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### A Battlefield Map for NFL v. Insurance Industry Re: Concussion Liabilities

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# A Battlefield Map for NFL v. Insurance Industry Re: Concussion Liabilities

CHRISTOPHER C. FRENCH\*

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## ABSTRACT

When the superstar athlete—“Iron Mike” Webster—a nine-time National Football League (NFL) Pro Bowler, four-time Super Bowl Champion, Hall of Fame center for the Pittsburgh Steelers—died at age fifty with severe brain dysfunction after becoming homeless and living in a truck, it was discovered he had a previously nameless disease, Chronic Traumatic Encephalopathy (CTE). The discovery of CTE opened the floodgates on interest in delayed manifestation brain diseases caused by repeated blows to the head. As part of that flood, many retired NFL players brought numerous class actions against the NFL for their alleged brain diseases caused by the repeated blows to the head they received while playing in the NFL. That litigation recently settled with the NFL’s liability totaling approximately \$1 billion, and now the battle over who will pay that \$1 billion liability is being fought between the NFL and more than thirty of the NFL’s insurers in a New York state court (the *NFL v. Insurance Industry* litigation).

This Article is the first scholarly effort to analyze the *NFL v. Insurance Industry* litigation. In doing so, it provides a battlefield map regarding the principal legal issues that will govern the outcome of the *NFL v. Insurance Industry* litigation: (1) choice of law, (2) “trigger,” (3) “allocation,” (4) “number of occurrences,” and (5) the “expected or intended” exclusion. The Article then compares and contrasts the law on these issues for New York, the state in which the *NFL v. Insurance Industry* is being litigated, and Pennsylvania, the state in which the underlying NFL players’ class actions were adjudicated, and predicts potential outcomes under each state’s laws.

## INTRODUCTION

A homeless man in Pittsburgh lived alone in a truck with one of its windows replaced with a garbage bag and duct tape.<sup>1</sup> He had lost a lot of money before becoming homeless, but he could not remember how that occurred.<sup>2</sup> He often forgot to eat, and when he did eat his diet routinely consisted of Pringles and Little Debbie pecan rolls.<sup>3</sup> He used Super Glue to hold his rotting teeth in place.<sup>4</sup> In order to sleep, he used a Taser gun to knock himself unconscious.<sup>5</sup> Sometimes he laid catatonic in the fetal position for days.<sup>6</sup> The man died at age fifty.<sup>7</sup>

Who was this unfortunate man? He was a super star athlete—“Iron Mike” Webster. Iron Mike was a nine-time NFL Pro Bowler, four-time Super Bowl Champion, Hall of Fame center for the Pittsburgh Steelers for fifteen years.<sup>8</sup> It has been estimated that he received approximately 25,000 blows to the head over the course of his career.<sup>9</sup> By the time his life prematurely ended at age fifty, brain tau proteins plagued his brain like brain sludge—clogging up brain function and killing brain cells that controlled for mood, emotions, and executive functioning.<sup>10</sup> An autopsy revealed that Iron Mike suffered from a brain disease now known as Chronic Traumatic Encephalopathy (CTE).<sup>11</sup>

Iron Mike is not alone. Since he died, scientists have discovered that a high percentage of NFL players have CTE or other types of delayed-

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1. See Greg Garber, *A Tormented Soul*, ESPN (Jan. 24, 2005), <http://www.espn.com/nfl/news/story?id=1972285> [<https://perma.cc/FV7P-WHQK>] [hereinafter Garber, *A Tormented Soul*]; Jeanne Marie Laskas, *Bennet Omalu, Concussions, and the NFL: How One Doctor Changed Football Forever*, GQ (Sept. 14, 2009, 8:01 PM), <http://www.gq.com/story/nfl-players-brain-dementia-study-memory-concussions> [<https://perma.cc/GN9C-R7AJ>].

2. See Laskas, *supra* note 1.

3. See Laskas, *supra* note 1; see also Greg Garber, *Wandering through the Fog*, ESPN (Jan. 27, 2005), <http://www.espn.com/nfl/news/story?id=1972288> [<https://perma.cc/PLJ5-NBQP>] [hereinafter Garber, *Wandering Through the Fog*].

4. See Garber, *Wandering Through the Fog*, *supra* note 3; Laskas, *supra* note 1.

5. Laskas, *supra* note 1.

6. Garber, *A Tormented Soul*, *supra* note 1.

7. See Garber, *A Tormented Soul*, *supra* note 1; Laskas, *supra* note 1.

8. See Laskas, *supra* note 1.

9. *Id.*; see also Greg Garber, *Blood and Guts*, ESPN (Jan. 25, 2005), <http://www.espn.com/nfl/news/story?id=1972286> [<https://perma.cc/PH74-FYZJ>].

10. See Laskas, *supra* note 1.

11. *Id.*

manifestation brain diseases when they die.<sup>12</sup> Indeed, so many former NFL players have such brain diseases that former players filed numerous class actions against the NFL.<sup>13</sup> The player class encompassed by the litigation totals approximately 20,000 former NFL players.<sup>14</sup> The parties recently settled, and the NFL agreed to pay a settlement valued at approximately \$1 billion.<sup>15</sup>

The NFL, in turn, sought coverage from more than thirty of the biggest insurance companies in the world that sold Comprehensive General Liability (CGL) insurance policies to the NFL between 1968 and 2012.<sup>16</sup> When the insurers refused to pay, litigation between the NFL and its insurers ensued with competing lawsuits filed by insurers in New York state court and by the NFL in California state court.<sup>17</sup> The California state court stayed the NFL's lawsuit in favor of the insurers' New York litigation.<sup>18</sup>

This Article addresses five major issues most likely to dictate the outcome of this battle of the titans (the *NFL v. Insurance Industry*): (1) choice of law, (2) "trigger," (3) "allocation," (4) "number of occurrences," and (5) the "expected or intended" exclusion. Resolution of these issues will determine which insurers, if any, are responsible for the NFL's defense and indemnity costs and what amounts each insurer will be required to pay.

Choice of law is the question of which jurisdiction's laws should govern the dispute. State law generally governs insurance disputes, and the laws vary significantly from state to state.<sup>19</sup> The insurers likely will argue that

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12. See, e.g., *Turner v. NFL (In re Nat'l Football League Players Concussion Injury Litig.)*, 307 F.R.D. 351, 400 (E.D. Pa. 2015) ("Accepting the findings in the McKee Study as accurate, at least 89% of the former NFL players studied by Dr. Stern, Dr. McKee, and their colleagues would have been compensated under the [NFL] settlement [for long-term brain injuries] while living."), *aff'd*, 821 F.3d 410 (3d Cir. 2016); Laskas, *supra* note 1 ("[A] UNC follow-up [study] in 2005 . . . showed that repeatedly concussed NFL players had five times the rate of 'mild cognitive impairment,' or pre-Alzheimer's disease. That study showed retired NFL players suffering Alzheimer's disease at an alarming 37 percent higher rate than the average guy walking down the street.")

13. *In re Nat'l Football League Players Concussion Injury Litig.*, 821 F.3d 410, 421 (3d Cir. 2016).

14. *Id.* at 420.

15. *Id.* at 447.

16. See *Nat'l Football League v. Fireman's Fund Ins. Co.*, 157 Cal. Rptr. 3d 318, 326 (Ct. App. 2013).

17. See *id.* at 325; *Alterra Am. Ins. Co. v. Nat'l Football League*, Civ. No. 652813/2012 (N.Y. Sup. Ct. Aug. 22, 2012); *Discover Prop. & Cas. Co. v. Nat'l Football League*, Civ. No. 652933/2012 (N.Y. Sup. Ct. Aug. 21, 2012).

18. See *Fireman's Fund Ins. Co.*, 157 Cal. Rptr. 3d at 348.

19. See, e.g., ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 68 (5th ed. 2012) ("In essence, the McCarran-Ferguson Act gave supremacy to state regulation of the business of insurance . . ."); PETER J. KALIS ET AL., *POLICYHOLDER'S GUIDE TO THE LAW OF INSURANCE COVERAGE* § 26.03[B] (1st ed. 1997 & Supp. 2016) ("Insurance contracts are interpreted according to state law. Not surprisingly,

New York law, the forum state and the NFL's headquarters, should control because New York generally is viewed as the most insurer-friendly state in the country.<sup>20</sup> The NFL likely will argue for the law of one or more other states that favor its position. Of the many potential states the NFL could argue governs the dispute, this Article will consider Pennsylvania law, the jurisdiction that handled the underlying players' class action litigation, as an alternative to New York law. Winning the choice of law battle between New York and Pennsylvania could largely dictate the outcome of the entire dispute because of the differences between New York's and Pennsylvania's insurance laws.<sup>21</sup>

"Trigger" is the insurance term used to describe what must occur in order to implicate an insurer's obligations under its policy.<sup>22</sup> The CGL policies at issue in the *NFL v. Insurance Industry* litigation are "occurrence" based policies, which means the injury for which the policyholder seeks coverage must occur during the insurer's policy period in order for the insurer to have any obligations with respect to the policyholder's liabilities.<sup>23</sup> Each insurer likely will argue that the injuries at issue in the NFL players' concussion litigation either predate or postdate their policies or that the policyholder cannot prove when the injuries occurred. Thus, the insurers will argue that the claims against the NFL have not triggered their policies. The NFL, on the other hand, likely will argue that the brain diseases suffered by the players are progressive diseases that began with the first blow to

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the manner in which the courts of the various states address similar interpretive issues can vary widely from one state to the next.").

20. See, e.g., Jeffrey W. Stempel, *Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute*, 12 CONN. INS. L.J. 349, 469 (2006) ("New York law is particularly popular for Bermuda insurers and others in the industry because New York is viewed as a somewhat pro-insurer jurisdiction that has a few particularly favorable rules aiding insurers.").

21. See, e.g., KALIS ET AL., *supra* note 19, § 26.03[B].

22. See, e.g., *id.* § 2.01 ("To 'trigger' a policy, a specified event—e.g., bodily injury or property damage—must take place during the policy period."); 7 STEVEN PLITT ET AL., COUCH ON INSURANCE § 102:23 (June 2016 Update) ("Under a liability policy providing coverage for each 'accident' or each 'occurrence' during the policy period, a risk insured against by the policy must occur during the policy period in order for coverage to be triggered." (citing *Mangerchine v. Reaves*, 63 So. 3d 1049, 1054 (La. Ct. App. 2011))); Gregory A. Goodman, *Insurance Triggers as Judicial Gatekeepers in Toxic Mold Litigation*, 57 VAND. L. REV. 241, 245 (2004) ("The trigger of coverage is a legal test applied by courts to determine which policy has coverage obligations under a claim brought by the policy holder." (citing MITCHELL L. LATHROP, INSURANCE COVERAGE FOR ENVIRONMENTAL CLAIMS § 1.16 (2002))).

23. PLITT ET AL., *supra* note 22.

each player's head and will progress until the player ultimately dies. Consequently, each player's claim triggers every policy year on the risk from the time the player entered the NFL until a brain disease manifested or the player died.

"Allocation" is the insurance term for determining how much each insurer must pay when multiple policies are triggered with respect to the same claim.<sup>24</sup> Many of the insurers likely will argue for "pro rata" allocation, which evenly divides the liability associated with a claim over the entire time period the injury occurred.<sup>25</sup> On the other hand, the NFL—and perhaps some higher level excess insurers—likely will argue for "all sums" allocation, which allows the policyholder to pick which policy year(s), of multiple policy years that a claim triggers, should pay.<sup>26</sup> Under "all sums" allocation, the policyholder can slot all of its liabilities into one or more policy years, and thus avoid paying numerous deductibles or self-insured retentions (SIRS).<sup>27</sup> The insurers required to pay under "all sums" allocation can then seek contribution from the insurers in other triggered policy years.<sup>28</sup>

The "number of occurrences" issue is the question of how many players' claims should be lumped together for deductibles/SIRs and limits of liability purposes. The issue's resolution can have enormous financial implications.<sup>29</sup>

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24. See, e.g., KALIS ET AL., *supra* note 19, § 3.01 ("Policyholder-insurer disputes over the proper trigger of coverage . . . are invariably followed by disputes over the 'scope' of coverage afforded by each triggered policy in effect during the injury process. This is sometimes also referred to as the allocation issue." (citation omitted)); 15 PLITT ET AL., *supra* note 22, § 220:25 ("Many environmental damage and toxic exposure cases, for example, involve injuries that occur over a number of years. Because in these types of cases it is virtually impossible to allocate to each policy the liability for injuries occurring only within its policy period, the courts are left with the nettlesome problem of how to allocate damages among the policies." (citing Michael G. Doherty, Comment, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. 257, 258 (1997))); Michael G. Doherty, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. 257, 257–58 (1997) ("Progressive injuries frequently occur over time periods in which a liable party had insurance coverage under several different insurance policies, often provided by a number of insurance companies. In most of these cases, it is both scientifically and administratively impossible to allocate to each policy the liability for injuries occurring only within its policy period. When it is impossible to determine the proportion of damage that occurred within each period, the law must allocate damages among the policies." (first citing *Montrose Chemical Corp. v. Admiral Ins. Co.*, 913 P.2d 878, 881 (Cal. 1995); then citing KENNETH S. ABRAHAM, ENVIRONMENTAL LIABILITY INSURANCE LAW: AN ANALYSIS OF TOXIC TORT AND HAZARDOUS WASTE INSURANCE COVERAGE ISSUES 120–23 (1991))).

25. KALIS ET AL., *supra* note 19, §§ 3.01, 3.01[B][2].

26. *Id.*

27. See KALIS ET AL., *supra* note 19, § 3.01[C].

28. *Id.* §§ 3.01, 3.02.

29. *Id.* § 3.03[B] ("Depending on a policy's per occurrence and aggregate limits and the amount of any applicable self-insurance features, the number of occurrences determination is tantamount to determining the extent of the policyholder's recovery."); PLITT ET AL., *supra*

It generally is in the insurers' financial interest to argue for multiple occurrences if the policies contain significant deductibles/SIRs or if the policies contain aggregate limits, which policies today typically do. Older CGL policies, on the other hand, do not necessarily contain aggregate limits.<sup>30</sup> Conversely, if the NFL's policies have high deductibles/SIRs, then the NFL likely will argue that all of the players' claims arise from a single occurrence.

Finally, the insurers likely will argue that they have no liability for any of the NFL's defense or indemnity costs due to the "expected or intended" exclusion which typically is present in standard form CGL policies.<sup>31</sup> As a general matter, insurance is intended to cover only fortuitous injuries.<sup>32</sup> Consequently, CGL policies expressly exclude coverage for any injuries or damages expected or intended by the policyholder.<sup>33</sup> Due to this exclusion, the insurers likely will argue that prior to purchasing their policies the NFL knew that repetitive blows to the head can lead to long-term brain injuries, yet the NFL did little, if anything, to warn against or prevent such injuries to NFL players. Thus, the NFL intended, or at least expected, the injuries for which it is now liable and the insurers should not be required to pay for these non-fortuitous liabilities. The NFL undoubtedly will dispute such an assertion and the applicability of the exclusion.

This Article proceeds in three parts. Part I discusses delayed manifestation brain diseases caused by repeated blows to the head and the NFL players' class action litigation. Part II sets forth the relevant insurance policy provisions at the center of the *NFL v. Insurance Industry* litigation. Part III addresses the differences between the insurance laws of New York and Pennsylvania regarding the principal issues identified above that likely will dictate the outcome of the *NFL v. Insurance Industry* litigation and the potentially divergent outcomes under the respective states' laws.

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note 22, § 172:12 ("[W]here the liability policy defines 'occurrence' as a series of related incidents, acts, or omissions resulting in injury, there will be a single 'occurrence' even though there have been multiple causative acts, if the acts are causally related to each other as well as to the final result." (footnote omitted)).

30. See, e.g., KALIS ET AL., *supra* note 19, § 3.03[A][3].

31. See, e.g., DONALD S. MALECKI, *COMMERCIAL GENERAL LIABILITY COVERAGE GUIDE*, app. J § 1.2.a, at 571 (11th ed. 2015).

32. See, e.g., JERRY & RICHMOND, *supra* note 19, at 413 (citing *Waller v. Truck Ins. Exch.*, 900 P.2d 619, 626 (Cal. 1995)); 7 PLITT ET AL., *supra* note 22, § 102:7 ("Implicit in the concept of insurance is that the loss occur as a result of an event that is fortuitous rather than planned, intended, or anticipated." (footnote omitted)).

33. See, e.g., MALECKI, *supra* note 31.



I. A NEW TYPE OF LONG-TAIL INSURANCE CLAIM: BRAIN DISEASES  
CAUSED BY REPEATED BLOWS TO THE HEAD

A. *The Cumulative Impact of Repeated Blows to the Head*

Today, it generally is accepted that repeated blows to a person's head cumulatively can cause long-term brain diseases that may not manifest for many years.<sup>34</sup> Dr. Bennet Omalu, a Nigerian forensic pathologist, recently named one type of these long term brain injuries Chronic Traumatic Encephalopathy (CTE) after he discovered an abnormal buildup of Tau Protein in Iron Mike's brain during an autopsy.<sup>35</sup> According to Boston University's CTE Center, what we now call "CTE has been known to affect boxers since the 1920s."<sup>36</sup> With boxers, it was referred to as "dementia pugilistica" or "punch drunk" syndrome.<sup>37</sup> In a person with CTE, the "brain degeneration [causes] . . . memory loss, confusion, impaired judgment, impulse control problems, aggression, depression, and, eventually, progressive dementia."<sup>38</sup> Other brain function problems that can result from repeated blows to the head include: "Alzheimer's Disease, dementia, depression, deficits in cognitive functioning, reduced processing speed, attention and reasoning impairment, loss of memory, sleeplessness, mood swings, and personality changes."<sup>39</sup> One of the revelations regarding CTE that has brought the disease to the forefront of public consciousness and concern is the theory that sub-concussive blows can cause CTE, which means a person does not have to be repeatedly knocked out or suffer repeated concussions in order to get the disease.<sup>40</sup> To the contrary, according to the theory, repetitive, smaller blows can cause these debilitating brain diseases.<sup>41</sup>

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34. See *What is CTE?*, B.U. CTE CENTER, <http://www.bu.edu/cte/about/what-is-cte/> [<https://perma.cc/43WL-P8T8>] (last visited Nov. 4, 2016).

35. See, e.g., Laskas, *supra* note 1.

36. *What is CTE?*, *supra* note 34; see also *Turner v. NFL (In re Nat'l Football League Players Concussion Injury Litig.)*, 307 F.R.D. 351, 398 n.50 (E.D. Pa. 2015), *aff'd*, 821 F.3d 410 (3d Cir. 2016).

37. See *What is CTE?*, *supra* note 34.

38. *What is CTE?*, *supra* note 34; see also *Turner*, 307 F.R.D. at 362.

39. *Turner*, 307 F.R.D. at 362.

40. See, e.g., Rick Maese, *Repeated Hits to the Head More Significant than Concussions, New Study Suggests*, WASH. POST (Mar. 31, 2016), [https://www.washingtonpost.com/sports/redskins/repeated-hits-to-head-more-significant-than-concussions-new-study-suggests/2016/03/31/58dd9c6c-f750-11e5-9804-537defcc3cf6\\_story.html](https://www.washingtonpost.com/sports/redskins/repeated-hits-to-head-more-significant-than-concussions-new-study-suggests/2016/03/31/58dd9c6c-f750-11e5-9804-537defcc3cf6_story.html); Maxwell Strachan, *Six Sentences that Every Parent of a Football Player Should Read*, HUFFINGTON POST (Nov. 12, 2015, 1:37 PM), [http://www.huffingtonpost.com/entry/football-child-subconcussive-hits\\_us\\_5644d543e4b045bf3dee2490](http://www.huffingtonpost.com/entry/football-child-subconcussive-hits_us_5644d543e4b045bf3dee2490) [<https://perma.cc/EEV8-KYQY>].

41. For a full discussion of the theory and the science underlying it, see Ann McKee et al., *The Spectrum of Disease in Chronic Traumatic Encephalopathy*, 136 BRAIN 43 (2013), and Robert Stern et al., *Clinical Presentation of Chronic Traumatic Encephalopathy*, 81 NEUROLOGY 1122 (2013).

*B. The Players' Class Actions Against the NFL*

On July 19, 2011, seventy-three former NFL players sued the NFL, a league that generates approximately \$10 billion in annual revenues,<sup>42</sup> in state court in California.<sup>43</sup> The complaint contained both negligence and fraud counts.<sup>44</sup> In essence, the players alleged that the NFL negligently failed to protect players from the risk of long-term brain injuries due to concussions and sub-concussive blows to the head and fraudulently concealed such risks from the players.<sup>45</sup> More specifically, the players alleged that the NFL “fostered a culture surrounding football that glorified violence and a gladiator mentality, encouraging NFL players to play despite head injuries.”<sup>46</sup> Further, the players alleged that the NFL created a committee in 1994 to study the effects of concussive and sub-concussive injuries on the players and then “obfuscated the connection between NFL Football and long-term brain injury, despite knowing ‘for decades’ that such a connection exists.”<sup>47</sup> The players also alleged that the NFL misrepresented to its players, the public, and Congress that “‘there was no scientifically proven link between repetitive traumatic head impacts and later-in-life cognitive/brain injury.’”<sup>48</sup>

A few weeks after the NFL players filed their initial lawsuit, they filed two other similar lawsuits, one in California state court and one in federal court in the Eastern District of Pennsylvania.<sup>49</sup> The Eastern District of Pennsylvania consolidated the actions, and former players eventually filed 300 substantially similar lawsuits against the NFL.<sup>50</sup>

*C. The Settlement of the NFL Players' Class Actions Against the NFL*

On August 29, 2013, the players and the NFL reached a tentative settlement that included a \$765 million fund for medical exams and to provide compensation for player injuries, but the federal district court declined to

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42. *Turner*, 307 F.R.D. at 421.

43. *See id.* at 361, 421.

44. *See id.* at 362; Jay Barry Harris, *We've Only Just Begun: Determining Who Pays After the Approval Of The NFL Concussion Settlement*, 83 DEF. COUNS. J. 156, 157 (2016).

45. *See Turner*, 307 F.R.D. at 362.

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.* at 361.

50. *Id.*

approve the settlement primarily due to concerns that the players would exhaust the funds prior to the expiration of the sixty-five year life of the settlement.<sup>51</sup> Five months later, the parties reached a new settlement, which the federal district court approved.<sup>52</sup> The settlement covers approximately 21,000 NFL players who retired before July 7, 2014, with only a total of 202 players opting out of the settlement.<sup>53</sup>

Under the approved settlement, there is no cap on the funds used to compensate injured players and projections indicate that the settlement will compensate players in the amount of approximately \$1 billion.<sup>54</sup> The maximum player compensation for the various types of brain diseases under the settlement is as follows:

<b>Qualifying Diagnosis</b>	<b>Maximum Award</b>
Level 1.5 Neurocognitive Impairment	\$1.5 Million
Level 2 Neurocognitive Impairment	\$3 Million
Parkinson's Disease	\$3.5 Million
Alzheimer's Disease	\$3.5 Million
Death with CTE	\$4 Million
ALS	\$5 Million <sup>55</sup>

The settlement agreement defines Levels 1.5 and 2 Neurocognitive Impairment and they generally require a decline in cognitive function and a loss of functional capabilities such as an inability to hold a job or do household chores.<sup>56</sup> Parkinson's disease and ALS both cause debilitating muscular and cognitive impairment including tremors, rigidity, and gait disorders.<sup>57</sup> ALS sufferers undergo a rapid and sweeping degeneration of the entire neuromuscular system such that the person eventually requires twenty-four hour medical care with a ventilator and feeding tube.<sup>58</sup>

On April 18, 2016, the Third Circuit affirmed the district court's approval of the settlement.<sup>59</sup>

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51. *Id.* at 364.

52. *Id.*

53. *See In re Nat'l Football League Players Concussion Injury Litig.*, 821 F.3d 410, 425 (3d Cir. 2016).

54. *See Turner*, 307 F.R.D. at 364; *In re Nat'l Football League Players Concussion Injury Litig.*, 821 F.3d at 447.

55. *See Turner*, 307 F.R.D. at 366.

56. *Id.*

57. *Id.* at 406.

58. *Id.*

59. *See In re Nat'l Football League Players' Concussion Injury Litig.*, 821 F.3d at 411.

II. THE NFL'S INSURANCE PROGRAM AND THE RELEVANT  
INSURANCE POLICY LANGUAGE

Historically, many corporate policyholders have purchased CGL insurance annually to create a seamless insurance program that will cover losses that span multiple policy periods. Such programs typically have multiple layers of coverage with primary insurance at the lowest level and excess insurance above the primary insurance, with the total limits of insurance in each policy year increasing as time moves forward.<sup>60</sup> The policies in the various policy years typically contain the same or similar language because the Insurance Services Office, Inc. (ISO) drafts standard form CGL policies used by most insurers.<sup>61</sup> The NFL's insurance program appears to fit this description and it appears that the NFL has hundreds of millions, if not billions, of dollars of coverage when the limits of the policies in its insurance program for each of the forty-four years of its insurance program are added together.<sup>62</sup> A graphic depiction of a typical insurance program of a corporate policyholder appears in Figure A:

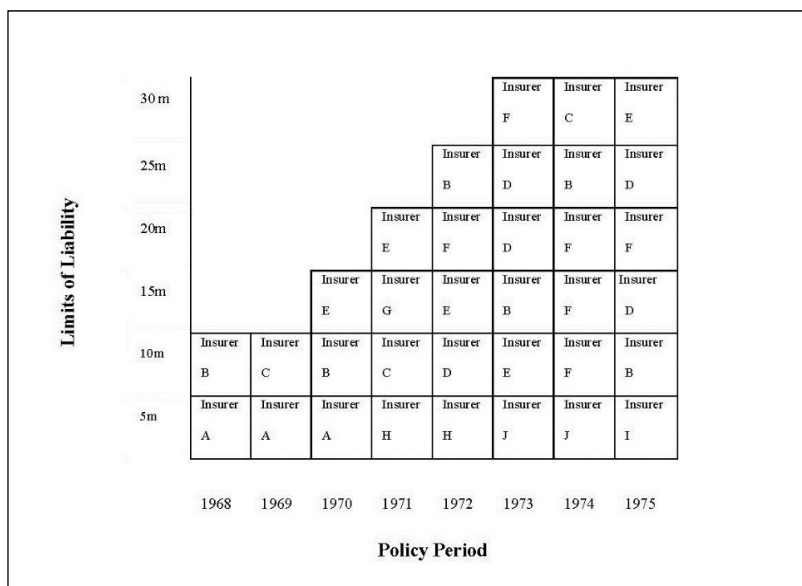
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60. See *infra* Figure A.

61. ISO is an influential organization within the insurance industry that provides a variety of services to many insurers. See, e.g., *U.S. Fire Ins. Co. v. J.S.U.B., Inc.*, 979 So. 2d 871, 879 n.6 (Fla. 2007). One of ISO's primary functions is to draft policy forms it then submits to state insurance regulators for approval. See, e.g., *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 772 (1993) (citation omitted). As a provider of services to approximately 1,400 property and casualty insurers, ISO "is the almost exclusive source of support services in this country for CGL insurance." *Id.* As a result, "most CGL insurance written in the United States is written on [ISO] forms." *Id.* (citation omitted).

62. See, e.g., *Nat'l Football League v. Fireman's Fund Ins. Co.*, 157 Cal. Rptr. 3d 318, 323 (2013); Affidavit of Anastasia Donias at Ex. 1, *Alterra Am. Ins. v. Nat'l Football League*, No. 652813/2012 (N.Y. Sup. Ct. Sept. 12, 2012), ECF No. 68 (showing Alterra's policy provides \$25 million in coverage to the NFL excess of \$50 million in underlying coverage).

FIGURE A: TYPICAL INSURANCE PROGRAM OF A CORPORATE POLICYHOLDER



Under the hypothetical insurance program reflected in Figure A, if a covered liability in the amount of \$20 million triggered only the 1971 policy year, then Insurer H would pay the first \$5 million, Insurer C would pay the next \$5 million, Insurer B would pay the next \$5 million, Insurer G would pay the next \$5 million, and Insurer E would pay the final \$5 million. In long-tail claims such as concussion-related brain disease cases where the time period in which the injuries were caused implicates multiple policy years and the amounts of the liabilities implicate multiple layers of coverage, the determination of each insurer's liability can become quite complex. For example, assume that the NFL's covered liability for a group of players totals \$25 million and it has been determined that the blows to the players' heads that gave rise to the liability began in 1968 and ended in 1975, and that the players' brain diseases began to manifest in 1980. What is Insurer B's coverage obligation? As one might suspect, answering that question is a difficult task that turns on the applicable law and policy language. The policy provisions relevant to the analysis are discussed below.

### A. *The Insuring Agreement*

Under ISO’s 2007 standard form CGL policy, for example, the basic insuring agreement language—the insurer’s promise to the policyholder—provides as follows:

#### COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY

##### 1. Insuring Agreement

- a. We will pay those sums that the insured becomes legally obligated to pay as damages because of “bodily injury” . . . to which this insurance applies. . . .
- b. This insurance applies to “bodily injury” . . . only if:
  - (1) The “bodily injury” . . . is caused by an “occurrence” that takes place in the “coverage territory;” [and]
  - (2) The “bodily injury” occurs during the policy period . . .<sup>63</sup>

In short, the policy covers the amount that the NFL must pay due to a “bodily injury” during the policy period caused by an “occurrence.”

### B. *The Definition of “Bodily Injury”*

“Bodily Injury” is defined as: “bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.”<sup>64</sup> There should be no debate that the NFL players’ brain diseases for which they have sued the NFL are bodily injuries.

### C. *The Definition of “Occurrence”*

Prior to 1986, ISO’s standard form CGL policies defined “occurrence” as “an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”<sup>65</sup> Beginning in 1986, and continuing today, ISO’s standard form CGL policy defined “occurrence” as “an accident, including continuous or repeated exposure to substantially

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63. INS. SERVS. OFFICE, INC., COMMERCIAL GENERAL LIABILITY OCCURRENCE FORM (2007), reprinted in MALECKI, *supra* note 31, app. J §§ I(1)(a), I(b)(1), at 570.

64. *Id.* app. J § V.3, at 582.

65. INS. SERVS. OFFICE, INC., COMMERCIAL GENERAL LIABILITY OCCURRENCE FORM (1973), reprinted in MALECKI, *supra* note 31, app. A, at 363.

the same general harmful conditions.”<sup>66</sup> Under both definitions, to determine whether there is a covered occurrence, the analysis focuses on whether an act or omission unexpectedly caused a bodily injury during the policy period. In short, did a bodily injury occur during the policy period as a result of an accident?

#### D. The “Expected or Intended” Exclusion

As many courts already treated the “expected or intended” language in the definition of an “occurrence” as an exclusion,<sup>67</sup> in 1986 ISO moved the expected or intended language to the exclusions section of CGL policies: “This insurance does not apply to . . . [b]odily injury’ . . . expected or intended from the standpoint of the insured . . . .”<sup>68</sup> This move did not, however, change the analysis of whether there has been a covered occurrence. The question is still whether the policyholder did something or failed to do something that resulted in a bodily injury during the policy period that the policyholder did not expect or intend.<sup>69</sup>

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66. INS. SERVS. OFFICE, INC., COMMERCIAL GENERAL LIABILITY OCCURRENCE FORM (1986), *reprinted in* MALECKI, *supra* note 31, app. B, § V(9), at 373; INS. SERVS. OFFICE, INC., COMMERCIAL GENERAL LIABILITY OCCURRENCE FORM (2007), *reprinted in* MALECKI, *supra* note 31, app. J § V(9), at 583.

67. *See, e.g.*, Upjohn Co. v. Aetna Cas. & Sur. Co., No. 4:88-CV-124, 1994 WL 1029337, at \*9 (W.D. Mich. July 22, 1994) (“[A]lthough the neither expected nor intended language appears in the occurrence clause, it essentially operates as an exclusion.”); Clemco Indus. v. Commercial Union Ins. Co., 665 F. Supp. 816, 820–21 (N.D. Cal. 1987) (determining that the “expected or intended” language is an exclusionary clause, and thus requires a narrow interpretation to provide the insured the greatest protection (citing *White v. Western Title Ins. Co.*, 710 P.2d 309, 313 (Cal. 1985))); Nat’l Farmers Union Prop. & Cas. Ins. Co. v. Kovash, 452 N.W.2d 307, 311 n.3 (N.D. 1990) (“A determination of coverage under the ‘expected or intended’ language in the definition of an occurrence generally involves the same determination as coverage under an exclusion for intentional acts.” (citing James L. Rigelhaupt, Jr., Annotation, *Construction and Application of Provision of Liability Insurance Policy Expressly Excluding Injuries Intended or Expected by Insured*, 31 A.L.R.4th 957, 971 (1984))).

68. COMMERCIAL GENERAL LIABILITY OCCURRENCE FORM (2007), *supra* note 63, app. B § (2)(a), at 467; COMMERCIAL GENERAL LIABILITY OCCURRENCE FORM (1986), *supra* note 66, app. B § (2)(a), at 269.

69. *See, e.g.*, KALIS ET AL., *supra* note 19, § 6.03[B][1] (“Most jurisdictions follow the rule that only expected or intended injury, as opposed to expected or intended acts, can preclude coverage.” (citations omitted)); *see also* U.S. Fire Ins. Co. v. J.S.U.B., Inc., 979 So. 2d 871, 883 (Fla. 2007) (“[T]hese policies provide coverage not only for ‘accidental events,’ but also injuries or damage neither expected nor intended from the standpoint of the insured.” (citation omitted)); Cherrington v. Erie Ins. Prop. & Cas. Co., 745 S.E.2d 508, 520 (W. Va. 2013) (“In determining whether under a liability insurance policy an occurrence was or was not an ‘accident’—or was or was not deliberate, intentional, expected, desired, or foreseen—primary consideration, relevance, and weight should ordinarily be given to the perspective or standpoint of the insured whose coverage under the policy is at issue.” (quoting *Columbia Cas. Co. v. Westfield Ins. Co.*, 617 S.E.2d 797, 797 (W. Va. 2005))).

### III. THE POTENTIAL OUTCOMES IN THE *NFL v. INSURANCE INDUSTRY* LITIGATION UNDER COMPETING STATE LAWS REGARDING FIVE OF THE PRINCIPAL ISSUES

#### A. Choice of Law

State law generally governs insurance disputes, and, as is the case in many complex insurance coverage disputes, the outcome of the *NFL v. Insurance Industry* litigation will be heavily dictated by which state's law is applied because insurance law varies considerably from state to state.<sup>70</sup> Indeed, the choice-of-law battle could be the most important battle in the case.<sup>71</sup>

CGL policies typically do not contain a choice-of-law provision that specifies which state's laws will apply, so the court must rely upon state choice-of-law rules to make this critical decision.<sup>72</sup> In the absence of a contractual mandate, courts typically only apply the law of a single state even if the case involves multiple parties from different states and the outcome of the litigation will impact the interests of multiple states.<sup>73</sup> Courts

70. See KALIS ET AL., *supra* note 19; see also 2 PLITT ET AL., *supra* note 22, § 24:1 (“In theory, the laws of two states cannot control the interpretation of a contract of insurance, and the choice of which jurisdiction’s law will govern can have serious consequences for an insurance dispute.”).

71. See, e.g., Peter J. Kalis, James R. Segerdahl & John T. Waldron, *The Choice-of-Law Dispute in Comprehensive Environmental Coverage Litigation: Has Help Arrived from the American Law Institute Complex Litigation Project?*, 54 LA. L. REV. 925, 933 (1994) (“The patchwork of state law that has evolved over the past decade or so has raised dramatically the profile of the choice-of-law issue in [complex] environmental coverage disputes. The resolution of this issue can be dispositive of whether a claim is covered, or, at a minimum, can substantially affect the value of the claim.”); Larry Kramer, *Choice of Law in Complex Litigation*, 71 N.Y.U. L. REV. 547, 553–54 (1996) (“Conflicts scholars don’t fight bitterly about the differences among approaches [to determining choice law] because we disagree about their aesthetic qualities. We fight because the differences matter in terms of outcomes.”).

72. See, e.g., Kalis et al., *supra* note 71, at 927 (“No express direction on this point is available by reference to the standard CGL policy form. The drafters’ failure to include a choice-of-law provision is a key omission in the form resulting in contractual silence on an issue that dramatically affects the rights of the parties to the contract. Moreover, the omission renders virtually unattainable the goals of efficiency, predictability, and uniformity inherent in the use of standardized forms.” (footnote omitted)).

73. See, e.g., Friedrich K. Juenger, *Mass Disasters and the Conflict of Laws*, 1989 U. ILL. L. REV. 105, 126 (arguing for a choice-of-law rule in mass tort cases under which the law of a single state would apply (citing *In re “Agent Orange” Prod. Liab. Litig.*, 580 F. Supp. 690, 696 (E.D.N.Y. 1984))); Kramer, *supra* note 71, at 547 (concluding there is a consensus that “choice-of-law practices should yield in suits consolidating large numbers



generally justify the application of a single state's law as an approach that promotes fairness, judicial economy, and consistency in the individual claims' outcomes.<sup>74</sup>

As the forum state, the New York state court judge adjudicating the *NFL v. Insurance Industry* litigation will apply New York law to determine which state's law will govern the substantive legal issues.<sup>75</sup> The traditional approach to choice of law for contracts provides that either the law of the place of contracting or the place of performance should apply to resolve disputes under the contract at issue.<sup>76</sup> In *Auten v. Auten*,<sup>77</sup> the New York Court of Appeals departed from the traditional approach, however, and adopted what is known as the "center of gravity" or the "significant contacts" approach. The "center of gravity" approach gives "the place 'having the most interest in the problem' paramount control over the legal issues arising out of a particular factual context."<sup>78</sup> Under this approach, courts analyze the relative contacts the states have with the dispute to determine which state has the most "significant contacts" that justifies applying that state's law.<sup>79</sup> Over time, the "center of gravity" approach adopted in New York has been shaped and influenced by the factors considered under the modern choice-

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of claims . . . [to] a single law in [complex litigation]," even though a primary argument of his paper is that courts and commentators generally are wrong that only a single state's law should apply in such cases); Thomas M. Reavley & Jerome W. Wesevich, *An Old Rule for New Reasons: Place of Injury As A Federal Solution to Choice of Law in Single-Accident Mass-Tort Cases*, 71 TEX. L. REV. 1, 24 (1992) ("We think that fairness demands that parties to cases concerning identical facts be treated equally under the law . . .").

74. Reavley & Wesevich, *supra* note 73; see also Arthur R. Miller & David Crump, *Jurisdiction and Choice of Law in Multistate Class Actions After Phillips Petroleum Co. v. Shutts*, 96 YALE L.J. 1, 64 (1986) (explaining that the application of multiple states' laws in class actions by a single judge is too difficult because a "nationwide class action may present an even greater problem because of the sheer burden of organizing and following fifty or more different bodies of complex substantive principles").

75. See, e.g., *Certified Multi-Media Sols., Ltd. v. Preferred Contractors Ins. Co. Risk Retention Grp.*, 150 F. Supp. 3d 228, 239 (E.D.N.Y. 2015) (stating that when New York is the forum state in which the case will be decided, the court applies New York choice-of-law principles); *MBIA Ins. Corp. v. Countrywide Home Loans, Inc.*, 965 N.Y.S.2d 284, 292 (N.Y. Sup. Ct. 2013) ("Since New York is the forum state, New York choice of law rules are applicable." (citing *Padula v. Lilarn Props. Corp.*, 644 N.E.2d 1001, 1002 (N.Y. 1994))); *Curbow Family LLC v. Morgan Stanley Inv. Advisors*, 950 N.Y.S.2d 845, 849 (N.Y. Sup. Ct. 2012) (stating that New York choice-of-law principles are determinative because New York is the forum state).

76. See RESTATEMENT (FIRST) OF CONFLICT OF LAWS §§ 332, 358 (AM. LAW INST. 1934).

77. *Auten v. Auten*, 124 N.E.2d 99, 101–02 (N.Y. 1954) (citing *Rubin v. Irving Trust Co.*, 113 N.E.2d 424, 431 (N.Y. 1953)).

78. *Id.* at 102 (citing Sanford H. Kadish, *Labor Arbitration and the Law in Utah*, 3 UTAH L. REV. 490, 498–99 (1953)).

79. *Id.*

of-law approaches reflected in the Restatement (Second) of Conflicts of Law.<sup>80</sup>

The Second Restatement offers seven general principles “relevant to the choice of applicable rule of law,” which include considerations such as the “policies of . . . interested states,” “the protection of justified expectations,” and “certainty, predictability and uniformity of result.”<sup>81</sup> With respect to contracts in particular, if the contract does not specify which state’s laws govern, there are five factors to consider when analyzing the seven general overriding principles: “[1] the place of contracting, [2] the place of negotiation of the contract, [3] the place of performance, [4] the location of the subject matter of the contract, and [5] the domicile, residence, nationality, place of incorporation and place of business of the parties.”<sup>82</sup> Thus, when determining questions of choice of law, New York courts typically analyze the significant contacts of the relative states and parties involved in light of these factors.<sup>83</sup>

In addition to the general factors discussed above, the Second Restatement also contains provisions to determine choice of law in disputes that involve liability policies.<sup>84</sup> Specifically, it provides the governing law should be:

[T]he local law of the state which the parties understood was to be the principal location of the insured risk during the term of the policy, unless with respect to the particular issue, some other state has a more significant relationship under the principles stated in § 6 to the transaction and the parties, in which event the local law of the other state will be applied.<sup>85</sup>

Thus, for simple insurance disputes, courts often presume that the principal place of the insured risk has the most “significant relationship” and that state’s law typically applies to the dispute. A showing that another state has a more significant relationship, however, can defeat that presumption and lead to another state’s law being applied.

The approach New York courts use to determine the law applicable to insurance disputes where the insured risk is spread across multiple states,

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80. *See, e.g.*, *Zurich Ins. Co. v. Shearson Lehman Hutton, Inc.*, 642 N.E.2d 1065, 1068 (N.Y. 1994) (using the factors provided in the Restatement (Second) of Conflicts of Law to determine which state has the most significant contacts).

81. RESTATEMENT (SECOND) OF CONFLICTS OF LAW § 6 (AM. LAW INST. 1971).

82. *Id.* § 188.

83. *See, e.g.*, *Zurich Ins. Co.*, 642 N.E.2d at 1068; *Jimenez v. Monadnock Constr., Inc.*, 970 N.Y.S.2d 577, 580 (App. Div. 2013).

84. *See* RESTATEMENT (SECOND) OF CONFLICTS OF LAW § 193.

85. *Id.*

however, is different and more complex<sup>86</sup> because the Second Restatement recognizes that no single location of the insured risk exists if the insured risk spreads across multiple states.<sup>87</sup> The goal of the analysis in such circumstances is to use the law of the state with the most at stake in the litigation, as opposed to the state that simply has the most contacts associated with the placement of the policies.<sup>88</sup> In short, the court should attempt to determine which state has the most at stake in the resolution of the case and then apply that state's law.

### 1. *The Argument for New York Law*

In 2007, the New York Court of Appeals had an opportunity to address choice of law in an insurance dispute that involved insured interests throughout the country in *Certain Underwriters at Lloyd's London v. Foster Wheeler Corp.*<sup>89</sup> In *Foster Wheeler*, the court needed to determine which policies were triggered and then apportion the policyholder's liabilities associated with a large number of asbestos-related bodily injury claims asserted throughout the country against the policyholder and one of its subsidiaries.<sup>90</sup> The court considered whether to apply New York law, the state in which numerous brokers who were involved with the placement of the policies were located, or New Jersey law, the state in which the policyholder's principal place of business was located.<sup>91</sup>

In its analysis, the court began with a recitation of New York's general choice-of-law principles, as discussed above, but encountered some difficulty when trying to determine the location of the insured risk.<sup>92</sup> The court stated, "the location-of-the-risk rule obviously cannot be applied without modification in the event the insurance policies in question cover risks that are spread through multiple states."<sup>93</sup> The policyholder's risks were "widely dispersed" and really "nationwide or global in scope."<sup>94</sup> That meant that the insured risk

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86. See, e.g., *Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.*, 822 N.Y.S.2d 30, 37 (App. Div. 2006), *aff'd*, 876 N.E.2d 500 (N.Y. 2007).

87. See RESTATEMENT (SECOND) OF CONFLICTS OF LAW § 193 cmt. b.

88. *Foster Wheeler*, 822 N.Y.S.2d at 37 ("[T]he choice-of-law analysis is not 'a mindless scavenger hunt to see which state can be found to have more contacts, but rather . . . an effort to detect and analyze what interest the competing states have in enforcing their respective rules.'" (quoting *Fireman's Fund Ins. Co. v. Schuster Films, Inc.*, 811 F. Supp. 978, 984 (S.D.N.Y. 1993))).

89. *Id.* at 31.

90. *Id.*

91. *Id.* at 36–38.

92. *Id.* at 33–34 (quoting, in part, *Zurich Ins. Co. v. Shearson Lehman Hutton*, 642 N.E. 1065, 1068–69 (N.Y. 1994)).

93. *Id.* at 33.

94. *Id.*

existed in no single state. Thus, the court had to turn to “broader choice-of-law principles.”<sup>95</sup>

In its analysis, the court cited *Auten* for the general proposition that the “center of gravity” approach aims to allow courts to apply the law of the state having the most paramount interest in the dispute.<sup>96</sup> To achieve that goal, the court considered the relative “governmental interests implicated by an insured’s claim against an insurer of risks located in multiple states,” which the court concluded “weigh in favor of applying the law of the insured’s domicile . . . .”<sup>97</sup> In addition, the court stated that the overall goal of “certainty, predictability and uniformity of result” set forth in the Second Restatement<sup>98</sup> also supported the application of the law of the policyholder’s domicile.<sup>99</sup> The court reasoned that the parties knew the location of the policyholder’s domicile at the time of contracting and consequently, applying the law of that state best reflected the parties’ expectations.<sup>100</sup>

Ultimately, the court in *Foster Wheeler* held that “where it is necessary to determine the law governing a liability insurance policy covering risks in multiple states, the state of the insured’s domicile should be regarded as the proxy for the principal location of the insured risk.”<sup>101</sup> In other words, when determining the law that applies to insurance policies that cover risks in multiple states, the court still treated the policyholder’s domicile as the place of the insured risk despite other states’ numerous contacts and interests in the dispute.

New York courts have applied the *Foster Wheeler* holding in other cases so the decision likely will strongly influence the judge tasked with determining the law applicable to resolving the *NFL v. Insurance Industry* litigation.<sup>102</sup>

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95. *Id.* at 34.

96. *Id.* (citing *Auten v. Auten*, 124 N.E.2d 99, 102 (N.Y. 1954)).

97. *Id.* The governmental interests identified by the court were:

- (1) regulating conduct with respect to insured risks within the state’s borders;
- (2) assuring that the state’s domiciliaries are fairly treated by their insurers; (3) assuring that insurance is available to the state’s domiciliaries from companies located both within and without the state; and (4) regulating the conduct of insurance companies doing business within the state’s borders.

*Id.*

98. RESTATEMENT (SECOND) OF CONFLICTS OF LAW § 6 (AM. LAW INST. 1971).

99. *Foster Wheeler*, 822 N.Y.S.2d at 34.

100. *Id.* at 34–35.

101. *Id.* at 35.

102. *See, e.g.*, *Appalachian Ins. Co. v. Di Sicurata*, 875 N.Y.S.2d 57, 58 (App. Div. 2009) (citing *Foster Wheeler*, 822 N.Y.S.2d at 35); *Liberty Surplus Ins. Corp. v. Nat’l*

Because the NFL's principal place of business is New York, this fact likely will weigh heavily in favor of applying New York law.<sup>103</sup> And, of course, many of the brokers involved in the placement of the policies, some of the insurers, and some of the underlying NFL player class members are also located in New York.<sup>104</sup> Consequently, under *Foster Wheeler*, New York law arguably should apply in the *NFL v. Insurance Industry* litigation.<sup>105</sup>

## 2. *The Argument for the Law of Another State Such as Pennsylvania*

Despite *Foster Wheeler*, one can also strongly argue that the law of a state or states other than New York should apply in the *NFL v. Insurance Industry* litigation. As discussed above, *Foster Wheeler* calls for a choice-of-law analysis under the general framework of the “center of gravity” or “significant contacts” approach formulated in the Second Restatement. Thus, when arguing choice of law, the parties can still argue that consideration of principles from the Second Restatement other than just the policyholder's domicile better reflect the goal of the “significant contacts” approach and should dictate the applicable choice of law. With that in mind, one can also argue to apply other state's laws, such as Pennsylvania, the state that handled the underlying NFL players' litigation against the NFL.

*Foster Wheeler* held that, in cases where the insured risk spreads across multiple states, the court will deem the “principal location of the insured risk,” as provided in Second Restatement Section 193, as policyholder's domicile.<sup>106</sup> That determination, however, is only the first step in the choice-of-law analysis. Section 193 then provides that if a state other than the principal location of the insured risk “has a more significant relationship under the principles stated in § 6 to the transaction,” then that state's law should apply.<sup>107</sup> Thus, courts can and should still entertain a choice-of-law analysis grounded in the general principles provided in Section 6 of the Second Restatement.<sup>108</sup>

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Union Fire Ins. Co., 888 N.Y.S.2d 35, 36 (App. Div. 2009) (citing *Foster Wheeler*, 822 N.Y.S.2d at 35).

103. See *Nat'l Football League v. Fireman's Fund Ins. Co.*, 157 Cal. Rptr. 3d 318, 321 (Ct. App. 2013).

104. See *id.* at 322–23.

105. *Foster Wheeler*, 822 N.Y.S.2d at 35.

106. *Id.*; RESTATEMENT (SECOND) OF CONFLICTS OF LAW § 193 (AM. LAW INST. 1971).

107. RESTATEMENT (SECOND) OF CONFLICTS OF LAW § 193.

108. Interestingly, the court in *Foster Wheeler* also entertained such an analysis. The court stated that “[Section 193] is the controlling factor in determining the law applicable to a liability insurance policy, thereby obviating the need to consider [the] Restatement factors [at Section Six].” *Foster Wheeler*, 822 N.Y.S.2d at 37. However, the court then said that even considering all of those factors, it would reach the same conclusion. *Id.*

*Davis & Partners, LLC v. QBE Insurance Corp.*<sup>109</sup> provides a good illustration of this point. In that case, the policyholder was a New Jersey company.<sup>110</sup> The underlying claim arose from an incident at a construction site in New York.<sup>111</sup> The outcome of the coverage case, which a New York state court decided, would differ if the court applied New York versus New Jersey law—the policyholder would lose under New York’s late notice law.<sup>112</sup> In conducting its choice-of-law analysis, the trial court rejected the argument that *Foster Wheeler* mandates that the law of the policyholder’s domicile state controls where the insured risks span multiple states:

[T]here is no per se rule that where the policy insures risks in more than one state, the place of the insured’s domicile must be applied [under *Foster Wheeler*]. Rather, the courts continue to apply the center of gravity test. Nor, contrary to [the additional insured’s] contention, are the courts limited, in applying the center of gravity test to consideration of the five factors enumerated in the Restatement of Law—the place of contracting, the place of negotiation, the place of performance, the location of the subject matter, and the contracting parties’ domiciles. Rather, the courts will also apply an interest analysis under which the respective governmental interests of the competing jurisdictions are considered. Under the center of gravity approach, while the Restatement factors are given “heavy weight,” “the spectrum of significant contacts—rather than a single possibly fortuitous event—may be considered. Critical to a sound analysis, however, is selecting the contacts that obtain significance in the particular contract dispute.”

The center of gravity approach thus seeks to identify the law of the state with the most significant relationship to the transaction and parties and to avoid inconsistent results where claims are brought under the insurance policy in different states. “[U]nderlying the rule that . . . the location of the insured risk carries little weight in a choice-of-law analysis where the risk is scattered throughout two or more states—is an understanding that, barring extraordinary circumstances, only one state’s law should govern an insurance agreement.”<sup>113</sup>

The trial court nonetheless then held New Jersey law, the policyholder’s domicile state, should apply and denied the insurer’s cross-motion for summary judgment that was predicated on application of New York law.<sup>114</sup>

On appeal, the court of appeals reversed the judgment in favor of the policyholder because the intermediate appellate court ultimately held New

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109. *Davis & Partners, LLC v. QBE Ins. Corp.*, No. 108041/10, 2013 WL 285577 (N.Y. Sup. Ct. Jan. 17, 2013), *rev’d on other grounds*, 979 N.Y.S.2d 311 (App. Div. 2014).

110. *Id.* at \*3.

111. *Id.* at \*1.

112. *Id.* at \*3 (citing *Argo Corp. v. Greater N.Y. Mut. Ins. Co.*, 827 N.E.2d 762, 763, 765 (N.Y. 2005)).

113. *Id.* at \*4 (final alteration in original) (citations omitted).

114. *Id.* at \*5, \*8.

York, not New Jersey, law should apply because of a New York choice-of-law provision in the policy and the fact that the incident giving rise to the claim occurred in New York—the appellate court rejected the application of the law of the policyholder’s domicile state.<sup>115</sup> The intermediate appellate court did not, however, take exception to the trial court’s point that *Foster Wheeler* does not mandate a conclusion that the law of the policyholder’s domicile state must apply whenever the insured risks span multiple states.<sup>116</sup> To the contrary, the trial court correctly stated that New York courts remain free to consider the general principles of the “center of gravity” approach as a whole in deciding choice-of-law issues under New York law.<sup>117</sup> Thus, the NFL can argue that, pursuant to the principles stated in Second Restatement Section 6, the law of another state besides New York, the NFL’s domicile state, should control because another state has a more significant relationship to the dispute than New York does.

Which, if any, state(s) has a more significant relationship to the dispute than New York? The NFL presumably preferred California, as evidenced by the fact it sued its insurers there, based upon: (1) the NFL’s marketing department has prior history in the state between 1970 and 2005, (2) approximately 12% of the former NFL players reside in California, (3) three NFL teams are located in California, (4) many NFL football games have been played in California, and (5) two of the insurers the NFL sued are located in California.<sup>118</sup> Unfortunately for the NFL, the California court in which the NFL sued already has found these California contacts insufficient to even allow the California court to proceed to hear the case when presented with a *forum non conveniens* motion to stay in favor of the insurers’ New York coverage cases.<sup>119</sup> Consequently, if the NFL could not even convince a California court to hear the case, then it seems unlikely that it will be able to convince a New York court that California has the greatest stake in the dispute such that California law should apply.

So, what state arguably has more contacts with the dispute than either New York or California? Pennsylvania.

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115. *Davis & Partners, LLC v. QBE Ins. Corp.*, 979 N.Y.S.2d 311, 313 (App. Div. 2014).

116. *See Davis & Partners, LLC*, 979 N.Y.S.2d 311.

117. *See id.* at 313; *see also* Brief of Appellant at 22, *Lapolla Indus., Inc. v. Aspen Specialty Ins. Co.*, 566 Fed. Appx. 95 (2d Cir. 2014) (No. 13-4436-CV), 2014 WL 345193, at \*23 (“Despite the *Foster Wheeler* opinion . . . New York courts still consider all the relevant factors rather than focusing exclusively on the insured’s domicile.”).

118. *See Nat’l Football League v. Fireman’s Fund Ins. Co.*, 157 Cal. Rptr. 3d 318, 321–22, 325, 326 (Ct. App. 2013).

119. *Id.* at 328–29, 348.

Pennsylvania courts consolidated more than 300 NFL players' lawsuits for litigation.<sup>120</sup> Pennsylvania courts certified the NFL players' class.<sup>121</sup> Pennsylvania courts handled the NFL players' class action, and then they vetted and approved the settlement.<sup>122</sup> Pennsylvania courts expended their time and resources on the NFL litigation.<sup>123</sup> Many of the NFL players covered by the settlement reside in Pennsylvania.<sup>124</sup> Four of the insurers sued by the NFL have their principle places of business in Pennsylvania and issued dozens of the insurance policies at issue.<sup>125</sup> Consequently, Pennsylvania has a strong interest in ensuring that insurance money will satisfy the NFL's approximately \$1 billion settlement obligation to former NFL players.<sup>126</sup>

In sum, the argument is that Pennsylvania, the state in which the underlying litigation proceeded and was resolved, has more connection to the dispute as a whole than New York does. New York is simply the NFL's and some insurers' and brokers' headquarters. Pennsylvania is the state that did the heavy lifting related to litigating and resolving the underlying dispute. Pennsylvania is the state in which the insurers' liabilities were established.

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120. See *In re Nat'l Football League Players' Concussion Injury Litig.*, 307 F.R.D. 351, 361 (E.D. Pa. 2015), *aff'd*, 821 F.3d 410 (3d Cir. 2016).

121. *Id.*

122. *Id.*

123. Numerous courts have held that the law of the state in which the underlying claims were litigated should control the outcome of the insurance coverage litigation because of that state's significant interests in the outcome of the insurance dispute. See, e.g., *Am. Guarantee & Liab. Ins. Co. v. U.S. Fid. & Guar. Co.*, 668 F.3d 991, 1000–1002 (8th Cir. 2012) (finding that the law of the state in which the underlying litigation took place was the correct choice of law because that state had the most significant relationship to the dispute); *Teti v. Huron Ins. Co.*, 914 F. Supp. 1132, 1135 (E.D. Pa. 1996) (stating that the location of the underlying litigation was an important factor in deciding to apply that state's law); *Soc'y of Mount Carmel v. Nat'l Ben Franklin Ins. Co.*, 643 N.E. 2d 1280, 1287 (Ill. App. Ct. 1994) (concluding that California law had the most significant relationship to the dispute in part because the underlying litigation was filed in California); *Kramer v. Ciba-Geigy Corp.*, 854 A.2d 948, 960 (N.J. Super. Ct. App. Div. 2004) (considering the fact that New Jersey was the state of the underlying litigation in concluding that New Jersey law applied to the dispute); *Portland Trailer & Equip., Inc. v. A-1 Freeman Moving & Storage, Inc.*, 49 P.3d 803, 810 (Or. Ct. App. 2002) (“Oklahoma has the more significant relationship, because it is the forum in which the underlying litigation occurred.”).

124. See Plaintiffs' Master Administrative Long-Form Complaint, *In re Nat'l Football League Players' Concussion Injury Litig.*, 307 F.R.D. 351 (E.D. Pa. 2015) (No. 2:12-md-02323-AB).

125. See *Nat'l Football League v. Fireman's Fund Ins. Co.*, 157 Cal. Rptr. 3d 318, 323–24 (Ct. App. 2013).

126. See *supra* notes 120–25 and accompanying text.



## B. “Trigger”

For a policyholder to obtain coverage under any particular insurance policy, the policyholder must prove that it “triggered” the policy—that an injury occurred during the policy period that requires the policy to respond.<sup>127</sup> In many situations the triggering event is an isolated and instantaneous occurrence, such as a car accident where the injury and the injury-causing event take place at the same time.<sup>128</sup> In delayed-manifestation brain disease cases, however, the timing of the occurrence that triggers coverage is not as clear because repeated blows to the head over the course of many years cause such diseases and the brain damage itself may not manifest for many more years. In such cases, an issue necessarily arises regarding which insurance policies in existence during the injury process are triggered and, assuming that the other conditions of the policies are satisfied, must provide coverage.

Courts across the country have adopted different approaches to determining when bodily injuries arising from a long-term latent disease process trigger coverage.<sup>129</sup> Courts commonly use the following four trigger approaches: (1) when the initial exposure to the harmful condition occurred (“initial

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127. See *supra* note 22 and accompanying text.

128. See, e.g., KALIS ET AL., *supra* note 19, at § 2.01 (“Although the trigger issue exists in connection with any liability insurance claim, in many instances, its resolution is so obvious that it is scarcely considered. For instance, where a driver’s car collides with another’s vehicle, and the driver is sued for damage to the vehicle, the triggering event under an occurrence policy is the damage to the vehicle, and its timing is readily ascertained.”); James M. Fischer, *Insurance Coverage for Mass Exposure Tort Claims: The Debate over the Appropriate Trigger Rule*, 45 DRAKE L. REV. 625, 626 (1997) (explaining in the example of a car accident, “[t]he usual approach is to treat the accident as having happened when injury was sustained . . .”).

129. See, e.g., Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 VA. L. REV. 85, 95–96 (2001) (discussing trigger in connection with the emergence of long-tail claims); Mark W. Dykes, *Occurrences, Accidents, and Expectations: A Primer of These (and Some Other) Insurance-Law Concepts*, 2003 UTAH L. REV. 831, 838–40 (discussing the policy language and claims used to trigger coverage); Fischer, *supra* note 128, at 641–50 (discussing the most common approaches to trigger used by courts); Goodman, *supra* note 22, at 245 (2004) (“In the broadest sense, courts group the available trigger theories into the following four categories: the exposure theory; the manifestation or first discovery theory; the triple trigger or continuous trigger theory; and the injury-in-fact theory.”); Jamie A. Grodsky, *Genomics and Toxic Torts: Dismantling the Risk–Injury Divide*, 59 STAN. L. REV. 1671, 1700–01 (2007) (distinguishing “exposure,” “injury-in-fact,” and “exposure in residence” triggers for progressive diseases); Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1563–69 (2010) (discussing asbestos cases and the application of continuous trigger).

exposure”);<sup>130</sup> (2) when the disease manifested (“manifestation”);<sup>131</sup> (3) when the injury actually occurs (“injury in fact”);<sup>132</sup> and (4) all of the three preceding methods (“triple trigger” or “continuous trigger”).<sup>133</sup>

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130. See, e.g., *Cont'l Ins. Cos. v. Ne. Phar. & Chem. Co., Inc.*, 811 F.2d 1180, 1189 (8th Cir. 1987) (“Environmental damage occurs at the moment that hazardous wastes are improperly released into the environment[,] and [the] liability policy in effect at the time this damage is caused provides coverage.” (footnote omitted)), *aff'd in part*, 842 F.2d 977 (8th Cir. 1988) (en banc); *Clemtex, Inc. v. Se. Fid. Ins. Co.*, 807 F.2d 1271, 1276 (5th Cir. 1987) (finding that tissue damage takes place upon initial inhalation of asbestos); *Hancock Labs., Inc. v. Admiral Ins. Co.*, 777 F.2d 520, 524 (9th Cir. 1985) (“[T]he California Supreme Court would adopt the exposure theory to determine when bodily injury occurs.”); *Commercial Union Ins. Co. v. Sepco Corp.*, 765 F.2d 1543, 1546 (11th Cir. 1985) (endorsing exposure theory where “it is impossible practically to determine the point at which the fibers actually imbed themselves in the victim’s lungs . . . .”); *B.F. Goodrich Co. v. Am. Motorists Ins. Co.*, No. C84-1224A, 1986 WL 191786, at \*35 (N.D. Ohio May 22, 1986) (“[T]he trigger of coverage is the exposure which causes personal injury regardless of the time of the injury.” (footnote omitted)); *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 451 F. Supp. 1230, 1239 (E.D. Mich. 1978) (“[E]ach insurer on the risk when a currently deceased plaintiff was allegedly exposed is obligated to acknowledge coverage and to provide a defense and possibly indemnification.”), *aff'd*, 633 F.2d 1212 (6th Cir. 1980), *clarified*, 657 F.2d 814 (6th Cir. 1981); *Cole v. Celotex Corp.*, 599 So. 2d 1058, 1075–77 (La. 1992) (applying exposure trigger).

131. See, e.g., *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 523 F. Supp. 110, 118 (D. Mass. 1981) (applying manifestation trigger), *modified*, 682 F.2d 12 (1st Cir. 1982).

132. See, e.g., *E.R. Squibb & Sons, Inc. v. Lloyd’s & Cos.*, 241 F.3d 154, 166, 168–69 (2d Cir. 2001) (per curiam) (“[C]overage for [products liability] is triggered at times of actual injury [and] injury-in-fact can . . . include . . . the inevitable pre-disposition to illness or disability . . . caused by [the exposure].” (citations omitted)); *Abex Corp. v. Md. Cas. Co.*, 790 F.2d 119, 121 (D.C. Cir. 1986) (“[T]he insurer’s obligation to indemnify . . . arises when the asbestos causes real bodily injury during the policy period.”); *New York v. Amro Realty Corp.*, 697 F. Supp. 99, 102 n.5 (N.D.N.Y. 1988) (finding that coverage for property damage is triggered when property is “injured in fact”), *aff'd in part, rev'd in part on other grounds*, 936 F.2d 1420 (2d Cir. 1991); *Aetna Cas. & Sur. Co. v. Abbott Labs., Inc.*, 636 F. Supp. 546, 550 (D. Conn. 1986) (footnote omitted) (finding that liability coverage is triggered by occurrence of an injury in fact during the policy period); *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690, 703 (Ct. App. 1996) (endorsing an injury-in-fact analysis); *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30, 34–35 (Del. 1994) (“A policy is activated by bodily injury or property damage that takes place ‘during the policy period.’”).

133. See, e.g., *ACandS, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 973 (3d Cir. 1985) (“We hold that exposure, exposure-in-residence, and manifestation all constitute ‘bodily injury’ within the meaning of the policies.”); *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1041 (D.C. Cir. 1981) (“[E]ach insurer on the risk between the initial exposure and the manifestation of disease is liable to [the insured] for indemnification and defense costs.”) *vacated* 631 F. Supp. 34 (D.D.C. 1985); *Harleysville Mut. Ins. Co. v. Sussex Cty.*, 831 F. Supp. 1111, 1124 (D. Del. 1993) (applying continuous trigger where “it is impossible to identify a precise point in time when property damage occurs from the

## 1. Trigger Under New York Law

New York courts have not completely settled the trigger issue, as the only Court of Appeals decision to address the issue did so only tangentially.<sup>134</sup> For the most part, however, the lower New York courts and the Second Circuit generally utilize the injury-in-fact approach when resolving trigger of coverage issues for long-tail bodily injury claims.<sup>135</sup>

Under the injury-in-fact approach, an actual injury or damage-producing event triggers coverage.<sup>136</sup> Under this theory, a real, but undiscovered injury

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leaching of pollutants”), *aff’d*, 46 F.3d 1116 (3d Cir. 1994); *Chem. Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co.*, 817 F. Supp. 1136, 1153 (D.N.J. 1993) (applying continuous trigger theory for environmental claims (citing *Hatco Corp. v. W.R. Grace & Co.*, 801 F. Supp. 1334, 1344–46 (D.N.J. 1992))), *aff’d in part & remanded*, 89 F.3d 976 (3d Cir. 1996); *Liberty Mut. Ins. Co. v. Triangle Indus., Inc.*, 765 F. Supp. 881, 885 (N.D. W. Va. 1991) (applying New Jersey law that policies are triggered during the “continuous period from exposure to the manifestation of damages” (quoting *Gottlieb v. Newark Ins. Co.*, 570 A.2d 443, 445 (N.J. Super. Ct. App. Div. 1990))), *aff’d*, 957 F.2d 1153 (4th Cir. 1992); *Time Oil Co. v. Cigna Prop. & Cas. Ins. Co.*, 743 F. Supp. 1400, 1417 (W.D. Wash. 1990) (noting that Washington has adopted a continuous trigger theory); *Montrose Chem. Corp. of Ca. v. Admiral Ins. Co.*, 913 P.2d 878, 906 (Cal. 1995) (en banc) (applying “continuous injury” trigger); *Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467, 470 (Ind. 1985) (adopting continuous trigger because policyholder “could have reasonably formed an expectation that it was purchasing insurance coverage for all future liability arising from the manufacturing and selling of [a drug with harmful side effects]”), *aff’d*, 794 F.2d 710 (D.C. Cir. 1986); *Owens-Ill., Inc. v. United Ins. Co.*, 650 A.2d 974, 995 (N.J. 1994) (applying continuous trigger to progressive injury or damage claims); *J.H. Fr. Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502, 507 (Pa. 1993) (concluding that the policies of each insurer that was on the risk during the development of an asbestosis-related disease are triggered).

134. *See Cont’l Cas. Co. v. Rapid-Am. Corp.*, 609 N.E.2d 506, 511 (N.Y. 1993).

135. *See, e.g., In re Prudential Lines, Inc.*, 158 F.3d 65, 83–84 (2d Cir. 1998) (citations omitted) (reciting unchallenged findings of the trial court that injury-in-fact during the policy period triggers coverage, and, in asbestos-related injury context, injury-in-fact in the form of tissue damage occurs simultaneously or soon after asbestos inhalation and thus multiple policies are likely triggered); *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1194 (2d Cir. 1995) (noting that under New York law, coverage is based upon the occurrence of an injury-in-fact during the policy period), *modified*, 85 F.3d 49 (2d Cir. 1996); *Md. Cas. Co. v. W.R. Grace & Co.*, 23 F.3d 617 (2d Cir. 1993) (affirming the rule that policy coverage is triggered at the time of the injury, rather than at the time the injury was discovered in a case where the injury was sustained but not discovered until nine years later); *Cont’l Cas. Co. v. Emp’rs Ins. Co. (Keasbey)*, 871 N.Y.S.2d 48, 65 (App. Div. 2008) (holding that injury-in-fact, not exposure, triggers coverage); *Cortland Pump & Equip. v. Firemen’s Ins. Co.*, 604 N.Y.S.2d 633, 635–36 (App. Div. 1993) (holding the CGL policy language requires application of the injury-in-fact standard and that the lower court erred in its application of a discovery standard); *Nat’l Union Fire Ins. Co. v. TransCanada Energy USA Inc.*, 28 N.Y.S.3d 800, 808 (Sup. Ct. 2016) (concluding coverage does not depend on a temporal relationship with the causative event, but rather, whether the specified injuries were sustained during the policy period (citing *Labate v. Liberty Mutual Fire Ins. Co.*, 799 N.Y.S.2d 71, 73 (App. Div. 2005))).

136. *See Am. Home Prod. Corp. v. Liberty Mut. Ins. Co.*, 565 F. Supp. 1485, 1497 (S.D.N.Y. 1983), *aff’d as modified*, 748 F.2d 760 (2d Cir. 1984).

can trigger coverage, if it can be proven in retrospect to have existed during the policy period, regardless of when the injury manifests.<sup>137</sup> After a doctor has diagnosed the injury or illness, it may be inferred, from the nature of the gestation period and from the stage of the illness, that the harm actually began sometime earlier, thereby triggering coverage during an earlier policy period.<sup>138</sup>

New York courts applying injury-in-fact trigger to long-tail bodily injury claims require the policyholder to prove that an actual injury occurred during the relevant policy periods in order to trigger coverage during those policy periods.<sup>139</sup> As one might suspect, plaintiffs can have difficulty proving an injury occurred in any particular policy year when there are multiple injury-causing events over a period of years, but no actual injury or disease manifests until years or decades later.<sup>140</sup>

Under an injury-in-fact trigger, the NFL will need to prove when the brain disease for each former NFL player actually occurred.<sup>141</sup> Until experts testify and the other evidence is admitted, it currently is unknown exactly what the NFL will prove. Based upon the existing literature, however, it appears that the NFL should have experts who will testify that the brain disease process for players who have been subjected to repeated blows to the head is an ongoing, continuing process that begins with the first blow and continues until the player dies.<sup>142</sup> If the evidence proves this, then the NFL potentially

137. *Id.*

138. *See id.*

139. *Id.*

140. Some New York courts have deviated from an injury-in-fact trigger in cases where the policy language differs from ISO's standard form insuring agreement, discussed in Part II.A. *See, e.g., In re Liquidation of Midland Ins. Co.*, 709 N.Y.S.2d 24, 32 (App. Div. 2000) [hereinafter *LAQ*] (finding the policy "language can only be reasonably interpreted to obligate the insurer to indemnify if the injured individual was actually exposed by inhalation, not when the disease manifests itself") *overruled by In re Liquidation of Midland Ins. Co.*, 947 N.E.2d 1174, 1182 (N.Y. 2011); *Am. Motorists Ins. Co. v. E.R. Squibb & Sons, Inc.*, 406 N.Y.S.2d 658, 659 (Sup. Ct. 1978) (finding the policy was triggered based upon when the drugs causing the bodily injury were taken rather than at the onset of bodily injury, even though the drug exposure occurred before the policy period). In *Keasbey*, the Appellate Division noted that its trigger analysis in *LAQ* was limited to the policy language at issue there. 871 N.Y.S.2d at 60. The appellate court criticized the lower court for relying on *LAQ*—where the injury-causing event, not the injury itself, triggered coverage—and ignoring the language in the policies at issue that provided the bodily injury triggered coverage. *See id.* The court in *Keasbey* ultimately adhered to the injury-in-fact trigger. *Id.* at 65.

141. *See supra* Part III.B.

142. *See supra* Part I.A.

could trigger many years of coverage for each injured player—from the time the player received his first blow to the head in the NFL—no later than the first game for most players—until the player’s brain disease later manifests. In such a circumstance, the medical science would dictate that the injury-in-fact trigger yields the same result as continuous trigger with respect to which policy years are triggered.

If the NFL proves the disease process occurs when the blows to the head occur, for example, then the number of policy years triggered under an injury-in-fact trigger would be significantly less than under continuous trigger. Ultimately, the determination of which policy years are triggered will be a question of fact for the factfinder to determine.<sup>143</sup>

## 2. Trigger Under Pennsylvania Law

Pennsylvania is a continuous trigger state for delayed-manifestation bodily injury claims.<sup>144</sup> In *J. H. France Refractories Co. v. Allstate Insurance Co.*, the Pennsylvania Supreme Court adopted continuous trigger for asbestos-related diseases. The court based its holding on the policy language discussed in Part II of this Article and the evidence regarding the etiology and pathogenesis of asbestos-related diseases, which indicated the disease process begins with first exposure to asbestos fibers and continues until the person dies.<sup>145</sup>

As discussed above, assuming the medical evidence regarding delayed-manifestation long-term brain diseases due to repeated blows to the head is admissible, the disease process bears enough resemblance to asbestos-related diseases that it can be expected that continuous trigger for such claims would be applied under Pennsylvania law. Consequently, for each injured NFL player, the policies on the risk from the time the player received his first blow to the head in the NFL until the player’s brain disease manifests would be triggered. If the medical evidence supports such a conclusion, then the

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143. See, e.g., *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1193 (2d Cir. 1995), *modified*, 85 F.3d 49 (2d Cir. 1996) (“The jury and bench trials had to determine, among other things, when . . . in light of the medical evidence presented, injury took place with respect to the asbestos-induced bodily injury . . .”).

144. See *J. H. Fr. Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502, 506 (Pa. 1993) (adopting continuous trigger for asbestos-related diseases based on the medical evidence regarding the disease process).

145. *Id.* at 506. However, in the property damage context, the Pennsylvania Supreme Court has declined to adopt a bright-line rule that would apply continuous trigger to all cases involving continuous, progressive property damage over successive policy periods. See *Pa. Nat’l Mut. Cas. Ins. Co. v. St. John*, 106 A.3d 1, 17–24 (Pa. 2014) (distinguishing *J.H. France* and instead adopting manifestation trigger for damage to a dairy herd and its milk production).

same policy years would be triggered under New York’s injury-in-fact trigger and Pennsylvania’s continuous trigger approach.

A different result more favorable to the NFL could occur under a continuous trigger approach, however, if it cannot precisely prove how or when the brain disease process occurs because some injury essentially is assumed to occur during each policy period under a continuous trigger approach.<sup>146</sup> Thus, if the NFL cannot prove that actual injury to the player’s brain occurred during each policy period because the medical evidence is insufficient to prove that actual injury to the player’s brain occurred during each policy period between the date of the player’s first blow to the head and the date when brain disease manifests, as is required under an injury in fact trigger, such proof would not be required under continuous trigger.

### C. “Allocation”

Courts’ approaches to allocation—the amount of the policyholder’s liability to be paid by each triggered policy—also vary by state.<sup>147</sup> Because long-tail claims often trigger numerous policy periods and policies, many courts, based upon the “all sums” language in CGL policies discussed above in Part II.A of this Article, which states the insurer agrees to pay “all sums” for which the policyholder is liable,<sup>148</sup> have held that the policyholder can

146. *State v. Cont’l Ins. Co.*, 281 P.3d 1000, 1005 (Cal. 2012) (noting that for long-tail claims, it is appropriate to use continuous trigger because “[i]t is often ‘virtually impossible’ for an insured to prove what specific damage occurred during each of the multiple consecutive policy periods in a progressive property damage case” (quoting William R. Hickman & Mary R. DeYoung, *Allocation of Environmental Cleanup Liability Between Successive Insurers*, 17 N. KY. L. REV. 291, 292 (1990))).

147. *See, e.g.*, Christopher R. Hermann et al., *The Unanswered Question of Environmental Insurance Allocation in Oregon Law*, 39 WILLAMETTE L. REV. 1131, 1136–37 (2003) (footnotes omitted) (discussing the allocation problem in the environmental insurance context); Thomas M. Jones & Jon D. Hurwitz, *An Introduction to Insurance Allocation Issues in Multiple-Trigger Cases*, 10 VILL. ENVTL. L.J. 25, 37–50 (1999) (footnotes omitted) (discussing the methods for allocating indemnification obligations and defense costs); Jeffrey W. Stempel, *Domtar Baby: Misplaced Notions of Equitable Apportionment Create a Thicket of Potential Unfairness for Insurance Policyholders*, 25 WM. MITCHELL L. REV. 769, 807–23 (1999). Notably, in “manifestation” trigger jurisdictions, the allocation issue is straightforward because only a single policy year is triggered by each claim. *See* Nicolas R. Andrea, *Exposure, Manifestation of Loss, Injury-in-Fact, Continuous Trigger: The Insurance Coverage Quagmire*, 21 PEPP. L. REV. 813, 836–87 (1994). Thus, the loss does not need to be allocated among multiple triggered policy years.

148. “All sums” allocation is also inaccurately referred to as “joint and several” liability or allocation. *See, e.g.*, *Am. Nat’l Fire Ins. Co. v. B & L Trucking & Constr. Co.*, 951 P.2d 250, 254 (Wash. 1998) (en banc) (“[W]hen an insured sustains damages of a

select which of the triggered policy years will cover the liability subject only to the limits of coverage provided by the policies selected.<sup>149</sup> The other dominant allocation methodology used in many jurisdictions is pro rata allocation, which divides the liability equally among the policy years triggered.<sup>150</sup>

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continuing nature, its insurers are jointly and severally liable.” (citing *Gruol Constr. Co. v. Ins. Co. of N. Am.*, 524 P.2d 427, 431 (Wash. 1974))). The reason it is inaccurate to call it joint and several liability or allocation is because each insurer’s liability is capped at the limits of coverage the insurer provided, unlike under joint and several liability whereby the insurer would be liable for the entire liability regardless of the policy limits. *See, e.g., Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 690, 710 (Ct. App. 1996) (“In the present case, the trial court correctly explained that the doctrine of joint and several liability has no application to the obligations of successive insurers of a single policyholder. Nevertheless, the insurance companies insist that the trial court’s decision on the scope of coverage imposes joint and several liability upon the insurers. It does not. The trial court’s decision ensures that the policyholder is indemnified by one insurer for the full extent of the loss up to the policy’s limits . . . .” (footnote omitted)).

149. *See, e.g., ACandS, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 974 (3d Cir. 1985) (“[T]here is no proration of losses under a policy once coverage is triggered.”); *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1050 (D.C. Cir. 1981) (Policyholders may “collect from any insurer whose coverage is triggered, the full amount of indemnity that it is due, subject only to the provisions in the policies that govern the allocation of liability when more than one policy covers an injury”); *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481, 491 (Del. 2001) (finding “all sums” language in policy is inconsistent with pro rata allocation); *J.H. Fr. Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502, 506–07 (Pa. 1993) (finding each insurer that issued a CGL policy to manufacturer of asbestos-containing products liable for the entire loss subject to policy limits); *Am. Nat’l Fire Ins. Co.*, 951 P.2d at 254 (finding that “all insurers on the risk during the time of ongoing damage have a joint and several obligation to provide full coverage for all damages,” regardless of the amount that occurred during their policy period (citing *Gruol Constr. Co., Inc.*, 524 P.2d at 431)).

150. *See, e.g., Soc’y of the Roman Catholic Church of the Diocese v. Interstate Fire & Cas. Co.*, 26 F.3d 1359, 1367–68 (5th Cir. 1994) (dividing liability for damages based on each insurer’s share of coverage); *Commercial Union Ins. Co. v. Sepco Corp.*, 765 F.2d 1543, 1544 (11th Cir. 1985) (requiring all insurers that provided coverage to an asbestos manufacturer during periods of exposure to participate in defense and settlement on a prorated basis); *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1225 (6th Cir. 1980) (holding each of manufacturer’s insurers which issued policies covering various time periods liable for its pro rata share); *N. States Power Co. v. Fid. & Cas. Co. of N.Y.*, 523 N.W.2d 657, 658 (Minn. 1994) (en banc) (“[A]llocation of liability between multiple insurers consecutively on risk for pollution damages should be proportionate to damages which occurred during each policy period.”). New Jersey applies a variation of pro rata allocation that divides the liability among the triggered insurance policies based upon the percentage amount of the limits of each policy issued in relation to all of the insurance triggered by the claim. *See Carter-Wallace, Inc. v. Admiral Ins. Co.*, 712 A.2d 1116, 1124 (N.J. 1998) (allocating coverage among multiple liability insurers in proportion to the degree of the risks transferred or retained during the years of exposure); *Owens-Ill., Inc. v. United Ins. Co.*, 650 A.2d 974, 995 (N.J. 1994) *superseded by statute*, N.J. STAT. ANN. § 17:30A-5 (West 2016), *as recognized in Farmer Mut. Fire Ins. Co. of Salem v. N. J. Property-Liability Ins. Guar. Ass’n*, 74 A.3d 860, 863 (N.J. 2013) (“[W]hen progressive indivisible injury or damage results from exposure to injurious conditions for which civil liability may be imposed,

## 1. Allocation Under New York Law

New York allocation law recently became unclear. Prior to 2016, New York courts generally used pro rata allocation.<sup>151</sup>

In 2002, the Court of Appeals of New York addressed the allocation issue in the environmental contamination case of *Consolidated Edison Co. of New York, Inc. v. Allstate Insurance Co.*<sup>152</sup> The court rejected the policyholder's preference for "all sums" allocation, determining instead that pro rata allocation was the appropriate method for apportioning liability among the insurers.<sup>153</sup> While noting that different ways exist to prorate liability among successive policies, the court employed the "time-on-the-risk" method, thus prorating liability based upon the amount of time that the policy was in effect in comparison to the overall duration of the damage.<sup>154</sup>

In 2013, the Court of Appeals of New York re-affirmed the use of pro rata allocation in *Roman Catholic Diocese of Brooklyn v. Nat'l. Union Fire Ins. Co. of Pittsburgh.*<sup>155</sup> The court noted that pro rata allocation is particularly appropriate where it is difficult to tie specific injuries to particular policy periods and the policies provide coverage for bodily injury only if the injury "occurs during the policy period."<sup>156</sup>

On May 3, 2016, however, the New York Court of Appeals decision in *In re Viking Pump* created uncertainty in New York's allocation law.<sup>157</sup> In *Viking Pump*, two manufacturing companies sued some of their insurers for coverage for asbestos-related liabilities.<sup>158</sup> The policies contained standard form insuring agreements covering "all sums" for which the policyholders are liable for an injury or loss that occurs "during the policy period," as

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courts may reasonably treat the progressive injury or damage as an occurrence within each of the years of a CGL policy.").

151. See, e.g., *Roman Catholic Diocese v. Nat'l Union Fire Ins. Co.*, 991 N.E.2d 666, 676–77 (N.Y. 2013); *Consol. Edison Co. of N.Y., Inc. v. Allstate Ins. Co.*, 774 N.E.2d 687, 695–96 (N.Y. 2002); *Serio v. Pub. Serv. Mut. Ins. Co.*, 759 N.Y.S.2d 110, 115–16 (App. Div. 2003) (applying pro rata "time on the risk" analysis to case involving lead paint exposure); *Nat'l Union Fire Ins. Co. v. Farmington Cas. Co.*, 765 N.Y.S.2d 763, 765 (Sup. Ct. 2003) (reaffirming *Serio's* adoption of the time on the risk allocation analysis) (citations omitted).

152. *Consol. Edison Co. of N.Y.*, 774 N.E.2d 687.

153. *Id.* at 694.

154. *Id.* at 695.

155. *Roman Catholic Diocese*, 991 N.E.2d at 668.

156. *Id.* at 676–77 (assuming that if the plaintiff suffered "bodily injury" in each policy year, it would be consistent to allocate liability across all implicated policies rather than holding a single insurer liable for harm suffered in years covered by other successive policies).

157. *In re Viking Pump, Inc.*, 52 N.E.3d 1144 (N.Y. 2016).

158. *Id.*



discussed in Part II of this Article.<sup>159</sup> The policies also included “non-cumulation clauses.” The majority of the policies contained a non-cumulation clause that the insurers worded as follows:

If the same occurrence gives rise to personal injury, property damage or advertising injury or damage which occurs partly before and partly within any annual period of this policy, the each occurrence limit and the applicable aggregate limit or limits of this policy shall be reduced by the amount of each payment made by [the insurer] with respect to such occurrence, either under a previous policy or policies of which this is a replacement, or under this policy with respect to previous annual periods thereof.<sup>160</sup>

The remaining policies contained a non-cumulation clause that provided:

It is agreed that if any loss covered hereunder is also covered in whole or in part under any other excess Policy issued to the [insured] prior to the inception date hereof[,] the limit of liability hereon . . . shall be reduced by any amounts due to the [insured] on account of such loss under such prior insurance. . . . [I]n the event that personal injury or property damage arising out of an occurrence covered hereunder is continuing at the time of termination of this Policy the [insurer] will continue to protect the [insured] for liability in respect of such personal injury or property damage without payment of additional premium.<sup>161</sup>

Based on these non-cumulation clauses, the court rejected pro rata allocation and adopted “all sums” allocation for policies that contain non-cumulation clauses,<sup>162</sup> which many CGL policies do.<sup>163</sup> Although the language of the non-cumulation clauses at issue was not identical, the court ruled as it did because the very presence of the clauses in the policies is inconsistent with pro rata allocation.<sup>164</sup> Non-cumulation clauses “presuppose[] that two policies may be called upon to indemnify the insured for the same loss or occurrence.”<sup>165</sup> Thus, the court explained that the presence of a non-cumulation clause conflicts with the basic assumption underlying pro rata allocation—that multiple policies cannot cover the same loss or occurrence.<sup>166</sup> Non-cumulation clauses, according to insurers themselves, aim to address situations where multiple policies cover the same loss.<sup>167</sup> In other words, if the court used pro rata allocation despite the presence of non-cumulation clauses, then

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159. *Id.* at 1147.

160. *Id.*

161. *Id.* at 1147–48 (second alteration in original).

162. *Id.* at 1153.

163. *See generally* Christopher C. French, *The “Non-Cumulation Clause”: An “Other Insurance Clause” by Another Name*, 60 U. KAN. L. REV. 375 (2012) (discussing non-cumulation clauses and courts’ interpretation of them).

164. *In re Viking Pump, Inc.*, 52 N.E.3d at 1153.

165. *Id.* at 1153–54.

166. *Id.*

167. *Id.* at 1154.

the non-cumulation clauses would become meaningless surplusage.<sup>168</sup> Because the law favors contractual interpretations that give meaning to all of the terms in a policy if it is reasonable to do so, the court concluded that pro rata allocation does not apply to such policies.<sup>169</sup>

The *Viking Pump* decision does not overrule *Con Edison*'s general use of pro rata allocation in New York.<sup>170</sup> It does, however, make clear that *Con Edison* does not create a “blanket rule” that any particular allocation approach should be automatically used in long-tail claim cases regardless of other provisions in the policies. Significantly, because prior to *Viking Pump*, most courts applying New York law simply assumed that *Con Edison* required pro rata allocation.<sup>171</sup>

Because neither party has disclosed whether any of the insurance policies in the NFL's insurance program have non-cumulation clauses, it is uncertain whether “all sums” or pro rata allocation would apply to the *NFL v. Insurance Industry* litigation if the trial court uses New York law. The application of pro rata allocation could significantly impair the NFL's ability to collect 100% reimbursement of its liabilities to former NFL players if its insurance program has significant deductibles or SIRs, or if some insurers in the program are insolvent. If courts use an “all sums” allocation, on the other hand, then the NFL likely could find enough policy years to cover its liabilities—except for the amounts subject to applicable deductibles/SIRs—because it appears the NFL's insurance program has hundreds of millions, if not billions, of dollars of coverage when the annual limits of coverage are aggregated.<sup>172</sup>

## 2. Allocation Under Pennsylvania Law

In 1993, the Pennsylvania Supreme Court adopted “all sums” allocation in *J. H. France Refractories Co. v. Allstate Ins. Co.*<sup>173</sup> *J.H. France* involved

168. *Id.*

169. *Id.* at 1153–54.

170. *See* *Consol. Edison Co. of N.Y., Inc. v. Allstate Ins. Co., Inc.*, 774 N.E.2d 687, 694–96 (N.Y. 2002) (citation omitted).

171. *See, e.g.*, *Olin Corp. v. Am. Home Assurance Co.*, 704 F.3d 89, 102 (2d Cir. 2012) (“We agree . . . that New York state court decisions and those prior decisions of this Court endorsing the pro rata approach foreclose us from interpreting [the policy's condition] as imposing joint and several liability.”).

172. *See, e.g.*, Affidavit of Anastasia Donias at Ex. 1, *Alterra Am. Ins. v. Nat'l Football League*, No. 652813/2012 (N.Y. Sup. Ct. Sept. 12, 2012), ECF No. 68 (showing that one of the NFL's policies provides \$25 million in coverage to the NFL excess of \$50 million in underlying coverage).

173. *See* *J.H. Fr. Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502, 507 (Pa. 1993).

insurance coverage for a manufacturer's liability for asbestos liabilities.<sup>174</sup> The policy language at issue was the standard form language discussed in Part II of the Article.<sup>175</sup> The intermediate appellate court had applied pro rata allocation when apportioning the liabilities among the triggered policies.<sup>176</sup> The Pennsylvania Supreme Court reversed, reasoning:

First, and most compelling, is the language of the policies themselves. Each insurer obligated itself to "pay on behalf of the Insured *all sums* which the Insured shall become legally obligated to pay as damages because of bodily injury to which this insurance applies." We have already ascertained that any stage of the development of a claimant's disease constitutes an injury "to which this insurance applies" under each policy in effect during any part of the development of the disease. Under any given policy, the insurer contracted to pay *all sums* which the insured becomes legally obligated to pay, not merely some pro rata portion thereof. . . . There is *nothing* in the policies that provides for a reduction of the insurer's liability if an injury occurs only in part during a policy period. As we interpret the policies, they cover [the manufacturer's] entire liability once they are triggered.<sup>177</sup>

Under "all sums" allocation, the insurers selected by the policyholder to cover the loss can then seek contribution from other insurers whose policies were triggered but not selected by the policyholder: "This conclusion does not alter the rules of contribution or the provisions of 'other insurance' clauses in the applicable policies. There is no bar against an insurer obtaining a share of indemnification or defense costs from other insurers under 'other insurance' clauses or under the equitable doctrine of contribution."<sup>178</sup>

As discussed above, in the *NFL v. Insurance Industry* litigation, application of the "all sums" allocation approach likely would give the NFL the greatest recovery from its insurers. Due to equitable contribution and "other insurance" clauses found in standard form CGL policies, however, the actual financial consequences for the insurers might be the same under either pro rata allocation or "all sums" allocation because the insurers' liabilities to the NFL could be re-apportioned among the insurers after the NFL has been paid in full.

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174. *Id.* at 504.

175. *Id.* at 505.

176. *Id.* at 506.

177. *Id.* at 507–08 (citation omitted).

178. *Id.* at 509; *see also* *Koppers Co. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440, 1454 (3d Cir. 1996) (noting that under "all sums" allocation, an "other insurance" clause does not prohibit the policyholder from selecting the policy to respond, but rather permits an insurer to seek contribution from other insurers (citing *J.H. Fr. Refractories Co.*, 626 A.2d at 507)); *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1050 (D.C. Cir. 1981) (holding the insured can collect from any triggered insurer and liability is apportioned among all).

## D. “Number of Occurrences”

The number of occurrences issue is the question of how many claims should be lumped together for purposes of the deductibles/SIRs and the policies’ limits of liability.<sup>179</sup> In simple cases such as a car accident, there is only one occurrence—the car accident that causes bodily injuries, property damage, or both—so the number of occurrences issue is not important. In long-tail claims such as the NFL players’ delayed manifestation brain disease claims, on the other hand, where the injured players were exposed to multiple injury-causing events over a long period of time, determining the number of occurrences could be a significant issue in determining the amount of the NFL’s insurance recovery. In situations where a policyholder faces multiple claimants/claims with large liabilities associated with each claim and the available insurance has high per occurrence limits with low deductibles/SIRs, the policyholder often prefers that each claim be treated as a separate occurrence to increase the amount of its recovery.<sup>180</sup> Conversely, if the applicable insurance has high deductibles/SIRs and the value of each claim separately is relatively small, then the policyholder may prefer to lump all of the claims together as a single occurrence to minimize the number of deductibles/SIRs it must satisfy.<sup>181</sup> And, of course, the insurers will take the opposite view depending upon which approach is more favorable to them. Consequently, policyholders and insurers often disagree about the method to determine the number of occurrences.

Courts typically apply one of two competing approaches in determining the number of occurrences: the “cause” test or the “effects” test.<sup>182</sup> The cause

179. See, e.g., KALIS ET AL., *supra* note 19, § 3.03[B].

180. See, e.g., Pittsburgh Corning Corp. v. Travelers Indem. Co., No. 84-3985, 1988 WL 5302, at \*2 (E.D. Pa. Jan. 21, 1988) (explaining that the policyholder was sued by thousands of asbestos claimants and would be limited to only \$10,000,000 in recovery if all of the claims were treated as a single occurrence but would recover \$60,000,000 if they were treated as separate occurrences).

181. See, e.g., Owens-Ill., Inc. v. Aetna Cas. & Sur. Co., 597 F. Supp. 1515, 1517 (D.D.C. 1984) (stating that the policyholder argued for a single occurrence for thousands of asbestos claims where the policies had self-insurance features between \$100,000 and \$200,000 per occurrence); Air Prods. & Chems., Inc. v. Hartford Accident & Indem. Co., 707 F. Supp. 762, 772 (E.D. Pa. 1989) (the policyholder argued for a single occurrence for hundreds of asbestos claims where the policies had per occurrence self-insurance features between \$50,000 and \$200,000), *order aff’d in part, vacated in part*, 25 F.3d 177 (3d Cir. 1994).

182. See, e.g., KENNETH ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION 493 (6th ed. 2015) (“Some version of the *cause test* is dominant, however, although New York and some other states refer to their cause tests as the ‘unfortunate event’ or ‘triggering

test essentially considers how many “causes” of the damage or injuries there are.<sup>183</sup> Under the cause test, a single cause can give rise to hundreds or thousands of injuries and claims.<sup>184</sup> The effects test looks at how many effects or injuries resulted.<sup>185</sup> Thus, a court could treat an accident that gives rise to multiple injuries and claims as multiple occurrences under the effects test, but a single occurrence under the cause test.<sup>186</sup>

Both tests are subject to manipulation, and commentators have noted that some courts have a tendency to apply the tests in such a way as to maximize the policyholder’s recovery.<sup>187</sup> Of course, courts’ sympathetic tendencies to policyholders in other factual contexts may not apply to a wealthy entity such as the NFL<sup>188</sup> if the evidence proves the NFL concealed or downplayed the risk of long-term brain injuries from NFL players.<sup>189</sup>

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event’ test. . . . The *effects test*, adopted by a few courts, vastly expands coverage in most, but not all, multiple injury cases.”); JERRY & RICHMOND, *supra* note 19, at 518–19 (“The majority rule follows the ‘cause analysis’: the number of occurrences depends on the number of causes. If there is one cause (such as one loss of control of a vehicle or one release of drugs into the market), there is one occurrence. . . . The minority rule, found mostly in older cases, follows ‘effect analysis’: the situation is viewed from the perspective of the injured party, so that multiple results constitute multiple occurrences.”); KALIS ET AL., *supra* note 19, § 3.03[B] (“Two principal competing tests [to determine the number of occurrences] have emerged: the ‘cause’ test and the ‘effect’ test.”).

183. See, e.g., KALIS ET AL., *supra* note 19, § 3.03[B][1]; JERRY & RICHMOND, *supra* note 19, at 518.

184. See, e.g., KALIS ET AL., *supra* note 19, § 3.03[B][1][a].

185. See, e.g., KALIS ET AL., *supra* note 19, § 3.03[B][2]; JERRY & RICHMOND, *supra* note 19, at 519.

186. See, e.g., KALIS ET AL., *supra* note 19, § 3.03[B][1]–[2]; JERRY & RICHMOND, *supra* note 19, at 518–19.

187. See, e.g., KALIS ET AL., *supra* note 19, § 3.03[B][3] (“[S]ome courts have even acknowledged explicitly that the amount a policyholder will recover is a factor to be considered in the number of occurrences determination.” (citing *Owens-Ill., Inc. v. Aetna Cas. & Sur. Co.*, 597 F. Supp. 1515, 1527 (D.D.C. 1984))); *Owens-Ill.*, 597 F. Supp. at 1527 (“If [the policyholder] were obligated to pay a deductible on each claimant’s lawsuit, [the policyholder] would be deprived of the security for which it paid. Such an interpretation would effectively emasculate the coverage purchased by [the policyholder] since no individual claim exceeds the amount of the deductible. On the other hand, the single occurrence interpretation maintains [the policyholder]’s reasonable expectations.”).

188. See, e.g., Harris, *supra* note 44 at 159 (“Some may say, with annual revenues exceeding \$10 billion, the NFL can afford it either way.”).

189. See *In re Nat’l Football League Players’ Concussion Injury Litig.*, 307 F.R.D. 351, 362 (E.D. Pa. 2015) (citations omitted) (“Through the MTBI Committee, the NFL Parties allegedly obfuscated the connection between NFL Football and long-term brain injury, despite knowing ‘for decades’ that such a connection exists. The MTBI Committee also allegedly pressured those who criticized its conclusions to retract or otherwise distance themselves from their findings. MDL Plaintiffs claim that, ‘[b]efore June of 2010, the NFL made material misrepresentations to its players, former players, the United States Congress, and the public at large that there was no scientifically proven link between repetitive traumatic head impacts and later-in-life cognitive/brain injury.’” (quoting Complaint at ¶¶ 108, 243,

### *I. Number of Occurrences Under New York Law*

New York courts use a version of the “cause” test known as the “unfortunate events” test to determine the number of occurrences. It was first articulated in *Arthur A. Johnson Corp. v. Indemnity Insurance Co. of North America*,<sup>190</sup> and later was held applicable to the term “occurrence” in *Hartford Accident & Indemnity Co. v. Wesolowski*.<sup>191</sup> Under this test, an occurrence is “an event of an unfortunate character that takes place without one’s foresight or expectation,” rather than the preceding cause of such an event.<sup>192</sup> Thus, the number of occurrences is determined by the number of unfortunate events that result in claims.

In practice, the application of the test can yield results similar to the “effects” test. For example, in explaining how the “unfortunate events” test works, the New York Court of Appeals stated:

[S]everal factors emerge as relevant to distinguishing injuries or losses that arise from a single occurrence as opposed to those that constitute multiple occurrences: whether there is a close temporal and spatial relationship between the incidents giving rise to injury or loss, and whether the incidents can be viewed as part of the same causal continuum, without intervening agents or factors.<sup>193</sup>

The court then applied the test in the context of long-tail asbestos-related bodily injury claims arising out of alleged exposure to asbestos from the policyholder’s turbines and concluded that “there were unquestionably multiple occurrences.”<sup>194</sup>

In the context of the *NFL v. Insurance Industry* litigation, it is not difficult to imagine each player’s claim being treated as an “unfortunate event” that

308, *In re Nat’l Football League Players’ Concussion Injury Litig.*, 307 F.R.D. 351 (E.D. Pa. 2012) (No. 2:12-md-023230-AB)).

190. See *Arthur A. Johnson Corp. v. Indem. Ins. Co. of N. Am.*, 164 N.E.2d 704, 708 (N.Y. 1959).

191. See *Hartford Accident & Indem. Co. v. Wesolowski*, 305 N.E.2d 907, 910 (N.Y. 1973).

192. See *Arthur A. Johnson Corp.*, 164 N.E.2d at 707–08 (citing *Croshier v. Levitt*, 157 N.E.2d 486, 491 (N.Y. 1959)) (holding the collapse of two retaining walls about an hour apart during a heavy rainfall constituted two “accidents” for the purpose of insurance coverage).

193. *Appalachian Ins. Co. v. General Elec. Co.*, 863 N.E.2d 994, 999 (N.Y. 2007).

194. *Id.* at 1001. In recent years, the New York Court of Appeals has reaffirmed the continued use of the unfortunate events test to determine the number of occurrences under New York law. See *Roman Catholic Diocese v. Nat’l Union Fire Ins. Co.*, 991 N.E.2d 666, 671–73 (N.Y. 2013) (applying the unfortunate events test to conclude that the incidents of sexual abuse in the underlying action constituted multiple occurrences).

gives rise to an occurrence. Nor is it hard to imagine the court treating each concussion or blow to the head a player suffered throughout his career as an “unfortunate event.” Whether such a result would favor the NFL or the insurers depends upon the policies’ deductibles/SIRs and limits of coverage. For example, if the amount the NFL pays is a high amount—\$5 million for each ALS claim—the policies have high or no aggregate limits, and the per occurrence deductible is small—\$25,000—then such a result might favor the NFL. If, on the other hand, most of the claim amounts paid are small and the policies have high deductibles or low aggregate limits, then the result would favor the insurers.

## 2. Number of Occurrences Under Pennsylvania Law

In 2007, the Pennsylvania Supreme Court adopted the “cause” test in *Donegal Mutual Insurance Co. v. Baumhammers*,<sup>195</sup> in which the court found only a single occurrence—the parents’ failure to take away a firearm from their mentally ill son or to warn the police—in a situation where their son shot and killed five people over the course of several hours in multiple locations. In 2013, the Pennsylvania Supreme Court reiterated its support of the cause test in *Kinney-Lindstrom v. Medical Care Availability & Reduction of Error Fund*.<sup>196</sup>

Under the “cause” test, it is not difficult to imagine that either the NFL or the insurers, depending upon which side the argument favors, could successfully argue that a single occurrence caused the players’ delayed-manifestation brain diseases. For example, the single occurrence could be the NFL’s alleged failure to adopt better rules to protect players, or the NFL’s alleged failure to share its knowledge regarding the connection between repeated blows to the head and long-term brain diseases, or the NFL’s alleged failure to warn the players of the risk of long-term brain diseases due to repeated blows to the head. The factfinder could view any one of these “causes,” or another one, as the occurrence that gave rise to the thousands of NFL player brain diseases and subsequent claims.

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195. *Donegal Mut. Ins. Co. v. Baumhammers*, 938 A.2d 286, 294, 296 (Pa. 2007) (“We agree with the Superior Court’s adoption of the ‘cause’ approach for determining what constitutes an ‘occurrence’ pursuant to an insurance policy.”).

196. *Kinney-Lindstrom v. Med. Care Availability & Reduction of Error Fund*, 73 A.3d 543, 556 (Pa. 2013) (“[T]here is no reason for ‘occurrence’ to be construed in the MCARE Act in a manner markedly different from the way the term was interpreted in *Donegal* . . . Accordingly, we hold that the number of occurrences under Section 715 is determined by examining whether there is one or multiple instances of professional negligence that caused the harm alleged; the number of victims of the medical malpractice is not controlling when considering the MCARE Fund’s liability limit.” (footnote omitted)).

## E. “Expected or Intended” Exclusion

The “expected or intended” exclusion can trace its roots to the “fortuity” doctrine in the property insurance context. Although the term “fortuity” does not appear in insurance policies, some courts historically have incorporated this term into property insurance policies as an implied exclusion—non-fortuitous property losses implicitly are not covered.<sup>197</sup> The Restatement (First) of Contracts defines “fortuity” as follows:

A fortuitous event . . . is an event which so far as the parties to the contract are aware, is dependent on chance. It may be beyond the power of any human being to bring the event to pass; it may be within the control of third persons; it may even be a past event, such as the loss of a vessel, provided that the fact is unknown to the parties.<sup>198</sup>

The fortuity doctrine made its way into CGL insurance policies when insurers added the “neither expected nor intended language” into the definition of an “occurrence”<sup>199</sup> and, since 1986, as the “expected or intended” exclusion.<sup>200</sup> The fortuity doctrine also has some support as a matter of public policy—society wants to deter conduct that causes injuries—so there is an argument that insurance should not be permitted to cover injuries the policyholder intentionally causes.<sup>201</sup>

197. See generally Stephen A. Cozen & Richard C. Bennett, *Fortuity: The Unnamed Exclusion*, 20 FORUM 222 (1984) (describing the history and use of the fortuity doctrine).

198. RESTATEMENT (FIRST) OF CONTRACTS § 291 cmt. A (AM. LAW. INST. 1932); see also *Compagnie des Bauxites de Guinee v. Ins. Co. of N. Am.*, 724 F.2d 369, 372 (3d Cir. 1983) (citation omitted); *Mattis v. State Farm Fire & Cas. Co.*, 454 N.E.2d 1156, 1164 (Ill. App. Ct. 1983).

199. See *Bay Cities Paving & Grading v. Lawyers’ Mutual Ins. Co.*, 855 P.2d 1263, 1269 (Cal. 1993) (quoting *Mich. Chem. Corp. v. Am. Home Assurance Co.*, 728 F.2d 374, 378 (6th Cir. 1984)); *supra* Part II.D.

200. Some version of the “expected or intended” exclusion has been included in all of ISO’s occurrence-based and claims-made CGL Coverage Forms since 1986. See MALECKI, *supra* note 31, app. B–C, E–G, I–J; see also Kristin Wilcox, Note, *Intentional Injury Exclusion Clauses – What is Insurance Intent?*, 32 WAYNE L. REV. 1523, 1523 (1986) (noting that many “homeowner’s insurance policies exclude coverage for injuries caused intentionally by the insured”). In an example of the complexity and sometimes inconsistency of liability insurance, CGL policies also expressly cover numerous intentional torts under the Advertising and Personal Injury coverage provisions of the policies. See, e.g., MALECKI, *supra* note 31, app. J §§ I.1.a, V.14, at 471, 479; Christopher C. French, *The Insurability of Claims for Restitution*, 18 U. PA. J. BUS. L. 599, 641–42 (2016) (discussing coverage under CGL policies for intentional torts such as defamation and invasion of privacy, and the public policy arguments in favor of and against allowing such coverage).

201. See, e.g., H. Karen Cuttler, Comment, *Liability Insurance for Intentional Torts—Subrogation of the Insurer to the Victim’s Rights Against the Insured*: Ambassador Insurance



When attempting to understand and apply the exclusion, however, a few questions arise. For example, what exactly must the policyholder expect or intend in order for the exclusion to apply—the actions that gave rise to the injury or the resulting injury itself? And, should the policyholder’s expectations and intentions be analyzed from a subjective or an objective point of view?

With respect to the first question, the majority of courts hold that in order for the exclusion to apply the resulting injury or damage must be expected or intended—not the act giving rise to the injury or damage.<sup>202</sup> On the other end of the spectrum, a minority of jurisdictions follow the rule that

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Co. v. Montes, 32 RUTGERS L. REV. 155, 157 (1979) (stating that courts have refused to allow insurance to indemnify losses caused by intentional acts because such indemnity is against public policy); Peter Nash Swisher & Richard C. Mason, *Liability Insurance Coverage for Clergy Sexual Abuse Claims*, 17 CONN. INS. L.J. 355, 368 (2011) (“The underlying public policy rationale of this ‘intentional act exclusion’ in liability insurance is that it would defeat the purpose of insurance and encourage ‘moral hazard’ if a policyholder could be compensated for losses he intentionally brings about, knowing that the insurer would be liable for any resulting damages or personal injury.” (citing *W. Nat’l Assurance Co. v. Heckler*, 719 P.2d 954, 959–60 (Wash. Ct. App. 1986))).

202. See, e.g., *Hanover Ins. Co. v. Talhouni*, 604 N.E.2d 689, 691 (Mass. 1992) (“The focus in these cases is whether the insured ‘intended’ the injury, not whether the insured ‘intended’ the act.” (citing *Newton v. Krasnigor*, 536 N.E.2d 1078, 1081 (Mass. 1989))); *White v. Smith*, 440 S.W.2d 497, 508 (Mo. Ct. App. 1969) (explaining that, although some damages are foreseeable, “damages not intentionally inflicted but resulting from an insured’s negligence . . . may be caused by accident and within the coverage afforded by a liability insurance policy” (internal quotation marks omitted)); *Cont’l Cas. Co. v. Rapid-Am. Corp.*, 609 N.E.2d 506, 510 (N.Y. 1993) (“Resulting damage can be unintended even though the act leading to the damage was intentional. A person may engage in behavior that involves a calculated risk without expecting that an accident will occur.” (first citing *McGroarty v. Great Am. Ins. Co.*, 36 N.Y.S.2d 358, 364 (Ct. App. 1975); and then citing *Allstate Ins. Co. v. Zuk*, 78 N.Y.S.2d 41, 46 (Sup. Ct. 1948))); *Grand River Lime Co. v. Ohio Cas. Ins. Co.*, 289 N.E.2d 360, 365 (Ohio Ct. App. 1972) (recognizing that the term occurrence is broader than the term “accident” and may encompass a fully intended action that resulted in unintended damage); *Vt. Mut. Ins. Co. v. Singleton*, 446 S.E.2d 417, 420–21 (S.C. 1994) (explaining that an intentional injury exclusion did not bar coverage where the insured had not intended the injury resulting from his voluntary act); Richard L. Fruehauf, Note, *The Cost of Knowledge: Making Sense of “Nonfortuity” Defenses in Environmental Liability Insurance Coverage Disputes*, 84 VA. L. REV. 107, 131 (1998) (“Courts have had to decide whether the phrase ‘neither expected nor intended from the standpoint of the insured’ requires an objective or subjective ‘expectation’ on the part of the insured for coverage to be precluded. The majority of courts to consider the language have held that it imposes a subjective test for the insured’s expectation . . . .” (first citing *City of Carter Lake v. Aetna Cas. & Sur. Co.*, 604 F.2d 1052, 1058–59 (8th Cir. 1979); then *Honeycomb Sys., Inc. v. Admiral Ins. Co.*, 567 F. Supp. 1400, 1404 (D. Me. 1983); and then *Am. Family Mut. Ins. Co. v. Pacchetti*, 808 S.W.2d 369, 371 (Mo. 1991))); Swisher & Mason, *supra* note 201, at 376 (“Whether an accidental event occurred for the purpose of liability insurance coverage usually is considered from the viewpoint of the tortfeasor-insured.” (first citing *Capitol Indem. Corp. v. Blazer*, 51 F. Supp. 2d 1080, 1085 (D. Nev. 1999); and then citing *Agoado Realty Corp. v. United Int’l Ins. Co.*, 733 N.E.2d 213, 216 (N.Y. 2000))).

if any injury or damage is expected or intended, then the policyholder loses coverage even if the injury or damage that resulted is different than what the policyholder expected or intended.<sup>203</sup> The middle ground, followed by some jurisdictions, is that coverage is not lost if the policyholder expected an injury or damage that was different than, or significantly less severe than, what actually occurred.<sup>204</sup>

With respect to the second question, the majority rule is that the insurer must prove that the policyholder subjectively expected or intended to cause the resulting injury, as opposed to the policyholder objectively should have expected or intended to cause the injury at issue.<sup>205</sup> In the minority of

203. See *Lopez ex rel. Lopez v. Am. Family Mut. Ins. Co.*, 148 P.3d 438, 439 (Colo. App. 2006) (explaining that the intentional act exclusion applies “whenever *some* injury is intended, even though the injury that actually results differs in character or degree from the injury actually intended” (emphasis added) (quoting *Am. Family Mut. Ins. Co. v. Johnson*, 816 P.2d 952, 955 (Colo. 1991)); *Butler v. Behaeghe*, 548 P.2d 934, 939 (Colo. App. 1976) (holding in an assault case that where the insured “intentionally struck the plaintiff, he must be deemed to have intended the ordinary consequences of his voluntary actions”); *Ga. Farm Bureau Mut. Ins. Co. v. Purvis*, 444 S.E.2d 109, 110 (Ga. Ct. App. 1994) (concluding that an intentional act exclusion is applicable where “the insured acts with the intent or expectation that . . . injury occur, *even if the actual, resulting injury is different either in kind or magnitude from that intended or expected*” (quoting *Stein v. Mass. Bay Ins. Co.*, 324 S.E.2d 510, 511–12 (Ga. Ct. App. 1985))); *State Farm Fire & Cas. Co. v. Johnson*, 466 N.W.2d 287, 289 (Mich. Ct. App. 1990) (“Once intended harm is established, the fact of an unintended injury is irrelevant.”); *Farmers Mut. Ins. Co. v. Kment*, 658 N.W.2d 662, 668 (Neb. 2003) (“In order for the intentional or expected injury exclusion in a liability insurance policy to apply, the insurer must show that the insured acted with the specific intent to cause harm to a third party, but does not have to show that the insured intended the specific injury that occurred.”).

204. See, e.g., *Yount v. Maisano*, 627 So. 2d 148, 152 (La. 1993) (“[W]hen minor injury is intended, and a substantially greater or more severe injury results, whether by choice, coincidence, accident, or whatever, coverage for the more severe injury is not barred.” (quoting *Breland v. Schilling*, 550 So. 2d 609, 614 (La. 1989))); *United Servs. Auto. Ass’n v. Elitzky*, 517 A.2d 982, 988 (Pa. Super. Ct. 1986) (“Our interpretation affords maximum coverage to insured persons as coverage is precluded only for harm of the same general type as that which they set out to inflict.”).

205. Compare *U.S. Fid. & Guar. Co. v. Armstrong*, 479 So. 2d 1164, 1167 (Ala. 1985) (“[T]he legal standard to determine whether the injury was either expected or intended . . . is a purely subjective standard.”), and *Fire Ins. Exch. v. Berray*, 694 P.2d 191, 194 (Ariz. 1984) (explaining that the court looks “from the standpoint of the insured” to determine whether the insured “expected or intended” to cause injury), and *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 15 Cal. Rptr. 2d 815, 861 (Ct. App. 1993) (rejecting the objective “should have known” meaning of “expect” and instead adopting the word’s “plain meaning”), and *State Farm Mut. Auto. Ins. Co. v. McMillan*, 925 P.2d 785, 794 (Colo. 1996) (rejecting the insurer’s “objective viewpoint” argument and addressing the issue from the viewpoint of the insured), and *Great Am. Ins. Co. v. Gaspard*, 608 So. 2d 981, 985 (La. 1992) (“[T]he subjective intent

jurisdictions that apply an objective standard, there are a few variations of the test. In one version, the policyholder loses coverage if a “reasonable” person would have expected the injury at issue.<sup>206</sup> Under another version, the policyholder forfeits coverage if the policyholder knew or should have known that there was a “substantial probability” its actions would result in the injury at issue,<sup>207</sup> with “substantial probability” defined as whether “a reasonably prudent man” would know that adverse “results are highly likely to occur.”<sup>208</sup>

### 1. *Expected or Intended Exclusion Under New York Law*

The New York Court of Appeals has not directly addressed the issue of whether to use an objective test or subjective test to determine whether the “expected or intended” exclusion applies. Case law support for both

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of the insured is the key and not what the average or ordinary reasonable person would expect or intend.”), and *Patrons-Oxford Mut. Ins. Co. v. Dodge*, 426 A.2d 888, 892 (Me. 1981) (adopting a subjective standard and recognizing it as the majority standard), and *Quincy Mut. Fire Ins. Co. v. Abernathy*, 469 N.E.2d 797, 800 (Mass. 1984) (“Our cases have concluded that an injury is non-accidental only where the result was actually, not constructively, intended . . .”), and *Espinete v. Horvath*, 597 A.2d 307, 309 (Vt. 1991) (upholding a subjective standard and rejecting the use of an objective standard with respect to “inherently dangerous activity” where such activity was not explicitly excluded by the insurance policy), and *Queen City Farms, Inc. v. Cent. Nat’l Ins. Co. of Omaha*, 882 P.2d 703, 714 (Wash. 1994) (holding that a subjective standard applies), and *Farmers & Mechs. Mut. Ins. Co. v. Cook*, 557 S.E.2d 801, 807 (W. Va. 2001) (“[C]ourts must use a subjective rather than objective standard for determining the policyholder’s intent.”), with *City of Carter Lake*, 604 F.2d at 1058–59 (using an objective standard of “knew or should have known” in determining if a result was “expected”), and *In re Tex. E. Transmission Corp.*, 870 F. Supp. 1293, 1321 (E.D. Pa. 1992) (“Texas law determines an insured’s intention ‘objectively’ and not ‘subjectively.’”). See also BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 8.03[c] (14th ed. 2008).

206. See, e.g., *Auto-Owners Ins. Co. v. Jensen*, 667 F.2d 714, 717 n.2 (8th Cir. 1981) (“[I]n determining whether the damages were expected under the terms of the policy the appropriate standard to be applied is an objective one, i.e., whether a reasonable man in the position of the insured would have expected the damage to occur.”); *City of Carter Lake*, 604 F.2d at 1059 (asking, for purposes of determining coverage, “[i]f the insured knew or should have known that there was a substantial probability that certain results would follow his acts or omissions”); *In re Tex. E. Transmission Corp.*, 870 F. Supp. at 1321 (applying Texas law and explaining that the objective standard focuses on “what the insured knew or should have known”); see also OSTRAGER & NEWMAN, *supra* note 205, § 8.03[c].

207. See OSTRAGER & NEWMAN, *supra* note 205, § 8.03[c].

208. *City of Carter Lake*, 604 F.2d at 1059 n.4; see also *King v. Hartford Life & Accident Ins. Co.*, 414 F.3d 994, 1002 (8th Cir. 2005) (distinguishing between standards of “reasonably foreseeable” and “substantial probability” and expressing, “the latter requires not only that a reasonably prudent person would be alerted to the possibility of results occurring, but that such a reasonable person would be forewarned that the results are ‘highly likely to occur’” (quoting *City of Carter Lake*, 604 F.2d at 1059 n.4)).

an “objective” test<sup>209</sup> and the “subjective” test can be found under New York law.<sup>210</sup>

With respect to which party has the burden of proof regarding the NFL’s expectations or intentions, it may depend upon whether the court analyzes the pre-1986 or post-1986 policies. As discussed in Part II.D of this Article, the expected or intended language moved from the insuring agreement to the exclusions section of CGL policies in 1986. In most states, that is unimportant because the courts treat the language as an exclusion regardless of its location.<sup>211</sup> Under New York law, however, some cases place the

209. See, e.g., *Hereford Ins. Co. v. Segal*, 835 N.Y.S.2d 741, 742 (App. Div. 2007) (“[T]here is no insurance coverage under the terms of the policy if [the policyholder] reasonably expected that his own conduct would cause the resulting injury, or if the injuries that [the third-party victim] sustained were ‘expected or intended’ or could not fairly be characterized as unexpected, unusual or unforeseen.” (citations omitted)); *Utica Fire Ins. Co. v. Shelton*, 641 N.Y.S.2d 864, 866 (App. Div. 1996) (“Applying these principals to the particular facts of the instant case, it is clear that Naviloff’s eye injuries were to be reasonably expected by Shelton when he punched him in the eye.”); *Borg-Warner Corp. v. Ins. Co. of N. Am.*, 577 N.Y.S.2d 953, 959 (App. Div. 1992) (applying an objective standard to an “occurrence” definition and stating that “damages are *expected* if the insured knew or should have known that they were substantially probable”); *Moreau v. Orkin Exterminating Co.*, 568 N.Y.S.2d 466, 468 (App. Div. 1991) (citing *Broome* favorably); *County of Broome v. Aetna Cas. & Sur. Co.*, 540 N.Y.S.2d 620, 622 (App. Div. 1989) (“[P]roperty damages are expected if the actor knew or should have known there was a substantial probability that a certain result would take place.” (citing *Auto-Owners Ins. Co.*, 667 F.2d at 719–20)).

210. See, e.g., *Agoado Realty Corp. v. United Int’l Ins. Co.*, 95 N.Y.2d 141, 145 (N.Y. 2000) (“[I]n deciding whether a loss is the result of an accident, it must be determined, *from the point of view of the insured*, whether the loss was unexpected, unusual and unforeseen.”); *Cont’l Cas. Co. v. Rapid-Am. Corp.*, 609 N.E.2d 506, 510 (N.Y. 1993) (“For an occurrence to be covered under the [insurer’s] policies, the injury must be unexpected and unintentional. We have read such policy terms narrowly, barring recovery only when the insured intended the damages.” (citing *McGroarty v. Great Am. Ins. Co.*, 329 N.E.2d 172 (N.Y. 1975))); *Union Carbide Corp. v. Affiliated FM Ins. Co.*, 955 N.Y.S.2d 572, 575 (App. Div. 2012) (“Plaintiff’s ‘calculated risk’ in manufacturing its products despite its awareness of possible injuries and claims does not amount to an expectation of damage.”); *Siagha v. National Fire Ins. Co. of Pittsburgh*, 762 N.Y.S.2d 46, 47–48 (App. Div. 2003) (citing *Agoado*, 95 N.Y.2d at 145, that whether a loss was an accident must be determined from the point of view of the insured); *Liberty Mut. Ins. Co. v. Ho*, 735 N.Y.S.2d 286, (App. Div. 2001) (citing *Agoado*, 95 N.Y.2d at 145); *Zurich Ins. Co. v. White*, 633 N.Y.S.2d 415, 417 (App. Div. 1995) (“[W]e find that [the policyholder] clearly intended to paint the bridge but by virtue of the acts undertaken both before and after the claims of overspraying were revealed, did not intend to cause the resultant damages. . . . [Therefore, we find that] the damage was neither ‘intended’ nor ‘expected’ from the standpoint of the insured.” (citation omitted)).

211. See *supra* note 67.

burden of proof on the policyholder when the expected or intended language is found in the definition of “occurrence,” as it was prior to 1986.<sup>212</sup>

Thus, for pre-1986 policies, the NFL may need to prove that it did not expect or intend its players would suffer long-term brain diseases as a result of playing football. For the post-1986 policies, after the insurers moved the expected or intended language to the exclusions section of CGL policies, the insurers would have the burden of proving the NFL expected or intended that NFL players would develop long-term brain diseases.<sup>213</sup> With that said, it may not be particularly important which party has the burden of proof on the issue, however, because both sides likely will introduce evidence on the issue and the factfinder will decide which side’s position has more credibility.

With respect to the issue of exactly what type of harm the NFL needed to expect or intend in order for it to lose coverage, New York law again is mixed regarding whether a showing that the NFL expected or intended the specific harm suffered—in this instance, CTE—or only that some type of long-term injury to the brain could or would occur. Some New York case law supports the argument that only the intent or expectation of harm in general satisfies the exclusion.<sup>214</sup> On the other hand, other case law supports the argument that the policyholder must have expected or intended the same type of harm that resulted in order for the exclusion to apply.<sup>215</sup>

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212. See, e.g., *Consol. Edison Co. of N.Y., Inc. v. Allstate Ins. Co.*, 774 N.E.2d 687, 691–92 (N.Y. 2002) (“In our view, the contention that the requirement of an ‘accident’ or ‘occurrence’ itself operates as an exclusion is unpersuasive. Any language providing coverage for certain events of necessity implicitly excludes other events. Indeed, virtually all of the language in the policies following the initial grant of coverage has the effect of limiting the scope of coverage in one way or another.” (citation omitted)).

213. See, e.g., *Travelers Indem. Co. v. Northrop Grumman Corp.*, 3 F. Supp. 3d 79, 98 (S.D.N.Y. 2014) (the insurer had the burden to prove that the injuries were expected or intended by the policyholder); *Utica Mut. Ins. Co. v. Prudential Prop. & Cas. Ins. Co.*, 477 N.Y.S.2d 657, 660–61 (App. Div. 1984) (“It is the insurer which has the burden of proof to establish that a claim is encompassed by an exclusion in a policy . . . and any limitation in coverage must be described in clear and explicit language.” (citations omitted)), *aff’d*, 478 N.E.2d 1305 (N.Y. 1985); *Union Carbide Corp.*, 955 N.Y.S.2d at 575 (“Since plaintiff established coverage, the burden shifted to defendants to show that, pursuant to the policy’s exclusion, plaintiff intended the damages.” (citation omitted)).

214. See, e.g., *Monter v. CNA Ins. Cos.*, 608 N.Y.S.2d 692, 693 (App. Div. 1994) (coverage was barred where persons hired to break another person’s legs actually killed the man instead, because the harm was inherent in the nature of the acts alleged such that “whatever injuries occurred” from the assault were intentionally caused).

215. See, e.g., *Rapid-Am. Corp.*, 609 N.E.2d at 510 (“For an occurrence to be covered under the CNA policies, the injury must be unexpected and unintentional. We have read such policy terms narrowly, barring recovery only when the insured intended the damages. Resulting damage can be unintended even though the act leading to the damage was intentional.” (citing *McGroarty v. Great Am. Ins. Co.*, 36 N.Y.S.2d 358, 364 (Ct. App. 1975))); *McGroarty*, 36 N.Y.S.2d at 364 (“[A] broader view must be taken of the term for

For purposes of discussion and to contrast New York and Pennsylvania law, this Article will assume that New York state court judges would apply the objective test and only require the insurers to prove that the NFL knew or should have known that repeated blows to the head that its players receive could cause some long-term brain diseases. Can the insurers meet that standard? Perhaps.

If the insurers can prove the allegations in the NFL players' class action complaints are true, then yes. As discussed in Part I.B of this Article, the players alleged that the NFL "fostered a culture surrounding football that glorified violence and a gladiator mentality, encouraging NFL players to play despite head injuries."<sup>216</sup> The players also alleged that the NFL created a committee in 1994 to study the effects of concussive and sub-concussive injuries on the players and then "obfuscated the connection between NFL Football and long-term brain injury, despite knowing 'for decades' that such a connection exists."<sup>217</sup> In addition, the players alleged that the NFL misrepresented to its players, the public, and Congress that "there was no scientifically proven link between repetitive traumatic head impacts and later-in-life cognitive/brain injury."<sup>218</sup> If the insurers can prove all of those allegations, then the NFL could potentially lose all of its coverage after the date it acquired such knowledge due to the policies' "expected or intended" exclusion.

## 2. *Expected or Intended under Pennsylvania Law*

Although the Pennsylvania Supreme Court has not specifically addressed the issue, the intermediate appellate court has used the subjective test to determine whether the "expected or intended" exclusion applies, but only requires that the policyholder expect or intend some harm of the general

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otherwise how could we classify catastrophic results which are the unintended fruits of willful conduct? Certainly one may intend to run a red light, but not intend that the catastrophic result of collision with another car occur. Calculated risks can result in accidents."); *Union Carbide Corp.*, 955 N.Y.S.2d at 575 ("Plaintiff's 'calculated risk' in manufacturing its [asbestos-containing] products despite its awareness of possible injuries and claims does not amount to an expectation of damage." (citing *Rapid-Am. Corp.*, 609 N.E.2d at 510)).

216. *In re Nat'l Football League Players' Concussion Injury Litig.*, 307 F.R.D. 351, 362 (E.D. Pa. 2015).

217. *Id.*

218. *Id.*

type suffered, as opposed to the precise harm that resulted.<sup>219</sup> The insurer has the burden of proof on the issue.<sup>220</sup>

Would the outcome regarding the applicability of the “expected or intended” exclusion in the *NFL v. Insurance Industry* litigation under Pennsylvania law be different than under New York law? Again, perhaps.

Regardless of which party has the burden of proof, if the insurers prove the more egregious NFL players’ allegations discussed above are true—if the NFL actually knew of the risks of long-term brain diseases due to repeated blows to the head, but concealed that information from the players and the public—then the exclusion likely would apply under both New York and Pennsylvania law. Similarly, because both states only require a showing of an intent or expectation of the same general type of harm, it probably would not be important whether the NFL knew or should have known about CTE specifically, for example, if it did know that repetitive blows to the head cause other types of long-term brain diseases and then failed to warn or protect the players.

There is, however, a real difference between subjective knowledge or intent and objective knowledge or intent. Actual knowledge or intent is different than should have known or expected. So, if the evidence does not support the conclusion that the NFL actually knew about the risks of long-term brain diseases, but that the NFL should have known based upon the available medical studies, then the outcomes could be different under New York and Pennsylvania law.

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219. *United Servs. Auto. Ass’n v. Elitzky*, 517 A.2d 982, 987 (Pa. Super. Ct. 1986) (“In our state, the exclusionary clause applies only when the insured intends to cause a harm. Insurance coverage is not excluded because the insured’s actions are intentional unless he also intended the resultant damage . . . The exclusion is inapplicable even if the insured should reasonably have foreseen the injury which his actions caused . . . *Eisenman* appears to align Pennsylvania with those jurisdictions which hold that the exclusion applies if the insured intended to cause a harm of the same general type as that which did occur.” (first citing *Mohn v. Am. Cas. Co.*, 326 A.2d 346 (Pa. 1974); and then citing *Eisenman v. Hornberger*, 264 A.2d 673 (Pa. 1970))); *see also* *Aetna Life & Cas. Co. v. Barthelemy*, 33 F.3d 189, 192 (3d Cir. 1994) (“Pennsylvania has adopted a general liability standard . . . that looks to the insured’s actual subjective intent.” (citing *Wiley v. State Farm Fire & Cas. Co.*, 995 F.2d 457, 460 (3d Cir. 1993))).

220. *See Koppers Co. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440, 1446 (3d Cir. 1996) (“[T]he insurer bears the burden of proving the applicability of any exclusions or limitations on coverage, since disclaiming coverage on the basis of an exclusion is an affirmative defense. Our research has revealed no Pennsylvania case allocating the burden of proof on the fortuity requirement. We nonetheless predict that the Pennsylvania Supreme Court would place the burden on the insurer in this case.” (citation omitted)); *see also* *Rohm & Haas Co. v. Cont’l Cas. Co.*, 781 A.2d 1172, 1179 (Pa. 2001) (holding the insurer bears the burden of proof regarding the defenses of fraud and “known loss,” which are other types of fortuity defenses).

## CONCLUSION

Five major issues most likely will dictate the outcome of the \$1 billion *NFL v. Insurance Industry* battle: (1) choice of law, (2) “trigger,” (3) “allocation,” (4) “number of occurrences,” and (5) the “expected or intended” exclusion. How these issues are resolved will determine which insurers, if any, must pay for the NFL’s liabilities and what portion of the NFL’s \$1 billion in liabilities each insurer will be required to pay. The outcome could be dramatically different depending upon whether the court applies New York law or the law of another state such as Pennsylvania. Although New York is the NFL’s home field, in this insurance battle, the NFL probably would prefer to be playing a road game.



