold in the 1970s and 1980s, it is critical to understand both the older policies as well as the differences in the prior forms and today's contracts. This is important for several reasons. First, due to the presence of occurrence-based policies, older policies are still called upon to pay claims filed today. Thus, it is important for underwriters, brokers, and insureds to understand the differences in the coverage as well as the interpretation of the forms due to the fact that these policies impact both current and future claims. Second, even with the introduction of claims-made forms in 1986, occurrence-based forms continue to represent a significant portion of today's marketplace. For this reason, a clear understanding of the ways in which the various forms impact a firm's coverage and exposure to loss is important in today's market. Finally, as the market continues to change, a historical perspective on the evolution of the commercial liability market provides a good case study to illustrate the way the market evolves and reacts to emerging hazards as well as the impact that a changing legal environment can have on the interpretation of insurance policies.

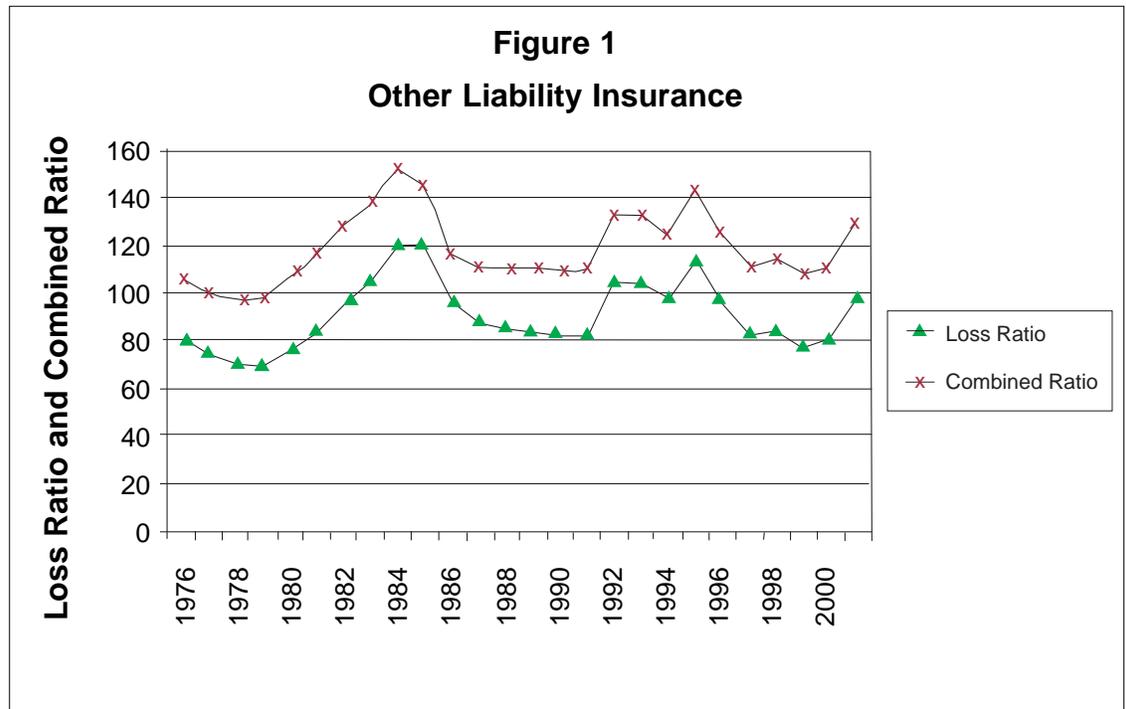
Historical Market Perspective

To understand the scope of the problems in the commercial liability insurance market over time, a look at the market conditions in the last 20 years is helpful. On a macro level, the insured losses became extreme in the first half of the 1980s. Table 1 reports aggregate statistics 1976 to 2001. Figures 1, 2, and 3 are drawn from the table. The "other liability" line includes the commercial general liability policy, known as comprehensive general liability before 1986. The "other liability" line's combined ratio in 1984 exceeded 151. The years 1983, 1984, and 1985 also exhibited extra-ordinary levels of claims adjustment expense (doubtless from litigation) increasing from 20.4 in 1976 to 33.5 percent of earned premium in 1984. The robust investment gains of the period partially offset the losses and litigation expenses during this time. Loss and combined ratios are presented in Figure 1.

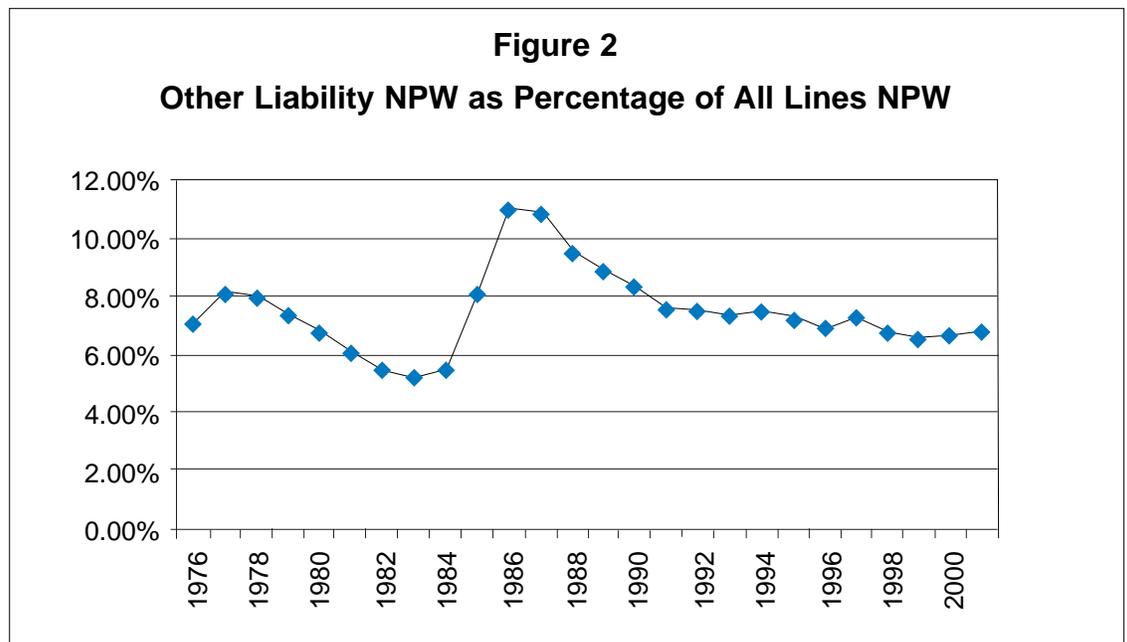
Table 1
Aggregate Statistics 1976 to 2001
Other Liability and All Lines

Other Liability				As Percent of Earned Premium			As Percent of Written Premium			Total All Lines	Other Liability as Percent of All Lines NPW	Growth Rate of Total All Lines NPW
Year	Net Premiums Written	Net Premiums	Growth Rate	Losses Incurred	Adjustment Expenses Incurred	Total Loss and Loss Adjusted Expenses	Combined Ratio	Net Investment Gain	Overall Operating Ratio	Net Premiums Written		
1976	4,251,298	3,927,941		59.4	20.4	79.8	107.1	10.3	96.7	60,418,098	7.04%	
1977	5,845,075	5,368,917	37.5%	55.3	19.1	74.4	100.0	9.7	90.4	72,396,929	8.07%	19.83%
1978	6,490,064	6,184,315	11.0%	52.1	18.4	70.5	97.3	9.9	87.5	81,689,931	7.94%	12.84%
1979	6,612,474	6,545,687	1.9%	51.8	18.2	70.0	98.2	12.2	86.0	90,122,619	7.34%	10.32%
1980	6,414,678	6,598,013	-3.0%	57.1	20.3	77.4	107.2	14.5	92.7	95,568,749	6.71%	6.04%
1981	6,046,292	6,103,671	-5.7%	61.2	23.2	84.4	116.0	19.4	96.5	99,275,575	6.09%	3.88%
1982	5,668,459	5,718,789	-6.2%	69.5	27.5	97.0	129.4	23.1	106.4	103,968,221	5.45%	4.73%
1983	5,679,295	5,730,651	0.2%	74.9	30.7	105.6	138.1	24.4	113.8	108,982,808	5.21%	4.82%
1984	6,479,268	6,250,809	14.1%	87.3	33.5	120.8	151.8	26.6	125.1	118,166,311	5.48%	8.43%
1985	11,544,152	9,317,086	78.2%	91.5	30.0	121.5	145.8	20.0	125.8	144,186,420	8.01%	22.02%
1986	19,364,568	16,586,068	67.7%	71.9	24.2	96.1	116.5	14.0	102.5	176,552,070	10.97%	22.45%
1987	20,873,777	20,075,818	7.8%	66.2	22.2	88.4	111.1	14.8	96.3	193,245,779	10.80%	9.46%
1988	19,077,182	19,734,356	-8.6%	60.4	25.1	85.5	109.9	18.5	91.5	202,014,698	9.44%	4.54%
1989	18,434,466	18,522,600	-3.4%	57.1	27.0	84.1	110.1	22.1	88.0	208,387,953	8.85%	3.15%
1990	18,123,123	18,221,355	-1.7%	55.2	27.4	82.6	109.4	22.7	86.7	217,824,840	8.32%	4.53%
1991	16,851,155	17,666,287	-7.0%	56.8	25.3	82.1	110.3	24.5	85.9	222,991,188	7.56%	2.37%
1992	17,005,977	16,944,287	0.9%	75.9	29.4	105.3	133.2	30.0	103.3	227,500,098	7.48%	2.02%
1993	17,751,659	17,005,148	4.4%	73.8	31.2	105.0	132.8	29.2	103.6	241,563,356	7.35%	6.18%
1994	18,802,092	17,902,749	5.9%	68.3	30.2	98.5	125.5	22.8	102.7	250,634,512	7.50%	3.76%
1995	18,581,740	18,097,427	-1.2%	79.3	35.7	115.0	143.6	27.6	116.0	259,681,292	7.16%	3.61%
1996	18,575,820	18,586,785	0.0%	67.7	28.7	96.4	123.5	28.1	95.4	268,552,807	6.92%	3.42%
1997	20,088,167	19,055,358	8.1%	58.1	25.1	83.2	110.6	30.5	80.1	276,412,769	7.27%	2.93%
1998	19,017,955	18,761,954	-5.3%	62.1	22.8	84.9	114.5	29.6	84.9	281,508,998	6.76%	1.84%
1999	18,764,629	18,105,524	-1.3%	53.0	25.3	78.4	109.1	30.6	78.4	286,879,280	6.54%	1.91%
2000	19,917,458	19,143,242	6.1%	60.2	22.0	82.1	112.0	28.7	83.3	299,553,563	6.65%	4.42%
2001	21,890,639	20,508,335	9.9%	73.9	25.4	99.3	130.2	22.3	107.9	323,448,636	6.77%	7.98%

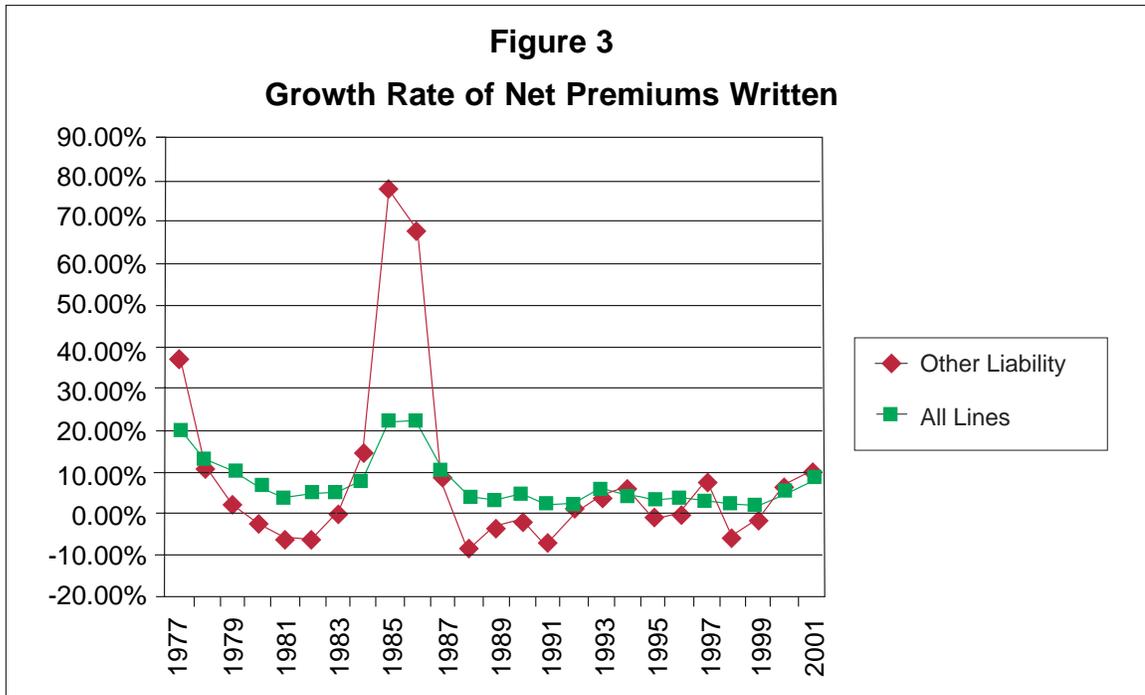
Source: Best's Averages and Aggregates from various years.



It is obvious such swings are disruptive to the economy and bad for society. Contemporary observers referred to the situation as the “insurance crisis,” though the implications reached well beyond the insurance industry. An example of the popular viewpoint is revealed by the title of a 1986 *Business Insurance* article: “The Insurance Crisis: Now Everyone Is in a Risky Business” (Farrel, Welch, and Houston, 1986). The recent hard market continues at this time, but is far less severe.



The years of the early 1980s were “soft market” years, which were followed by the great hard market of 1985 and 1986 when rate increases of 400 percent in general liability were commonplace (Cain, 1985). Macro-level confirmation of this can be seen in the extreme right-hand column of Table 1 through the growth in net premiums written. Figure 2 isolates “other liability” as a percent of total net premium and shows it nearly doubling as the hard market ensued. In an effort to put this in context with the changes in the entire market at that time, Table 1 reports growth rates in other liability and all lines net premiums written. The relationship between the two growth rates is presented graphically in Figure 3. From Figure 3, it is easy to see the dramatic changes in the CGL marketplace during the mid-1980s.



Defining “Occurrence” and Determination of Triggers and Allocation Methods

What Is an Occurrence?

By definition, an occurrence-based CGL policy responds only if the bodily injury or property damage occurs during the policy period. Since the adoption of the 1986 forms, the point is explicit: “This insurance applies only to ‘bodily injury’ or ‘property damage’ which occurs during the policy period.” It is worth emphasizing that the policy says nothing about the timing of the occurrence. The occurrence could have happened 50 years before, it could have happened simultaneous to the injury, or could have been continuously happening. It makes no difference.²

Conceptually, product claims can be viewed as one of two types. One is a single-point claim where the injury can be definitively identified in time. A consumer operating a power saw who cuts off two fingers because of a product design flaw provides an example of a single-point claim. The policy in force at the time of injury responds. There remains almost no ambiguity about how and when the occurrence is defined.

The second type of claim, often called latent-injury claim, is more problematic. Exposure to a harmful substance such as the inhalation of asbestos is a common example of a latent injury claim. With this type of claim, one cannot say for certain when the injury takes place. Whether the injury is the inhalation, the incubation within the human body, the first manifestation of symptoms, or something else is open to debate. There are many examples including breast implants, tread separations of tires, and exposure to substances such as benzene, vinyl chloride, tobacco, diet pills, and DES. Likewise, there are property damage claims from metal fatigue and other causes, such as during the winter of 2000 when a 100-year water pipe ruptured in the Chicago financial and business district, that are examples of latent injuries (Osnos, 2000).

Determining Policy Triggers

For a CGL to respond, whether written on an occurrence or some other basis, the policy must be triggered. The purpose of the trigger is to fix the loss to a policy period. This is an obvious task in the case of single-point occurrences, such as the power saw example. However, it is not as obvious in latent-injury situations that might trigger coverage in multiple policies if the time of injury or damage is difficult to determine. This question has opened the door to a variety of policy interpretations by the courts. Common policy trigger theories include the exposure, manifestation, triple triggers, and injury-in-fact theories.³

The selection of an appropriate trigger is based on applicable case law. An example may be seen in the court rulings related to DES. DES is a synthetic estrogen used as early as the 1940s to prevent miscarriages, marketed by Eli Lilly between 1947 and 1969. Unfortunately, it caused cancer in the female offspring decades later, a classic long-tail latent injury.⁴ *Eli Lilly v The Home Insurance Company* was a DES case adjudicated by the federal courts construing Indiana law in 1985. Despite the fact that Lilly had relatively lower limits in the earlier years, Lilly argued for an exposure trigger because it would trigger all policies from 1942. The insurers argued for a manifestation theory that would trigger only those policies on the risk when latent injuries became apparent, more than a decade later. Judge Norma Holloway Johnson borrowed from an asbestos ruling, *Keene v Insurance Company of North America* and asserted the triple-trigger theory (Tarnoff, 1984). She ruled that each policy on the risk at any time between exposure and manifestation should be triggered. Moreover, each is triggered on a cumulative basis so that a given policy can be liable for more than the claims identified to be in the policy period.

Triple trigger or continuous trigger is exactly what the insurance industry did not want. The industry countered that a single-point trigger, when the policies were written with one policy and one set of limits for each claim, was appropriate. The continuous trigger can lead to a situation commonly referred to as “stacking.” In such a case, the cumulative limits of all policies between exposure and manifestation are stacked upon each other and are available for claims. Moreover, policies are stacked and liable beyond the extent of losses in the policy period.

For example, suppose a single consumer is exposed to a product in 1975, and the ill effects from the exposure manifest in 1984. With either an exposure or a manifestation theory, the loss is covered under one policy, the 1975 or 1984 policy, respectively. Suppose the insured had \$1 million CGL liability limit in each year from 1975 to 1984. The exposure theory would call for the 1975 policy to pay up to \$1 million and the manifestation theory would call for the 1984 policy to pay \$1 million. Only one policy is triggered and one pays. However, if an injury-in-fact or continuous trigger theory is applied, then more than one policy is triggered and the maximum insurance recovery

can approach \$10 million. Therefore, in this example, insurance industry potential payout has been increased from \$1 to \$10 million. It is safe to say that when the policies were written, the maximum recovery contemplated by the rates for each of the 10 policies was \$1 million for a particular claim, not \$10 million.

To say the maximum payout is \$10 million is not to say the insurers must pay \$10 million. Each of the 10 policies is triggered but each will pay only for the bodily injury during the policy periods. There remains the issue of allocating the losses to the appropriate policy years.

The Use of Various Allocation Methods

Allocation follows naturally from stacking, particularly in mass tort situations where many claims are presented to insurers at once. The question is, which policy pays if more than one is triggered? Two general approaches to allocation have been applied in American courts: the pro-rata approach and the all-sums approach.

Consider the thousands of breast implants introduced into the human body beginning in 1968. Suppose the claims are being settled in 1992. Since the alleged injuries were continuous and cumulative, it is assumed the loss was fairly even over the period. Insurers support a pro-rata allocation theory. With this method, the total loss is allocated on a pro-rata basis across the triggered years. Allocation to each year occurs, even if there was no insurance coverage because (1) of terms and conditions, (2) the insured did not have adequate limits, (3) the insured had substantial retention levels, or (4) the policies are lost. To the extent these conditions prevail, it becomes likely the insurers in aggregate will pay less than the cumulative limits. *Stonewall v Asbestos Insurance Claim Management Corporation* is a 1995 case that supports this approach. Other well-known and often cited cases of the application of pro-rata liability are *Owens-Illinois*, and *Carter Wallace* (Shelly, 1995).

The alternative to pro-rata is all-sums allocation, which is favored by policyholders. It is also sometimes known as the decision not to allocate or the joint and several liability approach. CGL forms in use before 1986 promised to pay “all sums” while policies since 1986 promise only to pay “those sums.” In *J.H. France Refractories v Allstate*, the Pennsylvania court found any one policy in force in a period when injury has been sustained could be called upon to pay the entire loss up to its limit of liability (Marley, 1993). Thus, the insured is allowed to select a policy (more than one if limits are needed) to collect from, leaving the insurers selected to seek contribution from other insurers. The court suggested that the selected insurers should look to their other insurance clauses to settle contribution issues. In its pure form, all sums suggest that insurers should not look to the insureds to contribute at all even for periods when there was no collectible insurance because each of the policies using the standard ISO language promised to pay “all sums.” Thus, the “decision to not allocate.”

There are some serious issues. The most obvious is fairness. The insured may have made the decision not to insure in some particular policy period, but that decision has no negative consequences as long as cumulative coverage in the other periods is adequate. Additionally, the reliance upon other insurance clauses is highly problematic. The purpose of the other insurance clauses is to enforce the principle of indemnity and prevent double recovery. They are constructed to apply to potential disputes between insureds and insurers and not those between insurers. The all-sums theory has not become dominant, although the choice depends upon individual courts and judges. Decision rules vary from state to state, but most courts today apply some sort of pro-rata allocation theory.

Alternatives to Occurrence Coverage: Claims-Made and Occurrence/Claim Aggregation

Claims-Made Forms

In the 1984 to 1985 period, the domestic insurance industry through the Insurance Services Office (ISO) decided to develop claims-made general liability forms. That period was during the heart of the hard market. Litigation had been costly and time-consuming, and much of it had concerned the key issue: when did the injury occur?

The 1986 ISO forms included major changes (including the still-standard absolute pollution liability exclusion). For the first time, there were two standard CGL forms: one occurrence and one claims-made. Claims-made insurance covers claims made during the policy period as long as the injury occurs after the retroactive date stated in the declarations (usually the first day of claims-made coverage). The insured is required to report occurrences that might lead to claims.

The industry was enthusiastic about claims-made in the 1986 period. The obvious advantage is that a particular claim can only be made once. Even if the claim involves continuous injury, all the injury goes into one policy period. In praise of the claims-made approach, the Insurance Services Office offered the following advantages to policyholders:

- One and only one “claims-made” policy will respond to a given claim, disputes over which policy applies will be reduced.
- Limits can be kept current to reflect expected claims patterns.
- There is complete continuity of coverage upon renewal and replacement provided the retroactive dates are left intact.
- If the policy is cancelled or not renewed after injury or damage occurs, the form guarantees that the insured may purchase an endorsement extending the “tail” period [from the automatic 60 days].
- A discount to reflect the fact that the time between the policy inception and the average claim date is shorter under a claims-made policy.
- A set of further discounts to be applied in the first four years of “claims-made” coverage to reflect the fact that, during that period fewer claims will be covered because some of them will be for injury or damage before the retroactive date. (Insurance Services Office, 1985).

One of the shortcomings of the ISO claims-made forms is what is called forward stacking. For major claims, such as breast implants or DES, the earliest error, act, omission, causative agency, common origin, or common cause can inspire claims over multiple periods going forward. This forward stacking is defeated by “occurrence aggregation,” discussed later. Notwithstanding, each claim can only be made once and, thus, will fall into one policy aggregate, which, from the insurers’ perspective, is less costly than traditional occurrence-based coverage. In 1983, ISO considered what was called a “discovery” trigger but abandoned the project in favor of the two forms now in use: a claims-made and an occurrence form (Densmore, 1983).

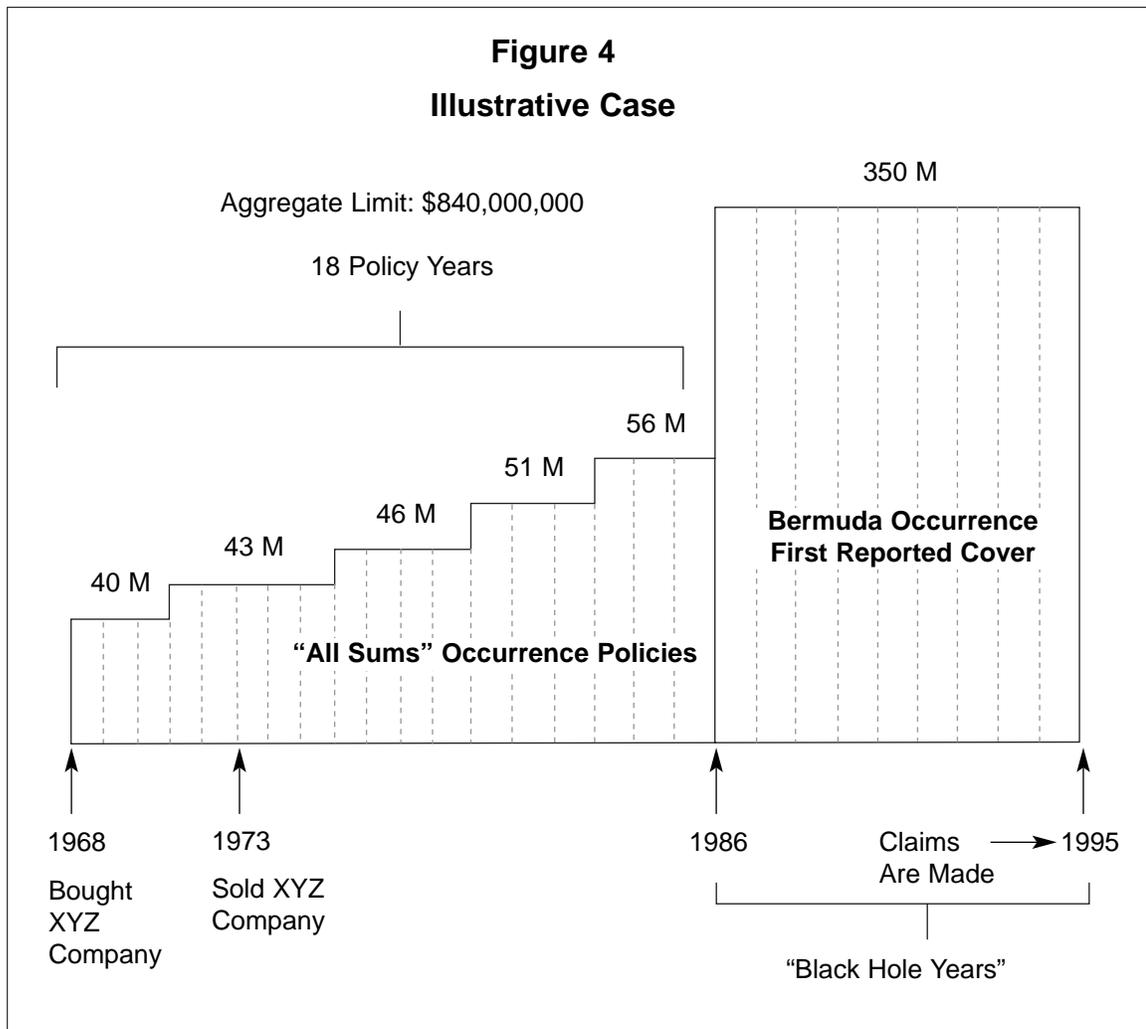
Occurrence-First-Reported Forms

Meanwhile, a similar approach called occurrence first reported was being developed in Bermuda and elsewhere for use in excess liability coverage. Occurrence-first-reported coverage allows the insured to report occurrences before claims develop, eliminating the risk of cancellation after occurrence and before claim. This is generally called

“circumstance reporting.” Often, the policy language also includes an “occurrence aggregation” feature. Occurrence aggregation is in use today in high-layer liability markets by companies such as XL, ACE, and AIG Excess, and the London market. Its effect is to direct all claims from a product into one policy period by attaching them to the earliest error, act, or omission, causative agency, common origin, or common cause. This type of coverage was put into use in the mid-eighties. It is generally found only with attachments at the \$25 million level. Coverage is often written for \$500 million or more.

A Case Study

The following hypothetical case is designed to illustrate some of the concepts discussed. It is loosely based on more than one actual instance with which the writers are familiar. The reader should consider it merely a hypothetical account of ABC, a Fortune 500-size company. ABC bought a small company, XYZ, in 1968 and sold it to the managers of XYZ in 1973. XYZ manufactured and sold a medical device that became inserted into the human body. During this period, ABC had occurrence CGL insurance with aggregate limits in the years 1968 to 1986 as indicated in Figure 4. XYZ had modest limits of its own but they proved to be inadequate. Thus, the financial responsibility reverted to ABC. Note that all ABC’s 18 years of occurrence limits aggregated total \$840 million.



Beginning in 1986, ABC stopped buying occurrence insurance and arranged its liability program in Bermuda. The reader will note the date as the height of the hard market. A number of major insurers including ACE and XL came into being at this time in response to the insurance availability crisis. At that time, virtually all Bermuda insurance was written on an occurrence-first-reported basis with an occurrence aggregation provision. In 1995, ABC was confronted with a very serious mass product liability situation involving tens of thousands of claimants seeking substantial sums. The Bermuda coverage responded because the occurrences were first reported during the policy period. However, because of occurrence aggregation, the flood of claims could only be first reported in one policy period. Due to occurrence aggregation, only one year's Bermuda limits were available, in the example \$350 million. The limit was seriously inadequate.

ABC naturally sought recovery from the occurrence insurers. With occurrence policies, ABC can seek to recover up to \$840 million using the argument that the injury was a continuous one. Thus, each policy in effect after the initial exposure must respond on an individual claimant's loss. Therefore, a claimant exposed in 1974 would have an injury covered in each policy year from 1974 through 1985, as well as by the Bermuda policy. The insurers were called upon to pay the entire loss.⁵

Hindsight is 20/20. The drafters of the 1966, 1973, and, to a lesser extent, the 1986 CGL policies probably would like to do it all over again differently. Had they anticipated such a revolutionary change in the legal system as occurred since 1966, they would likely not have been so openhanded in extending coverage. That said, one must wonder why it took so long (13 years) to change. Moreover, one must also wonder why so little attention has been directed at moving away from occurrence-based coverages.⁶

Problems with the Proposed Alternatives

For a variety of reasons, claims-made policy forms have not been widely embraced by insureds and, thus, not widely sold in the CGL marketplace. From the insured's perspective, there is the obvious risk that an occurrence can happen and the insurer cancels or non-renews or renews only with an advanced retroactive date. This is the reason that virtually all claims-made policies have an extended reporting period provision (called a "tail"). The tail extends the period during which claims can be reported beyond the end of the policy period. The ISO CGL has a very generous provision of five years to report claims as long as occurrences are reported within 60 days of the policy period. It also offers the opportunity to buy a supplementary tail, which effectively puts the policy on an occurrence basis after the fact.

There are other potential problems for the insured. Changing insurers can become difficult because the insured would want the retroactive date to be stable (i.e., be the same as the retroactive date of the previous policy) and there is no guarantee the succeeding insurer will be amenable. Thus, insureds might fear they will become permanently attached to their insurer regardless of changes in price, service, or policy provisions.

Additionally, claims-made policies cannot be stacked in the way described above. A claim can only be made once. At the end of a claims-made policy year, if the total claims made fall short of the limit of the insurance, the limit is unused or wasted. It cannot be stored away for a rainy day the way occurrence limits can. In the case study, ABC was prevented from recovering \$350 million for each year from 1986 to 1995 but only \$350 million for one year.

One of the major questions posed by policyholders is whether the occurrence-first-reported or claims-made forms are “real insurance.” Insureds have taken the position that these new coverages are inferior and were initially purchased only under the duress of the hard market. Such coverages are a “black hole” into which an insured throws money and cannot stack the limits if the policy period ends without claims being filed.

The origins of this argument are in asbestos. There it had been argued by a policyholder that, because there were certain periods (1984 to 1986) where insurance had become totally “unavailable” for asbestos companies, there should be no allocation to those years. Suppose ABC makes this argument. The significance of the argument has to do with allocation. In our hypothetical example, the occurrence insurers would argue the loss should be allocated to each year up until 1995. The insured would like to force all the loss onto the occurrence carriers and might do so by arguing that “real insurance” was not available from 1986 to 1995, and they were forced to throw their money into a “black hole.” The case involved pro-rata liability, and the insured prevailed. Losses were not allocated to those years because the insured had no occurrence insurance and, therefore, involuntarily self-insured. Thus, the losses were forced back into the occurrence years and the insurers paid more.

In the ABC case, the policyholder might argue (contrary to fact) that only claims-made or occurrence-first-reported insurance was available after the mid- to late-1980s. Therefore, insurance was unavailable and losses should not be allocated to those years. The policyholder’s position would be that claims-made insurance is inferior to occurrence insurance, and buying such insurance was akin to throwing your money into a “black hole.” In this hypothetical case, the argument prevailed and the claims-made years were excluded from allocation, thus substantially increasing recovery from the occurrence carriers.

Conclusions and Implications

The purpose of this article is to review some of the issues associated with the use of occurrence-based policies and the alternatives proposed to those forms such as claims-made and occurrence-first-reported forms. Based on the continuing struggles with asbestos and environmental liability claims, it is obvious that the debate on the use of occurrence and claims-made forms is far from over. The scope of firms impacted by these issues continues to grow. Almost any company that has a building 20 or more years old might have an exposure.

Changes to the CGL forms over time have alleviated some of the problems with forms sold in the 1970s and early 1980s. For one, the 1986 generation of policies offered relief in the form of the aggregate.⁷ This was in contrast to the 1973 CGL form that had an aggregate to which product liability claims for bodily injury did not apply. Curiously, product liability property damage claims did apply. Such an arrangement made sense in the *caveat emptor* era. Property damage claims were more likely to accumulate from a product or batch of products. In the modern era, it is bodily injury claims that pose a serious threat of accumulation. With no aggregates in place, these pre-1986 forms await wave after wave of long-tail claims.

It is important to understand the issues surrounding not only the current sale of occurrence, claims-made, and occurrence-first-reported forms, but also the implications of the use of these forms for prior periods. In an era of mergers and acquisitions, increased reporting standards, and an ever-changing legal environment, it is important for managers and investors to understand the extent of coverage available for latent injury exposures stemming from activities beginning long ago.

From the standpoint of the insurance industry, court interpretations on policy triggers and allocation methods, as well as emerging risks, have created several waves of claims much larger than the insurance industry anticipated. A review of articles related to the impact of asbestos and environmental exposures on insurers' loss reserves and firm value illustrates the dramatic impact that these types of claims continue to have on insurers.⁸ From the standpoint of the insured, occurrence-based CGL forms continue to be preferred over claims-made forms in most cases. This presents a challenge to insurers as they strive to price these policies adequately.

Endnotes

1. For a more complete review of the changes in the CGL policies over time, see Flanigan (1999).
2. Since 1966, the standard American market CGL has covered occurrences. In earlier editions, there was a requirement that bodily injury and property damage be "caused by accident, which is sudden, unintended, and unexpected." The 1973 CGL (which remained in use through 1986) in common with the 1966 promised: "The company will pay on behalf of the insured all sums, which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies caused by an occurrence." It defined occurrence as "an accident, including continuous and repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured."
3. For a more complete discussion of the various trigger theories, see McGuire, McCullough, and Flanigan (2004).
4. A particularly grim footnote is that the effects of DES skips generations so the granddaughters of women who had sons contract cancer (Wojcik, 1997).
5. The likely sequence would be that ABC would seek to recover the entire aggregate losses from the occurrence insurers even though they had recovered \$350 million from the Bermuda carriers because the Bermuda insurance written then (and now) is excess and non-contributory. It is possible that a court in another lawsuit would require that ABC offset.
6. As a curious historical note, the idea of pinning the losses from an occurrence to a single policy period is not new. The 1955 CGL included the following language: "Subject to the limit of liability with respect to 'each accident,' the limits of bodily injury liability and property damage liability stated in the declarations as 'aggregate products' are respectively the total limits of the company's liability for all damages arising out of the products hazard. All such damages arising from one lot of goods or products prepared or acquired by the named insured or by another trading under his name shall be considered as arising from one accident." The second sentence was generally known as the "batch clause" and might well be an ancestor of occurrence or claim aggregation. The 1966 CGL dropped the batch clause and narrowed the application of the products aggregate. The remainder of the story is billions of dollars of losses.
7. The 1986-generation of forms also brought about the first industry CGL on a claims-made basis. Press reports at the time cited widespread concern by risk managers that they would have claims-made coverage forced upon them. These concerns quickly evaporated as markets went soft.
8. See for example Colquitt, Hoyt, and McCullough (2003) for a discussion of the impact of asbestos and environment losses on insurer firm value.

References

- Cain, Carol, and Robert A. Finlayson, "Rate Hikes, Capacity Crunch Worsen with July 1 Renewals," *Business Insurance*, v. 19. p. 1, July 15, 1985.
- Colquitt, L. Lee, Robert E. Hoyt, and Kathleen A. McCullough, "The Impact of Asbestos and Environmental Reserves Increases on Shareholder Wealth," working paper, University of Georgia, May 2003.
- Densmore, Bill, "First-Discovery Trigger No Longer in CGL Draft," *Business Insurance* v. 17. p. 2., January 3, 1983.
- Elliot, Curtis M., and Emmet J. Vaughan, "Fundamentals of Risk and Insurance," John Wiley & Sons, 1972.
- Farrel, Christopher, Randy Welch, and Patrick Houston, "The Insurance Crisis: Now Everyone Is in a Risky Business," *Business Week*, pp. 88-92, March 10, 1986.

- Flanigan, George B., "Evolution of CGL Coverage: A Four-Decade Perspective," *CPCU Journal*, Spring 1999.
- Insurance Services Office, *Workshop Student's Guide, Commercial General Liability*, ISO, New York, 1985.
- McGuire, Charles, Kathleen A. McCullough, and George B. Flanigan, "Exposure Triggers and Allocation Methods: Learning Lessons from Prior Court Rulings," *Risk Management and Insurance Review*, Spring 2004.
- McLeod Douglas, "The Worst Is Yet to Come, Reinsurers, Brokers Predict," *Business Insurance*, v. 19. p. 1, July 15, 1985.
- Mehr, Robert I., and Emerson Cammack, *Principles of Insurance*, 6th Edition, Richard D. Irwin Inc., Homewood, Illinois, 1976.
- Osnos, Evans, and David Mendell, "Wet, Wild Day in Loop," *Chicago Tribune*, p. 1, February 8, 2000.
- Sara Marley, "Policyholder Victory; Pennsylvania Adopts Triple-Trigger Coverage Theory for Asbestos," *Business Insurance*, v. 27. p. 49, June 7, 1993.
- Schachner, Michael, "A High Price for Certainty: CNA, Chubb Pay Billions to Cap Fireboard Liability," *Business Insurance*, v. 27. p. 1, Sept. 6, 1993.
- Shelly, William P., Richard C. Mason, "Fundamentals of Insurance Allocation," *Mealey's Litigation Report*, 1995.
- Tarnoff, Stephan, "Keene Decision Applied to DES," *Business Insurance*, v. 18, p. 1. April 30, 1984.
- Tarnoff, Stephan, "Federal Judge Issues New Coverage Theory," *Business Insurance*, v. 17, p. 1, July 4, 1983.
- Wojcik, Joanne, "Court Extends Coverage Trigger," *Business Insurance*, v. 30. p. 2, July 8, 1996.