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The Tale of a Tail

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Abstract
The commercial general liability insurance industry shifted, in 1986, from the use of an "occurrence-based" to a "claims-made" policy form. So-called "tail" or "long tail" claims have continued nevertheless, to be asserted under the older "occurrence" policies which required that injury occur during the term of the policy, but not that the claim for such injury be made or brought at any particular time. In seeking state approval to use the new "claims-made" form in 1985-86, the insurance industry represented that the new form would not affect coverage under the old "occurrence" form. Despite that representation, insurers are now asserting, in the guise of an "allocation" claim, that "occurrence coverage" is progressively reduced as each year goes by between the date of the "occurrence" and when the claim is made. This assertion involves a contrived, intricate, and novel interpretation of an ambiguous insurance policy provision, and thus cuts across well-accepted canons of insurance policy interpretation. Such an interpretation would impair coverage that has already attached, and would also impair reasonable expectations on the part of the insured.

Keywords
CGL, liability insurance, torts, contracts, asbestos, environmental pollution, negligence

Disciplines
Environmental Law | Insurance Law | Torts

THE TALE OF A TAIL

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I. INTRODUCTION

The commercial general liability insurance industry shifted, in 1986, from the use of an "occurrence-based" to a "claims-made" policy form.[1] So-called "tail" or "long tail"[2] claims have continued nevertheless, to be asserted under the older "occurrence" policies which required that injury occur during the term of the policy, but not that the claim for such injury be made or brought at any particular time.[3] In seeking state approval to use the new "claims-made" form in 1985-86, the insurance industry represented that the new form would not affect coverage under the old "occurrence" form.[4] Despite that representation, insurers are now

1. *See* Hartford Fire Ins. Co. v. California, 509 U.S. 764, 773-76 (1993) (discussing the Insurance Services Office, Inc. (ISO)'s introduction on the market of "claims-made" policies and their regulatory approval in 1986).

2. *See* Carolyn M. Frame, *"Claims-Made" Liability Insurance: Closing the Gaps with Retroactive Coverage*, 60 TEMP. L.Q. 165, 166 n.7 (1987) (discussing the principal advantage of a claims-made policy for insurers as the avoidance of "tail liability").

3. *See* Ian Ayres & Peter Siegelman, *The Economics of the Insurance Antitrust Suits: Toward an Exclusionary Theory*, 63 TUL. L. REV. 971, 975 (1989) (explaining that under an old occurrence policy covering the year 1956, insureds were protected against claims made by workers who were exposed to asbestos during that year even if the claims were not filed until 1986).

4. *See* Letter from Michael A. Hatch, Esq., on file with the *William Mitchell Law Review*. During this 1985-86 period Mr. Hatch was the Minnesota Commissioner of Commerce and, as such, was the primary regulator of the business of in-

asserting, in the guise of an "allocation" claim, that "occurrence coverage" is progressively reduced as each year goes by between the date of the "occurrence" and when the claim is made.[5] This assertion involves a contrived, intricate, and novel interpretation of an ambiguous insurance policy provision, and thus cuts across well-accepted canons of insurance policy interpretation. Such an interpretation would impair coverage that has already attached, and would also impair reasonable expectations on the part of the insured.

II. THE RESULT OF THE INSURANCE INDUSTRY'S DECISION TO SWITCH FROM AN "OCCURRENCE" TO A "CLAIMS-MADE" POLICY

Insurers covering commercial general liability risks suffered increasingly serious losses in the 1970s and 1980s.[6] These losses resulted primarily from United States insureds' claims of injury from causes such as environmental pollution and inhalation of asbestos

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surance in the State of Minnesota. Mr. Hatch's letter includes the following information:

> Representatives of the Insurance Services Office (ISO) told me that insureds would not suffer as a result of a change to claims-made coverage. ISO explanatory materials stated:
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> . . . Business with growing businesses to protect would be able to up-to-date [sic] limits for current claims and not have to look for coverage in old policies with potentially inadequate limits. Under the occurrence form, the insured must select policy limits that will ultimately be used to protect the assets from claims or judgments made two, five or sometimes ten or more years after the expiration of the occurrence policy.
>
> . . . ISO representatives also stated that the obligation of insurers under the prior occurrence policies would stay the same notwithstanding the future shift to claims-made coverage. ISO also presented materials representing that the claims-made policies would be excess over any applicable prior insurance.
>
> . . . Neither ISO nor insurers ever advised me, or to my knowledge any other State of Minnesota officials or the Minnesota public generally, that the switch to claims-made policies would result in gaps or reductions of prior occurrence "all sums" policies. Moreover, they never suggested that occurrence trigger concepts could be applied to claims-made policies or years in a way to reduce the long tail liability protection of existing policies.

Id.

5. *See* Frame, *supra* note 2, at 184 (discussing the severe gaps in coverage that can occur during the transition from "occurrence based" to "claims-made" policies).

6. *See generally* George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1534-35 (1987) (asserting that the insurance losses were due to changes in the liability system which caused insurance for commercial risks to unravel).

fibers.[7] These losses not only affected the operations of United States-based insurers, both direct underwriters and reinsurers, but also the world market in insurance and reinsurance, predominantly written through Lloyd's of London.[8]

To limit substantial insurer exposure to future claims, general liability insurers dictated, beginning in late 1985, a major change in the form and content of the policy used to cover business commercial risks.[9] The previously available "occurrence based" policy was replaced by a "claims-made" policy.[10] "Occurrence based" coverage, adopted as a new standard form in 1966,[11] had been interpreted over the ensuing twenty-year period, in accordance with express policy terms, to apply to injury occurring during the specific term of the insurance policy, but regardless of when the claim was first made.[12] Coverage under the policy was triggered by the occurrence of injury during the applicable policy period.[13] The event causing the injury did not need to occur during the policy year; it could have occurred years earlier.[14] What was required was that injury of a kind covered under the policy, caused by a covered event,

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7. *See* David Ornelas, Insurance Law: An Analysis of Lloyd's of London (Apr. 7, 1997) (unpublished manuscript, on file with the *William Mitchell Law Review*) (noting Hurricane Hugo and the bombing of Pan Am Flight 103 as additional causes of financial losses for Lloyd's of London) (citing Allen v. Lloyd's of London, 94 F.3d 923, 927 (4th Cir. 1996)).

8. *See id.* More recently, as losses for various syndicates at Lloyd's mounted, several syndicates (partnerships) began calling on their guarantors (partners), known popularly as "names." *See id.* at 5, 9-11. Since the liability of each syndicate is unlimited, the result was a major loss or, in some cases, bankruptcy for some of the "names." *See id.* at 9-11. Major litigation brought by such names against members of Lloyds in both England and the United States has attracted substantial media attention. *See id.* at 11.

9. *See* Ayres & Siegelman, *supra* note 3, at 974. The major changes were aimed at eliminating tail liability and reducing losses by including legal defense costs as part of the stated policy limits. *See id.*

10. *See id.*; *see also infra* Part II.E. (discussing the efforts to reduce the volume of losses attributable to any particular policy by replacing "occurrence based" policies by "claims-made" policies).

11. *See infra* notes 70-71 and accompanying text for the standard 1966 policy definition of "occurrence."

12. *See infra* note 76 and accompanying text.

13. *See* Frame, *supra* note 2, at 168-69. Under the exposure theory developed by the courts, liability was imposed on any insurer who provided coverage at any time the claimant was exposed to the harm. *See id.* at 170.

14. *See id.* Under the triple trigger theory, liability was allocated "to all insurers providing coverage effective at any time during the period extending from initial exposure to the manifestation of injury or disease," and the insurers were thus liable for the entire loss. *Id.* at 171.

result during the policy year.[15] Throughout the 1970s and 1980s, a number of courts held that once a particular policy was "triggered," coverage under that policy extended to any continuation of that injury that developed in years following the specific policy year.[16] Because of these interpretations of the general liability policy, insurer losses for a particular policy year were extended by losses which developed in subsequent years, but which resulted from the same "occurrence."[17] As a consequence, insurers "on the risk" for a particular policy year found that claims could be asserted many years after the specific policy year.[18] Losses attributable to that year continued to be asserted years after the specific policy terminated, and the curve of such lines of losses, in a number of situations, increased over the subsequent years.[19] Insurers were thus unable, at any particular time, to draw a line across the losses attributable to a particular policy year and "close the books" for that year.[20] They were therefore unable to establish the ultimate total cost to the underwriters or syndicates for that year.[21] This liability, following years after the close of a particular policy year, became known as "tail" or "long tail" liability.[22]

A key reason for substituting the "claims-made" standard policy in 1986 for the previously available "occurrence" based policy was to eliminate this "tail."[23] While the "claims-made" policy continued to define the risks covered in terms of "occurrence,"[24] a new

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15. *See infra* note 103 and accompanying text for a discussion of "triggered" occurrence based coverage.

16. *See* Frame, *supra* note 2, at 170.

17. *See id.* at 171.

18. *See id.* at 170-71.

19. *See* Ayers & Siegelman, *supra* note 3, at 972 (citing *Sorry, Your Policy is Canceled*, TIME, Mar. 24, 1986, at 18 (noting that as a result of increased claims, litigation and premium increases came to be known as the insurance crisis)).

20. To eliminate their responsibility for these past risks, insurance companies included, in some "claims-made" policies, provisions which ended liability for injuries that occurred before a certain cut-off date, typically the date upon which the first claims-made policy was issued to the insured. *See* Ayers & Siegelman, *supra* note 3, at 972.

21. *See* Brander v. Nabors, 443 F. Supp. 764, 767 (N.D. Miss. 1978) (stating that occurrence policy provides unlimited prospective coverage), *aff'd*, 579 F.2d 888 (5th Cir. 1978).

22. *See* Ayers & Siegelman, *supra* note 3, at 974 n.16 (discussing "occurrence" tail liability in environmental pollution and asbestos cases).

23. *See id.* at 974-75 (discussing tail liability); *see also infra* Part II.F for an explanation of the way in which a "claims-made" policy functions.

24. *See* Jeanne H. Unger, *Introducing the 1996 ISO/CGL Policy, Plus, The Roles of Defense and Coverage Counsel*, 1996 MINN. INST. LEGAL EDUC. 3, *reprinted in* Insur-

condition was introduced to limit coverage under a specific policy to claims-made during the course of that specific policy year.[25] Under this form of policy, claims coming to light after a specific policy period expired would not be covered.[26] This policy was intended to permit insurers to draw a line across losses attributable to a particular policy year, and thus restrict liability allocable to that year to a relatively short period following the end of the policy year or term.[27] This change inevitably resulted in a substantial reduction of coverage for the insured.

A state may require that the form of each insurance policy, including terms and conditions, be approved by the state's commissioner of insurance before use.[28] In introducing the new "claims-made" general liability form,[29] the insurance industry told state authorities that the effect of the new "claims-made" policy would be prospective only.[30] The new form, it was said, would not affect insurance provided under the preceding "occurrence" form.[31] But, that explanation notwithstanding, liability insurers are now asserting a novel argument that "tail" liability under the old "occurrence" policies should be progressively reduced each year that passes between the end of the "occurrence" policies (1985) and the year in which the claim is made for coverage under the old "occurrence" policy.[32] The result of this argument would be the production of a phenomenon unique in the world of insurance—progressively disappearing coverage. Under this argument an insurer which might have been liable for a loss of $1 million (full policy limits) had the claim been asserted in 1985, can become liable for only one eighth of that loss ($125,000) if the filing of the un-

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ance Services Office, Inc. (ISO) 1996 CGL Policy.

25. *See* Frame, *supra* note 2, at 165.

26. *See id.*

27. *See* Unger, *supra* note 24, at 8 (stating that duties in the event of occurrence include notice of occurrence as soon as practicable, and information regarding the occurrence).

28. *See, e.g.*, MINN. STAT. § 72C.10 (1996) (stating that Minnesota requires that such approval be given for particular policies and insurers prior to the use of the form for insuring risks).

29. *See infra* Part II.F for a description of "claims-made" provisions found in earlier forms of insurance policies.

30. *See* Letter from Michael A. Hatch, Esq., *supra* note 4.

31. *Id. See also* H. James Wulfsberg & Timothy A. Colvig, *The 1986 Commercial General Liability Insurance Program*, 291 PLI Real Est. & Practice Course Handbook Series No. 593, 603 (Apr. 1, 1987).

32. *See id.* at 606-08.

derlying claim is delayed until 1992.[33]

The thesis of this article is that the coverage of the insured, determined by reason of the application and interpretation of the old "occurrence" policies and risks that became fixed under those policies during the "occurrence" policy term, should not be adversely and progressively reduced as a result of a decision of the insurance industry to switch from the "occurrence" to the "claims-made" policy format in 1986. The novel insurer argument is a contrived, intricate, and unique interpretation of language deliberately used in the "occurrence" policy—language that is patently ambiguous. No reasonable business person purchasing "occurrence" coverage from 1966 through 1985 could have foreseen such an argument. The notion of triggered occurrence insurance progressively disappearing as a result of a *later* change in a subsequent policy form would have been regarded as lacking any reasonable support in the language of the policy.[34] Under long-standing and universally applied canons of insurance policy interpretation such a novel argument should not prevail. Nor should it prevail in the light of an additional and more recent doctrine, now clearly a part of Minnesota law[35]— the doctrine that directs a court to give effect to the reasonable expectations of the insured.[36]

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33. The insurer argument can be illustrated as follows. Suppose that the specific "occurrence" based policy year was 1985 and that the policy limit of liability was $1 million. Suppose further, that the risk triggered under the 1985 policy was a spill of hazardous materials. Had a claim been asserted shortly after the spill for liability exceeding the $1 million policy limit, the insurer's obligation would have been to pay the $1 million. Now suppose that it became impossible for the insured to purchase coverage for this risk in years 1986 and thereafter. "Claims-made" coverage, even had it been written to cover environmental pollution risks, would have been triggered only if the claim was made in the specific year of the policy. Such "claims-made" coverage was the only form of general liability coverage available in 1986 and thereafter for businesses with diverse operations of substantial size. Thus, for the years 1986 through 1991, as a result of the function of the "claims-made" condition, the insured had no available insurance coverage under those policies for the 1992 claim. Despite a factual finding that the risk that attached under the 1985 policy caused initial injury in 1985, the triggered 1985 occurrence insurer argues that its liability should be limited to one eighth, because the injury from the 1985 spill continued up to the date of the claim.

34. *See* Hancock Lab., Inc. v. Admiral Ins. Co., 777 F.2d 520, 523 n.5 (9th Cir. 1985) (stating that one of the three general policy interpretation principles is that the court should strive to give effect to the objectively reasonable expectations of the insured).

35. *See infra* note 299 and accompanying text discussing the "reasonable expectations" doctrine under Minnesota law.

36. *See* Northern States Power Co. v. Fidelity & Cas. Co. of New York, 523

A. *How Conventional Liability Insurance Works*

Most people are familiar with liability insurance and how it operates in connection with the coverage they have for the operation of owned or borrowed automobiles.[37] Under the conventional automobile liability policy the insurer promises two distinct forms of coverage: (1) the provision of a legal defense in the event of a claim against the insured arising out of the insured's operation of an automobile; and (2) the payment of any reasonable settlement or judgment arising as the result of such a claim up to the limits of the policy.[38] No one would question that this coverage attaches at the time of an accident and extends to cover and include injury which becomes apparent only at a later time and after the term of the particular automobile policy has ended. In other words, coverage becomes fixed at the time of the accident and extends to include subsequently developing injury causally related to the accident.[39] In the same way the conventional understanding of general business liability coverage would be that if a tire exploded causing injury to the driver of the vehicle at the time of the explosion, the manufacturer would be covered under the policy in effect at that time for all damages resulting from the tire explosion although the claimant might have ongoing and developing injuries for years to come. Needless to say, subject to statute of limitations requirements, the result in these cases would not be affected in any way by

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N.W.2d 657 (Minn. 1994); Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co., 366 N.W.2d 271 (Minn. 1985); text discussion beginning at note 303 *infra*.

37. *See* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES app. H, at 1122-23 (student ed. 1988) (containing the liability coverage portion of a personal automobile insurance policy) [hereinafter KEETON & WIDISS].

38. *See id.* A personal automobile insurance policy states:

> We will pay damages for "bodily injury" or "property damage" for which any "insured" becomes legally responsible because of an auto accident. Damages include pre-judgment interest awarded against the "insured." We will settle or defend, as we consider appropriate, any claim or suit asking for these damages. In addition to our limit of liability we will pay all defense costs we incur. Our duty to settle or defend ends when our limit of liability for this coverage has been exhausted.

Id.

39. *See* Benike v. Dairyland Ins. Co., 520 N.W.2d 465, 466 (Minn. Ct. App. 1994) (finding that injuries caused by a power line downed during an accident were causally related to the accident); Mutual of Enumclaw Ins. Co. v. Jerome, 833 P.2d 429, 431 (Wash. Ct. App. 1992) (quoting insurance policy as stating that the insurer must pay all sums which insured must pay "because of bodily injury or property damage to which this insurance applies" caused by an accident resulting from the ownership, maintenance or use of an insured vehicle).

the date the plaintiff chose to file the claim.

Comprehensive general liability insurance, the kind of insurance coverage on which businesses rely for a variety of business operation risks, operates in essentially the same way. The standard liability policy not only imposes a "duty to defend" upon the insurer, requiring it to defend claims against the insured, but also provides that the insurer can select counsel, control the defense efforts, and settle claims within its sole discretion.[40] In reality, an insurer often "gets away" with breaching its duty to defend. If the insurer does not defend, the prudent commercial policyholder will retain counsel and defend the action rather than risk a large default judgment, attempting to mitigate damages. The policyholder then pursues reimbursement from the insurer.[41] Absent a finding of bad faith refusal to defend, the court may only require the insurer to repay the policyholder's counsel fees plus interest and the counsel fees incurred in obtaining coverage.[42] Although these amounts are not trivial, they often impose no penalty on the insurer that breaches the duty to defend.[43] Absent punitive liability, the insurer often attains substantial freedom to refuse to provide a defense.[44]

Some insurance policies, generally using standard language, provide the insurer with an option (but not an obligation) to defend and an obligation only to reimburse reasonable defense costs.[45] Depending on policy language and circumstances, defense costs are reimbursed as incurred.[46] These policies create a "duty to

40. *See* KEETON & WIDISS, *supra* note 37, § 9.1(b), at 988. Some standard policies alternatively require the insurer to reimburse the policyholder's defense costs without requiring the insurer to retain the attorneys.

41. *See id.* § 9.1(a).

42. *See id.* (stating that an insurer's refusal to defend is a breach of the insurance agreement).

43. *See* St. Paul Fire & Marine Ins. Co. v. National Computer Sys., Inc., 490 N.W.2d 626 (Minn. Ct. App. 1992) (stating that "[i]f any part of the cause of action against the insured is arguably within the scope of the [insurance] policy's coverage, the insurer must defend," but ordering the insurance company to pay only the reasonable attorney fees incurred in defending claims and not the costs of a counterclaim).

44. When an insurer declines to provide a defense for an insured, some courts treat it as a breach of the insurance agreement and award only contract damages. *See* KEETON & WIDISS, *supra* note 37, § 9.1(a), at 988.

45. *But see* Unger, *supra* note 24, at 1 (stating that the standard language of CGL states "[w]e will have the right and duty to defend the insured against any "suit" seeking those damages").

46. *See id.* at 9.

reimburse" rather than a duty to defend.[47] The standard liability policy provides for the defense, or reimbursement of defense cost, in addition to payment of the policy limits for indemnity as necessary.[48] A common variant, found particularly in excess policies, explicitly provides a set limit of coverage that includes both defense and indemnity in determining when policy limits have been exhausted.[49]

B. How the Comprehensive General Liability Policy ("CGL") Worked

From 1966 through 1985, the dominant liability insurance policy form used for the writing of business risks was the Comprehensive General Liability Policy (CGL), known as the "occurrence" based policy.[50] This form of policy was used to cover a variety of risks arising out of business operations including general liability risks, of which the escape of environmental pollutants became a notable example,[51] and products liability, covering risks arising out of the sale of allegedly defective products, including defective design, manufacture, operation, or failure to warn.[52] Considerable

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47. *See id.*

48. *See id.* at 6.

49. *See* Ayres & Siegelman, *supra* note 3, at 974 (listing the allegation made by the Attorneys General's anti-trust action, including that the insurers' "Revised CGL forms . . . end the historical obligation of the insurer to pay the full legal costs of defending a claim and substitute a defense cost cap, under which the insured's legal defense costs are counted as part of the stated policy limits . . . .").

50. *See id.* at 977 (describing the 1983 ISO Board of Directors decision to support both occurrence and claims-made forms and the subsequent turmoil that led to the ISO withdrawal of support of the occurrence form on July 1, 1987).

51. *See* Eugene R. Anderson et al., *Liability Insurance: A Primer For Corporate Counsel*, 49 BUS. LAW. 259 (1993). "[T]he insurance industry introduced, for a brief period of time in the mid-1970s, the Environmental Impairment Liability (EIL) insurance policy . . . . [T]he policy was sold on a 'claims-made' basis." *Id.* at 264. The EIL policy was not a CGL policy. *See* Steven G. Eggimann, *Commercial Insurance Issues: Toxic Torts*, 1986 MINN INST. LEGAL EDUC. 1 (1986) (enumerating various exclusions not generally found in CGL policies but found in EIL policies such as worker's compensation, willful acts, nuclear explosions, fines and penalties, and most importantly the exclusion of the duty or right to defend).

52. The CGL policy began with a "Declarations" page listing the different coverages packaged together under this form and the separate premiums allocable to each of the coverages activated under the particular policy. This page also specified the overall liability cap for each policy year, if there was one, and with respect to products liability coverage, limits "per occurrence," if any; deductibles, if any; and the aggregate products liability cap for each policy year, if there was one. *See* Anderson, *supra* note 51, at 266-69. For a comparison between current "occurrence policy," new "occurrence policy," and new "claims-made" policy, see Douglas L. Skor, *CGL Coverage Making the Transition: History of CGL Policy*, 1986

litigation has arisen over the application and interpretation of this CGL policy, including coverage of claims for injury resulting from environmental pollution and asbestos inhalation.[53] Much of this litigation has related to claims for gradual or progressive injury, occurring over a period of years, and therefore potentially covered by a number of different insurance policies.[54] Claims for gradual or progressive injury have raised questions of proof for the insured as to when the particular injury occurred (i.e., which policy year was implicated), how long the injury continued (i.e., which series of policies was potentially implicated), whether there was one occurrence or multiple occurrences, and how investigation and defense, as well as loss, costs should be allocated among the different

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MINN. INS. & LEGAL EDUC. app., at 1.

53. *See, e.g.*, Board of Regents of the Univ. of Minn. v. Royal Ins. Co. of Am., 517 N.W.2d 888, 892 (Minn. 1994) (discussing the "sudden and accidental" pollution exclusion interpretation).

54. *See infra* Part II (explaining the "trigger" of each "occurrence" based policy is the happening of injury during the policy term. Where injury, which may have been caused by an event which preceded the beginning of the particular policy term, continued across a series of years, each policy in effect during that sequence of years may be "triggered" depending upon the facts of the particular case).

In any particular insurance policy year, different insurers may be implicated as the result of the writing of excess insurance. *See* KEETON & WIDISS, *supra* note 37, § 7.8(e). It was not uncommon for an insured to purchase a policy from a primary insurer and then purchase additional coverage from an excess insurer or series of excess insurers. *See id.* Such excess insurers have been, in some cases, stacked in layers, with each successive layer constituting a joint venture between the insurers on the risk in that layer in accordance with an agreed upon percentage of the risk within that layer for each such participant, which is interpreted in varying ways depending upon the facts of the case. *See id.* Under such an arrangement, no excess insurer generally becomes liable until the amount of the underlying limits has been exhausted, and thereafter the process of exhaustion moves up layer by layer. *See id.*

Thus, in any particular policy year, it is possible that the happening of an insured event could "trigger" coverage under a sometimes bewildering number of insurance carriers. This process of using multiple layers, with participation by a number of insurance carriers in each layer, is, of course, a vehicle of choice for spreading a significant risk across a wide number of carriers.

The Supreme Court, in *Hartford Fire Insurance Co. v. California*, 509 U.S. 764 (1993) described "reinsurance," as an additional way of spreading insurance among a wide group of carriers. Primary insurers themselves purchase insurance to cover a portion of the risk they assume from the insured. This "reinsurance" serves at least two purposes, protecting the primary insurer from catastrophic loss, and allowing the primary insurer to sell more insurance than its own financial capacity might otherwise permit . . . . Insurers who sell reinsurance themselves often purchase insurance to cover part of the risk they assume from the primary insurer; such 'retrocessional reinsurance' does for reinsurers what reinsurance does for primary insurers. *Id.* at 772-73 (citations omitted).

insurers.[55]

C. The Evolution of the CGL Policy

Liability policies have existed in some form since the late nineteenth century.[56] However, general liability policies were not introduced in significant degree until the 1940s.[57] The standardized "comprehensive" general liability policy, or CGL, "first appeared in 1940-41 and was revised in 1943, 1955, 1966 and 1973."[58] The first such standard liability insurance policy used an "accident" as its "trigger" or basis for initiating coverage.[59] Typical pre-1966 CGL language provided that the insurer would pay on behalf of the insured all sums which the insured became legally obligated to pay as damages because of bodily injury, sickness or disease, including death at any time resulting therefrom, sustained by any person caused by accident.[60]

By the 1960s both insurers and insureds became concerned that in court the "accident" trigger might be interpreted as not covering gradual (no "big bang" accident) injury.[61] As one court put it, describing the type of form used by General Accident Insurance from 1960 to 1964:

> (a) From October 1960 to October 10, 1964, General Accident's policy provided property-damage-liability coverage for "all sums which the insured shall become legally obligated to pay . . . for damages because of injury to or destruction of property . . . caused by accident." The term

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55. *See Hartford Fire Ins. Co.*, 509 U.S. at 773.

56. *See* S. S. HUEBNER ET AL., PROPERTY AND LIABILITY INSURANCE 353 (3d ed. 1982).

57. *See* Frame, *supra* note 2, at 169.

58. John P. Arness & Randall D. Eliason, *Insurance Coverage for "Property Damage" in Asbestos and Other Toxic Tort Cases*, 72 VA. L. REV. 943, 945 (1986); Eugene R. Anderson et al., *Liability Insurance: A Primer For Corporate Counsel*, 49 BUS. LAW. 259, 262-63 (1993) ("[A]n executive of The Travelers Insurance Company described the new 1941 Comprehensive General Liability policy as follows: 'Take each policy needed . . ., weld them together in a Comprehensive coverage, limiting exclusions to a minimum and adding automatic coverage for any new venture an insured may care to undertake, and you have one of the most potent weapons for protection ever afforded a risk.'").

59. *See* I EUGENE R. ANDERSON ET AL., INSURANCE COVERAGE LITIGATION § 1.2, at app. A (1997) (describing evolution of the CGL language and reproducing the 1955, 1966, 1973, and 1985 policy language).

60. *See id.* at 447.

61. *See* Morton Int'l v. General Accident Ins. Co. of Am., 629 A.2d 831, 835-36 (N.J. 1993).

> "accident" was undefined. The policy afforded coverage "only to occurrences or accidents which happen during the policy period. . . ."[62]

Because the word "accident" was undefined, disputes arose concerning whether an accident had to be a sudden and episodic event or whether it could be an injury-causing process or system that took place over an extended period of time.[63] While courts construing the accident language policies found coverage for losses that resulted from gradual happenings as well as rapidly occurring events,[64] the Insurance Services Office (ISO), representing some 1,400 domestic property and casualty insurers, revised the standard comprehensive liability form.[65] The result was the drafting, approval, and release of the CGL occurrence based policy in October, 1966.[66] Practical considerations dictate that commercial liability insurers use the standard ISO approved form.[67]

Contemporaneous statements of drafters and insurer representatives made at or shortly before the occurrence based form was approved and issued, indicated an intention that the new form cover gradual and progressive injury.[68] These drafters and repre-

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62. *Id.*

63. *See id.* at 836.

64. *See, e.g.*, Moffat v. Metropolitan Cas. Ins. Co., 238 F. Supp. 165, 172-74 (M.D. Pa. 1964); Elco Indus., Inc. v. Liberty Mut. Ins. Co., 414 N.E.2d 41, 46 (Ill. App. 1980).

65. *See Moffat*, 238 F. Supp. at 171.

66. *See* ANDERSON ET AL., *supra* note 59, §1.2.

67. *See generally* Hartford Fire Ins. Co. v. California, 509 U.S. 764, 772 (1993). The ISO:

> is the almost exclusive source of support services in this country for CGL insurance . . . . ISO develops standard policy forms and files or lodges them with each State's insurance regulators; most CGL insurance written in the United States is written on these forms . . . . For each of its standard policy forms, ISO also supplies actuarial and rating information: it collects, aggregates, interprets and distributes data on the premiums charged, claims filed and paid, and defense costs expended with respect to each form . . . and on the basis of this data it predicts future loss trends and calculates advisory premium rates . . . . Most ISO members cannot afford to continue to use a form if ISO withdraws these support services.

Id.

68. *See* ANDERSON ET AL., *supra* note 59, § 4.2.

> [F]or insurance companies, the new tort liabilities presented tremendous opportunity for growth. As long as there were "satisfactory limitations in the area of the particular hazard," most insurance companies were willing to introduce language that would explicitly provide coverage for the hazard. Even in the area of gradual property damage, insurance companies seemed more willing, sanguine, and eager to provide

sentatives also recognized that multiple policies in multiple years might be implicated, discussed the potential sharing of risk among different insurers, and reported a decision not to include a working apportionment of loss formula applicable between the different CGL insurers.[69]

D. Language of the "Occurrence" Based Policy

Effective October 1, 1966, the standard policy form defined "occurrence" as follows:

> 'Occurrence' means an accident, including injurious exposure to conditions, which results, during the policy pe-

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the coverage.

See id. (citation omitted); *see also* Trial Transcript at 15547, Coordination Proceeding, Asbestos Insurance Coverage Cases, volume 133 (Cal App. Dep't Super. Ct. 1986).

> After extensive discussion it was agreed that with respect to product bodily injury liability insurance it is not the underwriting intent to require any element of suddenness as a condition of coverage afforded on a caused-by-accident basis. It is the intent to afford coverage for unintended and unexpected bodily injury resulting from exposure over a period of time no matter how long that period of time might be. This raises questions in connection with the application of policy limits as well as the policy period condition.

Id.

69. *See, e.g.*, R.A. Schmalz, *New Comprehensive General Liability and Automobile Program*, MUT. INS. TECH. CONF., Nov. 15-18, 1965, at 6.

> The policy applies under the new program to bodily injury or property damage which occurs during the policy period. Inasmuch as the new policies afford blanket occurrence coverage it is possible that where the injury actually occurs over two or more policy periods, the Claims Department will have to make some sort of reasonable allocation to each. There is no pro-ration formula in the policy, as it seemed impossible to develope [sic] a formula which would handle every possible situation with complete equity.

Id.; *see also* Norman Nachman, *The New Policy Provisions for General Liability Insurance*, 10 THE ANNALS 197, 199-200:

> The definition embraces an injurious exposure to conditions which results in injury. Thus, it is no longer necessary that the event causing the injury be sudden in character. In most cases, the injury will be simultaneous with the exposure. However, in some other cases, injuries will take place over a long period of time before they become manifest. The slow ingestion of foreign matters and inhalation of noxious fumes are examples of injuries of this kind. The definition serves to identify the time of loss for application of coverage in these cases, the injury must take place during the policy period. This means that in exposure-type cases, cases involving cumulative injuries, more than one policy contract may come into play in determining coverage and its extent under each policy.

Id.

> riod, in bodily injury or property damage neither expected nor intended from the standpoint of the insured.[70]

This language was intended to clarify that gradual continuing injury was covered. However, the language was still ambiguous and the new definition was more restrictive than the interpretation of "accident." As a result, in 1973, the Comprehensive General Liability policy was changed.[71]

As amended in 1973, the standard form definition provided that "occurrence" meant 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.[72]

The 1973 revisions thus stated even more clearly that gradual and progressive injury was covered.[73] The natural parsing of the words used indicates that the intended trigger is bodily injury or property damage resulting during the policy period.[74] There is no requirement that the "accident, including continuous or repeated exposure to conditions" occur during the policy period.[75] Clearly, there is nothing in the coverage language that affects the scope of coverage afforded by reason of the date the claim for injuries is

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70. Morton Int'l v. General Ins. Co. of Am., 629 A.2d 831, 836 (N.J. 1993).

71. *See* JOHN ALAN APPLEMAN, INSURANCE LAW AND PRACTICE § 4492, at 15 (1979).

72. *See* ANDERSON ET AL. *supra* note 59, app. A, at 462.

73. Since 1973, an "occurrence" has continued to be commonly defined to mean an "accident, including continuous or repeated exposure to substantially the same general harmful conditions." *See, e.g., The Insurance Professional's Policy Kit: A Collection of Sample Insurance Forms*, ALLIANCE OF AM. INS., 1995-96, at 388. The current version of the standard CGL policy provides that it applies "only if" an insured becomes "legally obligated to pay" because of bodily injury or property damage that "occurs during the policy period." *See id.*

The 1973 Form also provides that injuries expected or intended by the insured are not to be deemed accidental. This is the "intentional act exclusion" which, depending on the CGL form in question, was sometimes defined in the "Definitions" section of the policy or the insuring agreement, rather than in the exclusions section. *See generally* JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS § 24 (1994 & Supp. 1996) (reviewing and outlining intentional conduct defenses of insurers). The intentional act exclusion is not intended to preclude coverage for the insured's negligence. Even gross negligence and stupidity by the insured is not itself sufficient to make the intentional act exclusion applicable. *See, e.g.*, Arco Indus. Corp. v. American Motorists Ins. Co., 531 N.W.2d 168, 177 (Mich. 1995); Armstrong World Indus. v. Aetna Cas. & Sur. Co., 52 Cal. Rptr. 2d 690 (Ct. App. 1996); *see also* STEMPEL, § 24.3.

74. *See* ANDERSON ET AL., *supra* note 59, at 275.

75. *See id.* at 275-76.

first made against the insured.[76] Despite various efforts to define and refine the coverage afforded under the CGL policy, the language appears to be a walking ambiguity.[77] The colorful title of one recent article dealing with coverage disputes in product liability cases with delayed manifestation injuries and damages makes the point rather nicely: "Nailing Jell-O to a Wall. . . ."[78] Another set of authors said:

> The word "occurrence" is one of the least understood and most misunderstood words in today's insurance language. One author has described it as "elusive" and another as "haunting." Sometimes it means "cause," sometimes it means "effect," and sometimes, within the very same policy, it means "cause" in one place and "effect" in another. . . . It is impossible to overemphasize the fact that the occurrence concept is an integral part of the proposed claims-made coverage. . . . It is inexplicable that ISO did not resolve the "long tail," "latent injury," or "long term exposure" issue.[79]

A federal circuit court of appeals noted recently that even the insurance industry itself could not agree on any one consistent interpretation of this language in the CGL policy:

> The insurance industry has been and remains unable to agree on a consistent interpretation of the form wording in NGC's policies as applied to asbestos claims and other progressive injury claims. For example, on this appeal, CU takes the position that 'bodily injury' within the meaning of its policies occurs only at the point in time when the asbestos-related diseases were either manifested or became fully developed, while AMICO, joined by a second group of insurers, contends that only those policies in effect during the period of a claimant's exposure to asbestos must respond to the asbestos-induced bodily injury

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76. *See* ANDERSON ET AL., *supra* note 59, at 264. "In contrast [to a claims-made policy], an 'occurrence' policy provides coverage for injury or damage which happens during the policy period, regardless of when the claim for injury or damages is first made against the policyholder." *Id.*

77. "In its simplest terms, the occurrence is the causative event or happening that ultimately results in injury or damage." *Id.* at 272.

78. *See* Tung Yin, *Nailing Jell-O to a Wall: A Uniform Approach For Adjudicating Insurance Coverage Disputes in Product Liability Cases with Delayed Manifestation Injuries and Damages,* 83 CAL. L. REV. 1243 (1995).

79. Eugene R. Anderson et al., *Proposed New Claims-made Liability Insurance Policy: Panacea Or Golden Road To Disaster?,* 298 PLI Litig. & Admin. Practice Course Handbook Series No. 393, 415-17 (1986).

claims.[80]

E. The Plan to Reduce the Volume of Losses

In 1977 the ISO began to revise the CGL form once again.[81] For the first time, in 1984, the ISO proposed two CGL forms, one with the familiar "occurrence" type language, the other containing a new "claims-made" type language.[82] A dispute then arose within the ISO membership, with one faction pressing to eliminate the "occurrence" form, along with sudden and accidental pollution coverage, and advocating a cap on defense costs.[83] Notwithstanding this dispute, the ISO Board of Directors approved the two 1984 CGL forms, rejecting the changes sought by this faction.[84] Not content with this result, the faction threatened a general refusal by insurers to reinsure risks if the 1984 forms were used, and invoked the assistance of London-based underwriters to make good on that threat.[85] The language of the complaints in *Hartford*, as summarized in the Supreme Court opinion, suggest the rest of the story: "[A]s a consequence, many London-based underwriters, syndicates, brokers, and reinsurance companies informed ISO of their intention to withhold reinsurance on the 1984 forms, . . . and at least some of them told ISO they would withhold reinsurance until ISO incorporated all four desired changes . . . ."[86] This threat succeeded and the ISO 1984 forms were withdrawn from the market and replaced with forms, including the new "claims-made" form, containing the new provisions.[87] The final act in this drama, as summarized by the Court from the complaints, reads as follows: "After ISO got regulatory approval of the 1986 forms in most States where approval was needed, it eliminated its support services for the 1973 CGL form, thus rendering it impossible for most ISO members to continue to use the form."[88]

From and after the beginning of 1986, most insureds needing broad and significant liability coverage were unable to purchase

80. Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp., 73 F.3d 1178, 1192-93 (2d Cir. 1995).
81. *See* Hartford Fire Ins. Co. v. California, 509 U.S. 764, 773 (1993).
82. *See id.*
83. *See id.*
84. *See id.* at 774.
85. *See* Ayres & Siegelman, *supra* note 3, at 977.
86. *See Hartford Fire Ins. Co.*, 509 U.S. at 775.
87. *See id.*
88. *See id.* at 776.

"occurrence" based insurance in amounts of any consequence.[89] The only available policy for such insureds was the CGL "claims-made" version.[90]

F. How the CGL "Claims-Made" Policy Works

Several fundamental changes were made in the new "claims-made" form. First, to be valid under the policy, a claim now needed to be made during the policy term. This insurance applies to "bodily injury" and "property damage" only if a claim for damages is first made against any insured during the policy period.[91] In this fashion, the "trigger" of the new policy is the making of a claim in the policy year, rather than injury resulting during the policy year from an "occurrence" as provided under the earlier policy.[92]

Second, a "retroactive date" was often inserted to control the extent to which the new policy would cover claims for injury or property damage that occurred prior to the policy term. "[T]his insurance does not apply to 'bodily injury' or 'property damage' which occurred before the retroactive date, if any, shown in the Declarations or which occurs after the policy period."[93] The intention of the drafters was, apparently, that the insurer would fix as the "retroactive date" the date of first issuance of a "claims-made" policy to the insured, thus separating and differentiating the new "claims-made" coverage from any earlier "occurrence" coverage, particularly including any "tail," on at least a primary basis.[94]

Third, the coverage language of the "occurrence" policy, providing that the insurer would pay "all sums which the insured shall become legally obligated to pay as damages because of injury or damage to which this policy applies," was changed to "[w]e will pay those sums that the insured becomes legally obligated to pay as damages . . . ."[95]

Fourth, pollution or contamination coverage was almost com-

89. *See* Ayers & Siegelman, *supra* note 3, at 978.

90. *See id.* at 990. An "occurrence" policy form has now been reintroduced but is still commercially unavailable for many companies with numerous potentially significant risks. *See id.* at 992-93.

91. *See* Wulfsberg & Colvig, *supra* note 31, at 601.

92. *See id.* at 600-01.

93. *Id.* at 647.

94. *See, e.g.*,. Florida Hosp. Trust Fund v. Commissioner of Internal Revenue, 103 T.C. 140, 143 (T.C. 1994); Old Republic Ins. Co. v. Landauer Assoc., Inc., No. 88CIV.434, 1989 U.S. Dist. LEXIS 13422, at *18 (S.D.N.Y. Nov. 9, 1989).

95. Wulfsberg & Colvig, *supra* note 31, at 647.

pletely excluded.[96] Two authors described the new policy shortly after its issuance as follows: "[t]he new claims-made form is the insurance industry's response to these latent injury and long-term exposure cases. Under the claims-made policy, there will be only one policy, and one set of limits, applying to any particular latent injury claim."[97] These 1986 changes were the first major revision of the CGL form to restrict rather than expand coverage.[98]

The operative effect of these changes needs to be understood. Assume that property damage begins in 1980 and continues through 1984. Under the "occurrence" policy, the insured generally has coverage for each of the five years with a separate cap on liability for each of the five years. Thus if the liability cap was $1 million for each policy term, the insured may have access to $5 million of coverage. Under the "claims-made" policy, assuming the same facts, but adding an assumption that a claim is made only in the last year, 1984, even though the insured purchased and paid for insurance in each of the five years and both injury and damage occurred in each of these five years, recovery is generally limited to the policy in effect in 1984 (the year in which the claim is made). Thus, coverage is generally limited to $1 million.[99]

State insurance commissioner approval of the new "claims-made" form was provided for under many state laws.[100] ISO representatives, in seeking state approval, represented that the "claims-made" policy would not affect obligations under any outstanding "occurrence" based policies.[101]

In what may be viewed as an amusing alteration, the drafters of the "claims-made" form apparently decided to change the content of the word called out by the initial "C" in "CGL." Previously, the "C" stood for "comprehensive." With the "claims-made" policy the

96. *See id.* at 595-96.

97. *Id.* at 598.

98. *See* Frame, *supra* note 2, at 174.

99. The most significant difference between the occurrence basis coverage and the claims-made coverage is the limitation imposed by the latter on the tails of liability by requiring that notice of any claim be provided during the term of the policy. *See In re* Insurance Antitrust Litig., 723 F. Supp. 464, 468-70 (N.D. Cal. 1989); Sparks v. St. Paul Ins. Co., 495 A.2d 406, 410 (N.J. 1985); Hoechst Celanese Corp. v. Lloyd's of London, 656 A.2d 1094, 1095 (Del. 1995) (reviewing the differences between occurrence and claims-made policies); *see also* JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS § 32.3.3 (1994 & Supp. 1996).

100. *See In re Insurance Antitrust Litig.*, 723 F. Supp. at 469.

101. *See* Letter from Michael A. Hatch, Esq., *supra* note 4.

"C" apparently was now changed to "commercial."[102]

G. How the "Occurrence" Tail Has Worked Out as Illustrated in the Environmental Pollution and Asbestos Cases

Under the "occurrence" based policy, injury or damage must take place before the policy is triggered.[103] Mere accidents or negligence do not trigger that policy.[104] Only those occurrences that cause injury or damage are covered, and then only the insurer or insurers on the risk when the injury takes place "within the policy period" are responsible.[105] If the causative negligence predates injury by a large enough period of time, the insurer on the risk when the insured erred may not be responsible for coverage, while the insurer on the risk when the error produces injury is responsible for coverage.[106] The Minnesota case, *Singsaas v. Diederich*,[107] clearly illustrates the focus on injury rather than negligence as the trigger of CGL coverage.[108] In *Singsaas*, the insured improperly constructed industrial equipment in one year but the defect did not injure a worker until a later year.[109] The insurer on the risk when the equipment was constructed was not responsible and coverage was provided by the insurer on the risk at the time the injury occurred.[110] This basic proposition is sometimes obscured because policyholders normally retain the same liability carrier for several consecutive years, making an inter-insurer dispute over that cover-

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102. *See* Wulfsberg & Colvig, *supra* note 31, at 595 (stating that the new policy also has a new name—"Commercial General Liability," instead of "Comprehensive").

103. *See* Irene A. Sullivan & William T. Wright, Jr., *Hazardous Waste Litigation: CGL Insurance Coverage Issues*, 369 PLI Litig. & Admin. Practice Course Handbook Series No. 387 (1989).

104. *See, e.g.*, Young v. Insurance Co. of N. Am., 870 F.2d 610, 610-11 (11th Cir. 1989) (stating that mere negligent installation was insufficient to trigger coverage since no physical injury occurred); Greenlee v. Sherman, 536 N.Y.S.2d 877 (1989) (noting that in a property insurance case, there must be actual physical damage to the property before the policy is triggered).

105. *See* William R. Hillman & Mary R. DeYoung, *Allocation of Environmental Cleanup Liability between Successive Insurers*, 17 N. KY. L. REV. 291, 293 (1990).

106. *See, e.g.*, American Home Prods. Corp. v. Liberty Mut. Ins. Co., 748 F.2d 760, 763 (2d Cir. 1984); Dow Chem. Co. v. Associated Indem. Corp., 724 F. Supp. 474, 481 (E.D. Mich. 1989), *aff'd*, 935 F.2d 800 (6th Cir. 1991); Sentinel Ins. Co. Ltd. v. First Ins. Co., 875 P.2d 894, 915 (Haw. 1994); Singsaas v. Diederich, 238 N.W.2d 878, 880-81 (Minn. 1976).

107. 238 N.W.2d 878 (Minn. 1976).

108. *See id.* at 880-82.

109. *See id.* at 879-80.

110. *See id.* at 880.

age relatively unlikely.

The most prominent examples of insurers disputing the time of injury—and the fact and definition of injury itself—involve physical injuries or diseases that develop over an extended period of time as a result of exposure to an allegedly toxic material.[111]

The asbestos coverage litigation has been instrumental in developing a body of coverage law focusing on what "triggers" a CGL policy when the claimant alleges injury over a period of time, injury which is not immediately apparent to the victim.[112] Pollution claims have also contributed to the explosion of "trigger" law in the 1980s and 1990s.[113]

One type of environmental pollution claim involves the spill or discharge of toxic material on owned property,[114] which then gradually migrates through the soil until it reaches underground water such as an aquifer, or percolates through to adjoining neighboring property.[115] Injury to the aquifer (state property), or injury to an adjoining land owner's property, has generally been held to be covered under the CGL "occurrence" policy.[116] The insured's first problem was to establish the time of the actual happening of any such injury, if a specific date for the spill(s) was unknown, so that a specific policy year could be implicated.[117] The Minnesota Supreme Court has resolved this dilemma for the insured by adopting a rebuttable presumption[118] that the injury occurred in equal

111. *See* Michael G. Doherty, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. 257, 257 (1997) (noting that asbestos-related cases may take "decades" to evolve).

112. *See* Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1215-16 (6th Cir. 1980) (discussing occurrences which "trigger" a policy when a progressive injury is involved).

113. *See* Yin, *supra* note 78, at 1243 (noting that some products liability cases pose significant problems concerning the time a policy is triggered).

114. The "occurrence" policy typically excluded liability for injury to owned property. *See, e.g.*, KENNETH S. ABRAHAM, ENVIRONMENTAL LIABILITY INSURANCE LAW: AN ANALYSIS OF TOXIC TORT AND HAZARDOUS WASTE INSURANCE COVERAGE ISSUES 172-73 (1991).

115. *See id.* at 164-69 (explaining that damage to neighboring lands may be actual, imminent, or non-imminent).

116. *See id.* at 163-73 (detailing the application of CGL policies to third-party clean-up costs, as well as to costs incurred to clean pollution sources on the insured's own property).

117. *See id.* at 172-73 (explaining the importance of the timing of injury to the resolution of coverage issues).

118. *See* Northern States Power Co. v. Fidelity & Cas. Co., 523 N.W.2d 657, 664 (Minn. 1994) (stating that the insurer is given the burden of rebutting the presumption). Where the insured can establish precisely when the injury oc-

increments for each of the years between the occurrence of the first spill and the assertion of the date of discovery or cleanup.[119] Thus, the insurer on the risk at the time of the first spill is implicated first, and each successive policy thereafter, between the date of spill and date of discovery or cleanup, is also implicated, raising a question of allocation of the loss among the several insurers. Courts have concluded, appropriately, that insurers should not be able to escape liability on the basis of a burden of proof argument, since they clearly intended to provide coverage for gradual and progressive injury.[120]

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curred, as in *SCSC v. Allied Mutual Insurance Co.*, this presumption is displaced, and the policy implicated in the year of the "escape" is responsible for all damages which follow. *See* 536 N.W.2d 305, 314 (Minn. 1995). The Minnesota Supreme Court further clarified this point in its recent decision in Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724, 733 (Minn. 1997):

> It is inaccurate to conclude that a CGL insurer is never liable for damages occurring outside of the policy period. CGL policies come in many forms and it is a mistake to read our case law as if the scope of coverage has been resolved for all such policies, no matter what their language. The proper scope of coverage also will depend on the facts of the case. When environmental contamination arises from discrete and identifiable events, then the actual-injury trigger theory allows those policies on the risk at the point of initial contamination to pay for all property damage that follows. *See SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 318 (Minn. 1995) (despite continuing damage from leaching of chemicals into the groundwater after the policy period, only the primary and excess policies on the risk at the time of the discharge were triggered, but those policies responded to the entire loss). This interpretation of the policies is in accord with the common understanding of the terms "occurrence" or "accident."

119. *See Northern States Power Co.*, 523 N.W.2d at 664 (stating that when damages have occurred over multiple policy periods, "the trial court should presume that the damages were continuous from the point of the first damage to the point of discovery or cleanup. A party wishing to show that no appreciable damage occurred during a triggered policy period bears the burden of proving that fact"). *See*, however, the significant interpretation of NSP provided in the Minnesota Supreme Court's opinion in *Domtar*, 563 N.W.2d at 733-34:

> It is only in those difficult cases in which property damage is both continuous and so intermingled as to be practically indivisible that NSP properly applies. NSP provides a judicially manageable way for trial courts to adjudicate certain pollution-coverage disputes when it is difficult to determine when an "event" or "occurrence" or "damage" giving rise to legal liability has occurred. *NSP* does not establish hard and fast rules; it offers a practical solution in the face of uncertainty.

120. *See* Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1223 (6th Cir. 1980) (concluding that "bodily injury" includes asbestos inhalation); *see also* Northern States Power Co. v. Fidelity & Cas. Co. of New York, 523 N.W.2d 657 (Minn. 1994).

Asbestos produces injury as a consequence of inhalation.[121] This injury is compounded by cumulative exposure and inhalation.[122] Different courts have enunciated four main (and sometimes conflicting) standards for determining when a CGL carrier is obligated on these claims.[123]

1. Exposure

In cases involving exposure to asbestos or other hazardous material, courts have found liability insurance triggered when the claimant was exposed to conditions alleged to have caused the injury.[124] A leading asbestos coverage case employing the exposure trigger is *Insurance Co. of North America v. Forty-Eight Insulations, Inc.*[125] In addition to being decided on a wave of 1980s coverage litigation, *Forty-Eight Insulations* proved to be quite influential with other courts in its adoption of the exposure trigger. It was also influential in its decision to prorate the relative responsibilities of insurers and policyholder for external exposure to asbestos according to the respective time policies that were in effect or on the basis that a policyholder had chosen not to purchase available coverage.[126]

2. Manifestation or Discovery

Occasionally courts have concluded that applicable insurance coverage for insidious bodily injury is to be determined by the time the injury is "manifested" or becomes physically tangible and observable.[127] In some instances, courts have conditioned "trigger" on

121. *See Forty-Eight Insulations,* 633 F.2d at 1216 (noting that courts have concluded that the initial exposure to asbestos is an "occurrence").

122. *See Northern States Power Co.,* 523 N.W.2d at 664.

123. *See* Doherty, *supra* note 111, at 258; *see also* Jerry B. Edmonds et al., *Trigger of CGL Coverage in the Environmental Context: Perspective of Insurers' Counsel,* 28 GONZ. L. REV. 523, 537-48 (1992-93) (providing detailed explanation of each theory).

124. *See, e.g.,* Hancock Lab., Inc. v. Admiral Ins. Co., 777 F.2d 520 (9th Cir. 1985); Porter v. American Optical Corp., 641 F.2d 1128 (5th Cir. 1981); Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980).

125. 633 F.2d 1212 (6th Cir. 1980).

126. *See, e.g.,* Gulf Chem. & Metallurgical Corp. v. Associated Metals & Minerals Corp., 1 F.3d 365, 371 (5th Cir. 1993); Commercial Union Ins. Co. v. Sepco Corp., 765 F.2d 1543, 1544 (11th Cir. 1985); Ducre v. Executive Officers of Haller Marine, Inc., 752 F.2d 976, 992 (5th Cir. 1985); Porter v. American Optical Corp., 633 F.2d 1128, 1145 (5th Cir. 1981).

127. *See, e.g.,* Mraz v. Canadian Universal Ins. Co., 804 F.2d 1325 (4th Cir.

when a condition was capable of being discovered or diagnosed, even though it was not apparent to the casual observer or to the claimant.[128] For example, the district court opinion in *American Home Products Corp. v. Liberty Mutual Insurance Co.*,[129] which purported to apply an "injury-in-fact" trigger in a case involving drug product liability, in essence made the purported injury trigger a manifestation trigger by using as the operative date for determining insurance applicability the date when the drug-related disease became reasonably capable of medical diagnosis.[130] The Second Circuit modified the district court opinion by eliminating the lower court's requirement that injury be diagnosable and compensable within the policy period.[131] The Second Circuit found that this would tend to make the injury trigger operate like a manifestation trigger and could unfairly defeat coverage, particularly with insidious disease claims such as asbestos.[132]

3. Injury-In-Fact or Actual Injury Trigger

An injury-in-fact, or actual injury approach, makes the CGL insurer responsible for coverage where the evidence suggests that some injury actually occurred during particular policy periods.[133] For example, coverage is triggered by a showing that a real, but undiscovered, injury affected the claimant prior to the time injury was physically manifest or detectable.[134]

1986); Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co., 682 F.2d 12 (1st Cir. 1982).

128. *See* Doherty, *supra* note 111, at 257.

129. 565 F. Supp. 1485 (S.D.N.Y. 1983).

130. *See id.*

131. *See* American Home Prod. Corp. v. Liberty Mut. Ins. Co., 748 F.2d 760, 762 (2d Cir. 1984).

132. *See id.*

133. *See* Doherty, *supra* note 111, at 257.

134. *See, e.g.*, Sentinel Ins. Co. v. First Ins. Co., 875 P.2d 894, 917 (Haw. 1994) (stating that "proof of the actual onset of injury with precision is not necessary"); SCSC v. Allied Mut. Ins. Co., 536 N.W.2d 305 (Minn. 1995); Industrial Steel Container v. Fireman's Fund Ins. Co., 399 N.W.2d 156, 159 (Minn. Ct. App. 1987); *see also* Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1194 (2d Cir. 1995) (stating that "the plain meaning of the terms of the CGL policy provided that a policy was triggered by an injury-in-fact during the policy period"). The *Stonewall* court continued, applying New York law, "In the pending case, we decide only that both states would rule that, at least where the evidence establishes a progressive bodily disease, with injury-in-fact recurring throughout the disease process, all policies in effect at any time during that process are triggered." *Id.* at 1197.

Under its particular factual situation the Minnesota Supreme Court adopted

4. Triple Trigger or Continuous Trigger

Perhaps the most commonly adopted trigger is a hybrid that finds coverage activated by exposure, manifestation, or undetected, but alleged, injury.[135] Because the other three triggers are employed, this analysis is sometimes referred to as a triple trigger.[136] Since all insurers are implicated by the risk from exposure through manifestation, this approach is also referred to as a continuous trigger.[137] The *Keene*[138] decision is the first and best known of the continuous trigger cases and has been influential in many of the subsequent decisions adopting this viewpoint.[139]

H. Insurer Liability under a "Triggered" Policy for Continuing Injury

Once insurance coverage is "triggered" by an identifiable event and found applicable, the insurer continues to be responsible for ongoing injury and for the ongoing cost of injury even though such injury and cost extend well beyond the policy period during which the injury first took place.[140] The policy language providing coverage for injury "during the policy period" has been

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this approach to "occurrence" policies in its decision in *Northern States Power Co. v. Fidelity and Cas. Co. of New York*, 523 N.W.2d 657, 664 (Minn. 1994) (stating that damages which have occurred over multiple policy periods should be presumed to be "continuous from the point of the first damage to the point of discovery or cleanup" and that such damage merges "into one continuing occurrence"). *But see also,* SCSC v. Allied Mut. Ins. Co., 536 N.W.2d 305 (Minn. 1985); Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724 (Minn. 1997).

135. *See* Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981).

136. *See* Doherty, *supra* note 111, at 257.

137. *See id.*

138. *See Keene Corp.* 667 F.2d at 1034.

139. *See* JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS § 3.2, at 865-66 (1994); *see, e.g.*, Eli Lilly & Co. v. Home Ins. Co., 794 F.2d 710, 714 n.6 (D.C. Cir. 1986); ACANDS, Inc. v. Aetna Cas. & Sur. Co., 764 F.2d 968, 972 (3d Cir. 1985); Lac D'Amiante du Quebec, Ltee. v. American Home Assurance Co., 613 F. Supp. 1549, 1556 (D.N.J. 1985); Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 898-99 (Cal. 1995); Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co., 52 Cal. Rptr. 2d 690, 701 (Cal. Ct. App. 1996); Trustees of Tufts Univ. v. Commercial Union Ins. Co., 616 N.E.2d 68, 74 (Mass. 1993); Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 981 (N.J. 1994); J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502, 507 (Pa. 1993) ("Every insurer which was on the risk at any time during the development of a claimant's asbestos-related disease has an obligation to indemnify"). Illinois is said to have a "double trigger," which means that coverage is triggered for asbestos claims against the policyholder on the basis of both exposure and manifestation. *See* Zurich Ins. Co. v. Raymark Indus., Inc., 514 N.E.2d 150 (Ill. 1987).

140. *See* ANDERSON, *supra* note 59, at 7. *See also Domtar*, 563 N.W.2d at 733.

held not to limit the insurer's responsibility for such continuing injury.[141] Subsequent damages flowing from the injury taking place during the policy period are covered along with damages accruing during the policy period.[142]

A cogent exposition of this conclusion is found in a 1993 decision of the New Jersey Superior Court.[143] The court squarely as-

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141. *See Domtar,* 563 N.W.2d at 733.

142. *See id.* (finding the triggered policy fully responsible for ongoing losses related to covered occurrence until the policy limits are exhausted); California Union Ins. Co. v. Landmark Ins. Co., 193 Cal. Rptr. 461, 469 (Cal. Ct. App. 1983) ("[I]n a 'one occurrence' case involving continuous, progressive and deteriorating damage, the carrier in whose policy period the damage first becomes apparent remains on the risk until the damage is finally and totally complete, notwithstanding a policy provision which purports to limit the coverage solely to those accidents/occurrences within the time parameters of the stated policy term."); *see also* Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp., 73 F.3d 1178, 1202-03 (2d Cir. 1995) (applying New York law, where the court concluded that after the insurance coverage was triggered and found applicable, the insurer continued to be responsible for the ongoing cost of injury even though such costs extended well beyond the policy period where the injury first took place); Chemstar, Inc. v. Liberty Mut. Ins. Co., 41 F.3d 429, 436-37 (9th Cir. 1994) (applying California law and holding that when CGL property damage coverage was triggered, the insurer remained responsible for continuing deterioration of the claimant's property due to the insured's wrongful conduct); American Home Assurance Co. v. Libbey-Owens-Ford Co., 786 F.2d 22 (1st Cir. 1986) (claiming to apply Massachusetts law but considering authority from numerous jurisdictions and finding insurer of maker of defective windows used in the John Hancock building liable for all covered damages even if the damages continued past the end of the policy period but provided for apportionment of covered and uncovered property damage claims); Marathon Flint Oil Co. v. American States Ins. Co., 810 F. Supp. 850, 852 (E.D. Mich. 1992) (holding all triggered insurers responsible for ongoing injuries caused by occurrence); May v. Maryland Cas. Corp., 792 F. Supp. 63, 65 (E.D. Mo. 1992) (concluding that the insurer on the risk at the time of the insured's first acts of sexual abuse was responsible for the ongoing damage from continuing inappropriate behavior by the insured towards the claimant); Transamerica Ins. Co. v. Bellefonte Ins. Co., 490 F. Supp. 935, 939 (E.D. Pa. 1980) (finding in coverage disputes between successive insurers of the drugmaker accused of manufacturing a product causing birth defects, each triggered insurer responsible for ongoing damages from the occurrence).

143. *See* Owens-Illinois, Inc. v. United Ins. Co., 625 A.2d 1 (N.J. Super. Ct. App. Div. 1993). Although this decision was reversed in part on other grounds by the New Jersey Supreme Court, the Superior Court opinion remains sound. *See* Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974 (N.J. Sup. Ct. 1994). The Supreme Court decision altered the Superior Court decision regarding apportionment of insurer responsibility, but agreed generally with the statement quoted in the text that a triggered CGL insurer standing alone is responsible for the full consequences of covered bodily injury or property damage even if the injury continues beyond the policy period. *Id.* at 990. The court held that although the "all sums" language of the policy does not preclude allocation, policy language providing coverage for injury "during the policy period" cannot be invoked to limit

sessed the gravamen of the insurers' allocation-based defense and found it incorrect in both contract and equity.[144]

> Defendants contend that each insurer is required to pay only a prorated share of O-I's liability. They argue that once an insurer's coverage is triggered, its share would be determined by the duration of a claimant's exposure during its policy period in comparison to the entire duration of exposure to the insured's products.
>
> We disagree with this contention. However phrased, the insurers' argument is based on their characterization of asbestos-related diseases as consisting of a multitude of discrete injuries to the lung tissue. That description of the disease process defies reality. We declined to rely upon it in determining the triggering event of insurance coverage. It has no greater efficacy in determining the extent of coverage. In our view, questions of the trigger of coverage and the extent of coverage are inextricably intertwined. *We hold that once an insurer's coverage is triggered, it is liable for the full extent of the insured's liability up to the policy limits,* but subject to the "other insurance" clauses contained in the insuring agreement.
>
> Each policy has a built-in trigger of coverage. There is nothing in the policies that provides for a reduction in the insurer's liability if an injury occurs only in part of a policy period. The policies cover O-I's entire liability once they are triggered. For an insurer to be only partially liable for an injury that occurred in part during its policy period would deprive the insured of its objectively reasonable expectations pertaining to the coverage for which it paid.[145]

The California Supreme Court reached the same conclusion:[146]

> [W]e have reviewed the rationale of . . . [other California cases] which, together with the weight of more recent authorities, conclude that where successive CGL policies have been purchased, bodily injury and property damage that is continuing or progressively deteriorating through-

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insurer responsibility; subsequent damages flowing from injury taking place during the policy period are covered along with damages accruing during the policy period. *Id.* at 995-96.

144. *See Owens-Illinois*, 625 A.2d at 27.

145. *See id.* at 26 (emphasis added).

146. *See* Montrose Chem. Corp. of Cal. v. Admiral Ins. Co., 913 P. 2d 878, 901-02 (Cal. 1995).

> out more than one policy period is potentially covered by all policies in effect during those periods.[147]

In an even more recent decision, a California appellate court pointed out the illogical result of the insurers' position on coverage of the continuing injury:[148]

> In any event, the insurers' approach would essentially render the asbestos manufacturers' insurance coverage illusory, for by the time asbestos diseases caused detectable impairments (in the 1970's), insurance companies ceased issuing policies that adequately covered asbestos-related disease. Hence, the insurers' theory would deprive the manufacturers of coverage for product liability injuries of which they were unaware during the policy periods . . . .
>
> There is *nothing* in the policies for a reduction of the insurer's liability if an injury occurs only in part during a policy period.[149]

Referring to the prior California Supreme Court decision, this court found that case to support the proposition that an insurer may be liable for the entire loss up to the policy limits even though the continuing injury may extend over several policy periods:

> Although each policy is triggered only by the occurrence of an injury during the policy period, once a policy is triggered, the policy obligates the insurer to pay all sums for which the policyholder becomes liable. There is nothing in the policies limiting the scope of coverage to that portion of a continuous injury that developed during the policy period. . . . No matter what the tort liability of an asbestos manufacturer—whether joint and several, proportionate to fault or proportionate to market share—the indemnity obligations of its insurers are as set forth in part 2a above: to respond in full to the policyholder's liability obligations up to the policy's limits, subject to apportionment pursuant to "other insurance" clauses.[150]

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147. *See id.*

148. *See* Armstrong World Indus. Inc. v. Aetna Cas. & Sur. Co., 52 Cal. Rptr. 2d 690, 705. (Cal. Ct. App. 1996).

149. *Id.* at 706 (quoting Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034, 1048 (D.C. Cir. 1981) (emphasis in original)).

150. *Id.* at 707, 709, 712 (emphasis in original). Regarding the insurer's responsibility for continuing damage first taking place during the policy period, Professor Abraham notes:

> Would it be correct to say that each policy is liable only for the damage caused by the [hazardous] waste which first caused injury during the pe-

Although permitting the policyholder to exhaust coverage available for multiple years poses some risk of initially inequitable burdens, the potential inequity is remedied by simply giving the implicated insurers rights of contribution vis-à-vis one another.[151] This permits the insurers to settle accounts as to coverage responsibility without forcing the policyholder to receive less insurance than it bargained for, and paid for, and without forcing the policyholder to shoulder the financial burden of waiting for payment. Insurers are to some extent in the banking business.[152] In addition, if insurer responsibility (either occurrence or claims-made) is diminished by an allocation scheme, the policyholder could be overburdened while insurers with available policy limits remaining could be underburdened.[153] This result seems at least as problem-

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riod the policy was in force? That approach would most closely track the language of the pre-1986 standard CGL, which insures, in effect, against liability for damages because of bodily injury or property damage that occurs during the policy period. Thus, as long as some injury first occurred during a given policy period, the policy in effect during that period would be liable for all the injury ultimately resulting from that waste, even if some of the injury also occurred later. This, after all, is the approach that liability policies apply to ordinary injuries: *an insured who injures a victim in an auto accident in 1995, for example, is covered by her 1995 liability policy for all damages resulting, even if the victim suffers pain and incurs medical expense in 1995, 1996, 1997 and 1998.* Any other approach would be chaotic.

Could such a trigger be effectively applied, however, in the hazardous waste setting? Waste may leak from a single drum or group of drums for several years; or waste may be dumped directly onto the ground over several years. Once this material mixes together and begins to cause damage, the portion of damage caused by each separate discharge or discharges in each year normally cannot be disaggregated from the total damage at the site. In the absence of the proof required, is each policy immune from liability, or is each policy liable jointly and severally for all the damage? The latter approach entitles the insured to "stack" the limits of liability available from all triggered policies—possibly underburdening some policies and overburdening others.

See KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 481-82 (2d ed. 1995) (emphasis added).

151. *See* ABRAHAM, *supra* note 150, at 119, 122 (discussing contribution among triggered policies).

152. *See* ANDREW TOBIAS, THE INVISIBLE BANKERS 15 (1982). Compared to even large commercial policyholders, CGL insurers are in a better position to advance funds and equalize contributions among insurers at a later date. *See id. See also* text *infra* at notes 273-76.

153. *See* John H. Mathias et al., *Allocation: J.H. France and the Right to Select from Multiple Triggered Policies*, 4 COVERAGE 19, 21-22 (1994) (noting that allocation schemes other than joint and several liability are unfair to insureds).

atic as broad "joint and several" liability.[154]

I. Allocation Among Multiple Insurers

Since an insurance policy is, after all, a contract, the basic principle applied by the courts is, where possible, to give effect to the appropriately expressed intent of the parties.[155] Thus, in the first instance, a court will look to the language of the respective policies for guidance as to whether the separate provisions can be meshed together, each in accordance with its own terms.[156] If one policy says that its coverage is to be primary, and the other says that its coverage is to be excess, the court will give effect to that choice.[157] The only relevant language, in the CGL context, is usually found in the "other insurance" condition.[158] Because of the ISO decision not to include an express "meshing" provision each CGL insurer points the finger at the other CGL insurers.[159]

As a result, where two or more CGL policies are implicated on the same risk the respective "other insurance" clauses are often irreconcilable and cancel each other out.[160] In this situation courts have defined their responsibility as finding an equitable solution.[161] This search for an equitable solution applies both where there is an occurrence which triggers one policy and where there is an occur-

154. *See* STEMPEL, *supra* note 139, at 856-66 (finding the "joint and several" liability description a misnomer because no triggered insurer is ever liable for more than its policy limits absent bad faith while a jointly liable tortfeasor may be responsible for 100% of the liability even if it is only 1% at fault).

155. *See* Garrett G. Gillespie, *The Allocation of Coverage Responsibility Among Multiple Triggered Commercial General Liability Policies in Environmental Cases: Life After Owens-Illinois*, 15 VA. ENVTL. L.J. 525, 528-29 (1996) (discussing methods by which a court may resolve differences in the expressed intent of the parties).

156. *See id.* at 526.

157. *See* Drake v. Ryan, 514 N.W.2d 785, 789 (Minn. 1994) (observing that standard automobile insurance provides primary coverage to the insured for driving certain vehicles and excess coverage when an insured is driving a non-owned insured vehicle).

158. It is to be noted that this provision provides for allocation among multiple insurers, not among insurers and the insured. *See id.* at 790.

159. *See* Brooke Jackson, *Liability Insurance for Pollution Claims: Avoiding a Litigation Waste Land*, 26 TULSA L.J. 209 (1990) (noting that such finger-pointing is often done in an attempt to share the loss with other insurers).

160. *See* Fire Ins. Exch. v. American States Ins. Co., 46 Cal. Rptr. 2d 135, 138 (Cal. Ct. App. 1995) (stating in context of subcontractor and general contractor, "other insurance" clauses canceled each other out); Robert F. Kane, *Indemnification and Additional Insured Provision: A Primer*, 6 COVERAGE 1, 17 (1996).

161. *See* Hillman & DeYoung, *supra* note 105, at 306; Northern States Power Co. v. Fidelity & Cas. Co. of New York, 523 N.W.2d 657, 660 (Minn. 1994).

rence which triggers multiple policies.[162] As reviewed above, the courts have stated clearly that, in the first instance, the policy for the year during which injury occurred is implicated, and is liable up to the cap limits of the policy for injury in that year and all resulting injury in subsequent years caused by the same occurrence.[163] In this second situation, each insurance policy for each triggered year is potentially implicated.[164] Assuming adequate proof of the injury, the insured should be able to proceed against the insurer at risk on that first year and exhaust the limits of that coverage, and then, assuming an ability to prove resultant injury in subsequent years, proceed to the next year's insurer, and so on. According to one court, the insured may choose which insurer to pursue.[165] The insurers' remedy is allocation between themselves under the "other insurance" provision, but *not* against the insured.[166]

Where there is a series of continuing "occurrences" year by year, the situation may change. In this situation, each new year is a new insurance experience. This was the result arrived at by the court in the well-known *Forty-Eight Insulations* case.[167] The claimed basis of liability in this case was "failure on the part of the manufacturer to warn asbestos workers and other ultimate users of its products that asbestos was a dangerous product which, if inhaled, could cause an early death from cancer or other disease."[168] "[A]sbestosis is a progressive disease. It ordinarily takes years of breathing asbestos fibers for asbestosis to occur. . . . The more asbestos fibers a worker inhales, the more quickly a worker will contract asbestosis."[169] The court in this decision described the progressive and

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162. *See* Davis J. Howard, *"Contiguous Trigger" Liability: Application to Toxic Waste Cases and Impact on Number of "Occurrences,"* 22 TORT & INS. L.J. 624, 624-27 (explaining the distinction between single and continuing occurrences).

163. *See* Maryland Cas. Co. v. W.R. Grace & Co., 23 F.3d 617, 626 (2d Cir. 1993) (noting that an asbestos injury occurred at the point of installation, but not beyond that point); *see also* Howard, *supra* note 162, at 625 ("If injury and damage are deemed to occur at a single point in time, only one CGL policy will arguably provide coverage.").

164. *See* Howard, *supra* note 162, at 625 (noting that injuries developing over a period of years may implicate or trigger two or more CGL policies).

165. *See* Keene Corp. v. Insurance Corp. of N. Am., 667 F.2d 1034, 1041 (D.C. Cir. 1981).

166. *See* ABRAHAM, *supra* note 150, at 121 (noting that the proper remedy is a contribution action among the different insurers).

167. *See* Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1224 (6th Cir. 1980).

168. *Id.* at 1213.

169. *Id.* at 1214.

cumulative nature of the injury involved.[170] Based on the foregoing facts the insured urged that indemnity costs be allocated on the basis of the number of years that a worker inhaled asbestos fibers, and the court agreed.[171]

The critical importance of the distinction between an "occurrence" caused by an unknown quantity and quality of events, as opposed to identifiable, discrete events, is illustrated by recent decisions of the Minnesota Supreme Court involving environmental pollution.[172]

The first such case is *Northern States Power Co. v. Fidelity & Cas. Co. of New York*.[173] The issue before the Court was the allocation of damages between multiple insurers on the risk for pollution clean-up

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170. *See id.*

> The problem is that tiny asbestos particles can become airborne when asbestos is mined and processed, when asbestos materials are used at a construction or other site, and when old buildings containing asbestos are demolished. When these asbestos particles become airborne, a number of them are inhaled by persons in the area. The asbestos particles are deposited in the lungs. *If, over the years, enough asbestos particles are inhaled,* they can cause a variety of pulmonary diseases. Medical science is not certain exactly how these diseases develop, but there is universal agreement that excessive inhalation of asbestos can and does result in disease. These asbestos-caused diseases include mesothelioma, broncheogenic carcinoma (lung cancer), and asbestosis.

Id. at 1214 (emphasis added).

> Cumulative disease cases are different from the ordinary accident or disease situation. First, the underlying theory of tort liability is that the asbestos manufacturers continually failed to warn the asbestos workers and that, as a result of this, continuous breathing of asbestos particles allowed asbestosis to progress to the point where it caused death or injury."

Id. at 1219.

171. *See id.* at 1225.

> Forty-Eight has urged that indemnity costs can be allocated by the number of years that a worker inhaled asbestos fibers. By embracing the exposure theory, we have agreed. There is no reason why this same theory should not apply to defense costs. The different insurance companies will pro-rate defense costs among themselves. It is reasonable to treat Forty-Eight as an insurer for those periods of time that it had no insurance coverage.

Id.

The court also recognized that an insurer should be off the risk for years where there was no inhalation of asbestos fibers—the burden of such showing being upon the insurer. *See id.* "Accordingly, where an insurer can show that no exposure to asbestos manufactured by its insured took place during certain years, then that insurer cannot be liable for those years." *Id.*

172. *See* SCSC Corp. v. Allied Mut. Ins. Co., 536 N.W.2d 305, 318 (Minn. 1995); Northern States Power Co. v. Fidelity & Cas. Co. of New York, 523 N.W.2d 657, 658 (Minn. 1994).

173. 523 N.W.2d 657 (Minn. 1994).

costs.[174] In this case the court was not required to resolve any possible proration against the insured.[175] NSP had entered into a consent order with the Minnesota Pollution Control Agency in 1988 under which NSP was required to pay $1,600,000 in response costs, together with interest, and further monitoring costs of approximately $40,000 per year.[176] NSP then brought a declaratory judgment action against thirteen companies from which it had purchased liability insurance between the years 1946 and 1985.[177] NSP eventually settled with all of the insurers except one, the St. Paul.[178] Five policies, all in the standard CGL format, were at issue.[179] Each contained the standard "other insurance" condition seeking to make the policy excess over any other valid and collectible insurance.[180] NSP argued that all of the carriers were jointly and severally liable, and that the trial court should allocate damages between the carriers "pro rata by limits."[181] The supreme court spoke of NSP's argument as follows: NSP based this argument on the assumption that, under Minnesota law all policies were "triggered" if they were on the risk at any time during which damage occurred, and damage occurred continuously from the date of operations to the present.[182] In an accompanying footnote, the court explained that "[a] policy is 'triggered' if the policy provides some coverage for damages."[183] The trial court had held that St. Paul's "other insurance" clause did not conflict with those in the other policies and that, thus, the St. Paul policies provided excess coverage only.[184] The court of appeals reversed, holding that the St. Paul policies provided primary coverage, and holding further that "damages were to be allocated among the carriers in proportion to the injuries that occurred during each policy period. . . . "[185] The only issues on appeal to the Supreme Court were the "other insurance" and the allocation issues.[186] The court said:

In this case, however, we are not faced with the question

174. *See id.* at 658.
175. *See id.* at 661.
176. *See id.* at 659.
177. *See id.*
178. *See id.*
179. *See id.*
180. *See id.* at 660.
181. *Id.* (footnote omitted).
182. *Id.* at 660.
183. *Id.* at n.3.
184. *See id.* at 660.
185. *Id.*
186. *See id.*

> of whether these claims are "damages," but with how to allocate liability between insurers. This is a very different issue, one which may require a more flexible approach. As with all insurance contract-related issues, courts must consider many factors when deciding this issue, including the policy language, parties' intent or reasonable expectations, canons of construction and public policy.[187]

The court then went on to review the four different 'trigger' theories to be found in the decisions of courts in other states:

> [T]he "exposure" rule, whereby only those policies in effect when the claimant or property was exposed to hazardous materials are triggered; the "manifestation" rule, whereby only those policies in effect when the injury or damage was discovered are triggered; the "continuous trigger" where the policies in effect at the time of exposure, the time of manifestation, and all the time in between are triggered; and the "actual injury" or "injury-in-fact" trigger, whereby only those policies in effect when damage occurred are triggered. . . .

Minnesota follows the "actual injury" or "injury-in-fact" theory to determine which policies have been triggered by an occurrence causing damages for which an insured is liable.[188]

Noting that the choice of "trigger theory" is related to the issue of allocation, the court held a "pro rata by limits" allocation method to be inconsistent with the actual injury "trigger theory."[189] The court stated:

> The essence of the actual injury trigger theory is that each insurer is held liable for only those damages which occurred during its policy period; no insurer is held liable for damages outside its policy period. Where the policy periods do not overlap, therefore, the insurers are consecutively, not concurrently liable. . . .
>
> The question therefore becomes, how may a court allocate damages consistent with the "actual injury" trigger theory? One option would be to apportion the damages as proven; in other words, each policy would cover only those damages that are allocable to harm which occurred during the policy period. This is the approach followed by the court of appeals in this case. . . . A second option

187. *See id.* at 661.
188. *Id.*
189. *Id.*

> would allocate damages pro rata by each insurer's "time on the risk."[190]

The court then indicated its preference for allocation of damages "as proven," but noted the difficulties of proof in the case before it:

> The primary advantage of the first option, allocating damages to each policy "as proven," is that it is completely consistent with CGL policy language limiting liability to damages incurred "during the policy period." Practically, however, this option is unattractive given the scientific complexity of the issues involved, the extended period of time over which damages may have occurred before discovery, and the number of parties potentially involved. As one commentator has noted: [H]olding each policy to cover only that portion of the insured's liability that is allocable to the harm which occurred in the year in question . . . may be theoretically satisfying, but will almost always be infeasible. Given the progressive nature of the environmental harms in question, finding the facts necessary to apply this approach usually would be administratively difficult, scientifically impossible, or both. Consequently, the real issue is which approach to apply when for all practical purposes the bodily injury or property damage suffered during different policy periods is indivisible. . . .
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> . . . We have already concluded that the contamination of the groundwater should be regarded as a continuous process in which the property damage is evenly distributed over the period of time from the first contamination to the end of the last triggered policy (or self-insured) period, and we have also held that the total amount of the property damage should be allocated to the various policies in proportion to the period of time each was on the risk.[191]

The court observed that significant public policy reasons supported its conclusion: "[f]inally, as a public policy matter, this court cannot ignore the enormous difficulty insureds would face if, as is generally the case, they had the burden of proving the *amount* of damages for each policy at issue."[192]

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190. *Id.* (citation omitted).
191. *Id.* at 663 (emphasis added).
192. *Id.* (emphasis in original).

While indicating an intention to allocate by "time on the risk" on the facts before it, the court specifically noted that: "[w]hile such an allocation scheme is attractive for its simplicity, we recognize that damages are by nature fact-dependent and that trial courts must be given the flexibility to apportion them in a manner befitting each case."[193] With profound insight, the Minnesota Supreme Court concluded by noting: "We do not expect that this case will be the "last word" in this area. Environmental liability insurance law, like any other area of law, will have to develop over time and trial courts must be flexible in responding to new fact situations."[194]

In the second case *SCSC Corp. v. Allied Mutual Insurance Co.*,[195] the Minnesota Supreme Court had occasion again to consider CGL liability policies as applied to a case of environmental pollution.[196] SCSC had brought suit to determine its insurers' obligations under liability insurance policies for costs incurred as a result of soil and groundwater contamination.[197] For a period from 1976 to 1988, SCSC had operated a dry cleaning and laundry business at the site in question.[198] As part of that business, SCSC stored, repackaged, and delivered a chemical used in the dry cleaning business.[199] This chemical having percolated into the groundwater, SCSC was required by the Minnesota Pollution Control Agency to develop and pay for remedial work.[200] The jury concluded that the escape of the chemical was due to a significant spill that arose in 1977.[201] The trial court issued an order that every policy in effect during and after the 1977 spill was triggered "vertically."[202] One of the insurers involved argued that the trial court should have allocated damages on the basis of "time on the risk," and should have allocated damages to SCSC for uninsured years.[203] The jury, however, had found that the damage arose in 1977, and that the damages were not divisible for other years.[204] The trial court decided to trigger the relevant insurance policies "vertically" by year, beginning with the policies in effect in

193. *Id.*
194. *Id.* at 665.
195. 536 N.W.2d 305 (Minn. 1995).
196. *See id.* at 307.
197. *See id.* at 308.
198. *See id.* at 308-09.
199. *See id.* at 308.
200. *See id.* at 309.
201. *See id.* at 310.
202. *See id.*
203. *See id.* at 317.
204. *See id.*

1977.[205] The Supreme Court, however, determined otherwise:

> Under the facts of the present case, we reject the multiple-year vertical triggering approach taken by the trial court. We also decline Tower's invitation to apply NSP's pro rata by time on the risk triggering approach. In NSP, the damages occurred over multiple policy periods, and without evidence to the contrary, we concluded that such damages must be assumed to be continuous. Our decision in NSP was an equitable decision based upon the complexity of proving in which policy periods covered property damage arose. In the present case, however, we have sufficient evidence indicating that the damage arose from a single event in 1977. . . . Based on these findings, the only covered "occurrence" was the 1977 spill. The continual leaching of the chemicals from the soil into the groundwater did result in damages to SCSC because of property damage. However, only Allied's 1977 $100,000 primary policy and Tower's 1977 $1,000,000 excess policy are triggered. . . .[206]

An even more recent case, *Domtar, Inc. v. Niagara Fire Insurance Co.*,[207] dealt with another problem arising out of the standard CGL policy form and environmental pollution.[208] Domtar challenged the decision of the trial court allocating to Domtar the responsibility for damages to the site during periods when Domtar did not have insurance coverage.[209] Domtar operated a plant on the site in question from 1924 through 1929 and from 1934 to 1948.[210] The plant was closed in 1948 and sold in 1955.[211] The Minnesota Pollution Control Agency initiated a Request for Response Action against Domtar in 1991.[212] Between 1956 and 1970 Domtar purchased primary and excess coverage from several insurers.[213] There was no evidence of insurance coverage before 1956 or after 1970.[214] The jury found that pollution damage commenced in 1933 and that some damage oc-

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205. *See id.* at 310.
206. *Id.* at 318.
207. 552 N.W.2d 738 (Minn. Ct. App. 1996), *aff'd in part, rev'd in part*, 563 N.W.2d 724 (Minn. 1997).
208. *See id.*, at 742.
209. *See id.*
210. *See id.*
211. *See id.*
212. *See id.*
213. *See id.* at 743.
214. *See id.*

curred during the years insurance policies were in force.[215] The trial court directed that the remediation costs be allocated pro rata across the number of years 1933 through 1991.[216] Domtar, then, was held liable for damages allocated to the years from 1933 to 1956 and after 1970.[217] The court of appeals affirmed the trial court's decision.[218] The court of appeals relied on the fact that the supreme court in *Northern States Power Co.*, cited two cases, in which both courts allocated a portion of the loss to the insured for self-insured years.[219] "In sum, by reason of the NSP holding, the insurers do not have responsibility for parts of continuous damage that occurred outside their policy periods."[220] It is important to note that the court emphasized the continuing nature of the "occurrences," and that both cases dealt only with occurrence policies. The Minnesota Supreme Court recently affirmed the trial court's conclusions regarding the insurer's responsibility.[221] In so doing, the supreme court gave important further guidance on those situations to which NSP and its rebuttable evidentiary presumption applies and those to which it does not:

> It is inaccurate to conclude that a CGL insurer is never liable for damages occurring outside of the policy period. CGL policies come in many forms and it is a mistake to read our case law as if the scope of coverage has been resolved for all such policies, no matter what their language. The proper scope of coverage also will depend on the facts of the case. When environmental contamination arises from discrete and identifiable events, then the actual-injury trigger theory allows those policies on the risk at the point of initial contamination to pay for all property damage that follows. This interpretation of the policies is in accord with the common understanding of the terms "occurrence" or "accident."[222]

The court explained further:

> It is only in those difficult cases in which property damage is both continuous and so intermingled as to be practi-

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215. *See id.*
216. *See id.*
217. *See id.*
218. *See id.*
219. *See id.* at 744.
220. *Id.* at 745.
221. *See* Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724 (Minn. 1997).
222. *Id.* at 733 (citation omitted).

cally indivisible that NSP properly applies.[223]

III. HOW DOES "TIME ON THE RISK" WORK IN THE LIGHT OF THE SHIFT FROM "OCCURRENCE" BASED COVERAGE TO "CLAIMS-MADE" COVERAGE IN 1986?

As noted above, all three Minnesota decisions on environmental pollution referenced a rebuttable evidentiary presumption that the injuries or "occurrences" occurred in each and every year between the date of the "escape" and the date of the claim, and in *SCSC*, displacement of that presumption since there was a discrete identifiable event. These cases all dealt with the difficult issue of occurrence coverage for environmental contamination where neither the policyholder nor insurers specifically foresaw or underwrote for the legal risk posed by later enacted CERCLA.[224] Even so, where there was an identifiable event, *SCSC* and *Domtar* confirm that the occurrence insurers on the risk when that discrete identifiable event occurred are responsible for "all sums" liability.[225]

When the court did spread responsibility pro rata among insurers, it cited to cases where the insured could have purchased occurrence insurance in each and every year of exposure and the failure to purchase or have available such insurance coverage represented an election by the insured to "go bare," or assume the responsibility of an insurer itself for that year or such years.[226]

From and after 1986, for many large policyholders "occurrence" based coverage was no longer commercially available in amounts of any consequence.[227] The only available coverage thereafter was "claims-made."[228] How might proration by "time on the risk" work if the exposure span began before 1986 and continued into a period when only claims-made insurance was available? Consider the fol-

223. *Id.*

224. 42 U.S.C.A. §§ 9601-675 (1995 & Supp. 1998).

225. *See* SCSC Corp. v. Allied Mut. Ins. Co., 536 N.W.2d 305, 307 (Minn. 1995) (involving yearly percolation of chemicals into groundwater); Northern States Power Co. v. Fidelity & Cas. Co. of N.Y., 523 N.W.2d 657, 659 (Minn. 1994): Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724 (Minn. 1997).

226. *See Northern States Power Co.*, 523 N.W.2d at 659; *Domtar*, 563 N.W.2d at 733; Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980).

227. *See* Jim L. Julian, *Insurance Coverage for Environmental Clean-up Costs Under Comprehensive General Liability Policies*, 19 U. ARK. LITTLE ROCK L.J. 57, 58-9 (1996) (discussing the insurance industry's switch from occurrence to claims-made policies).

228. *See id.*

lowing example: Suppose that a substantial environmental spill occurred in 1981 and that a claim was asserted for injury attributable to that spill in 1990. Suppose further, that the insured had "occurrence" based coverage in the amount of $1 million for each of the five years 1981-1985. Suppose further still, that the insured had "claims-made" coverage for each of the years 1986-1990, likewise in the amount of $1 million for each such year. Assume that the rebuttable evidentiary presumption is not disproved. How should allocation by "time on the risk" be determined?

Following a recently asserted argument,[229] the "occurrence" insurers might take the position that the period of years over which the proration is to be calculated is ten—namely, 1981-1990. The "claims-made" insurers would without a doubt take the position that the policies for the years 1986-89 are not triggered, and therefore are in no way on the risk, since no claim was asserted within the term of the policy in each of those years. The "claims-made" insurer for the year 1990 might concede, in the face of an appropriate fact-finding that the 1990 policy was triggered. But the 1990 insurer would likely point to the newly included "other insurance" clause inserted in the "claims-made" policies which provides that the "claims-made" coverage is to be excess over any other available insurance (i.e. available to fill in for triggered policy exhaustion, gaps, insolvencies etc.). *Forty-Eight Insulations* and *Northern States Power Co.* only involved "occurrence" policies.[230] Would it be appropriate to treat the claims-made policies from 1986-90 as though they were "occurrence" policies, knowing that the trigger is entirely different and that the limits which the policyholder purchased from 1986 to 1989 would not be available, even on an excess basis, for a claim first asserted in 1990?

The Second Circuit Court of Appeals addressed this issue in the recent *Stonewall* decision.[231] This was a case of asbestos inhalation

229. *See* Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp., 73 F.3d 1178, 1204 (2d Cir. 1995). In *Stonewall,* the court directed proration against the insured for periods where the insured could have purchased applicable insurance but failed to do so. For periods when it was impossible for the insured to purchase applicable insurance the court directed *no* proration against the insured. See discussion at note 231 *infra.*

230. *See* Insurance Co. of N. Am. v. Forty-Eight Insulations, 633 F.2d 1212, 1216 (6th Cir. 1980); Northern States Power Co. v. Fidelity and Cas. Co. of N.Y., 523 N.W.2d 657, 664 (Minn. 1994).

231. *See Stonewall,* 73 F.3d at 1202-04. In *Stonewall,* the court discussed a variety of factors affecting an insurer's pro rata share of damages. *See id. See also* discussion at note 235 *infra.*

over a series of years.[232] The court had before it, among other issues, the question of allocation concerning periods when the insured had not purchased insurance.[233] As to those periods where the insured could have purchased applicable occurrence insurance but failed to do so, the court directed appropriate proration against the insured.[234] As to periods after which it became impossible for the insured to purchase applicable insurance, namely after 1985, the court modified the lower court decision so as to relieve the insured from any proration based on those years after which asbestos insurance became unavailable.[235] The court concluded that adopting the insurers' view of proration across the total number of years would leave the insured largely uninsured for current claims.[236]

> [W]e do not agree with the District Judge's subsidiary ruling that proration-to-the-insured should be applied to years after 1985 when asbestos liability insurance was no longer available. Judge Martin applied proration-to-the-insured even after 1985. His rationale was that NGC had "bargained away coverage by accepting asbestos exclusion clauses." We think that is not a realistic view of the situation. There is no reason to believe that any bargaining occurred with respect to the asbestos exclusion clauses.
>
> Moreover, we note that judges who have endorsed proration-to-the-insured have done so only to oblige a manufacturer to accept a proportionate share of a risk that it elected to assume, either by declining to purchase available insurance or by purchasing what turned out to be an insufficient amount of insurance. . . . Judge Martin's opinion appears to be the only one applying proration-to-the-insured to years when asbestos liability insurance was no

232. *See id.* at 1190. The underlying claims asserted in *Stonewall* included both asbestosis and asbestos-induced cancer claims. *See id.* With respect to these latter claims the district court had held that this type of injury occurred only at or shortly after inhalation of asbestos fibers and that only those policies in effect during that limited time period were triggered. *See id.* The circuit court remanded this aspect of the decision of the lower court for further consideration. *See id.* at 1219.

233. *See id.* at 1187.

234. *See id* at 1203. "When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable. . . ." *Id.* (citation omitted).

235. *See Stonewall*, 73 F.2d at 1191.

236. *See id.* at 1193.

longer available.[237]

This logic applies at least as forcefully to the situation where the insurers forced the substitution of "claims-made" coverage for the earlier "occurrence" based coverage. This created the prospective unavailability of prorating insurance after 1985, with the possible exception of one year's proration to the policy in force in the year in which the claim was finally asserted, if that policy was not determined to be excess.

Thus, in what appears to be the only reported case where occurrence insurers attempted to spread their tail liability into claims-made years, a federal court rejected the argument in the following terms:

> The insurers also argue that to the extent the Court finds the "continuous trigger" theory of coverage applies to Hatco's claims, Grace could have sought coverage under all of the EIL policies in effect from 1981 through 1985. This argument is without merit. Coverage under occurrence-based policies is triggered by damage resulting during the policy period. Coverage under claims-made policies is dependent only on whether the claim arose during the policy period. The continuous trigger theory of coverage is strictly an interpretation of the policy language of "occurrence-based" policies that holds coverage under multiple policies to be triggered when damage is indivisible and continuous during multiple policy periods. See Section II of this Opinion above. Thus, the continuous trigger theory has no application to "claims-made" policies, under which the occurrence of damage during the policy period is irrelevant.[238]

The trial court's conundrum in *Stonewall*, arrived at by applying *Forty-Eight Insulations* literally to the situation where the insurers had withdrawn the coverage, is derived from the evidentiary presumption that the injury occurred equally in each year from date of injury to date of claim.[239] This evidentiary presumption was created in the first place to aid the insured in overcoming an insurer argument that the insured was failing to establish actual injury during the particular policy year, and thus failing to establish that such policy was

237. *Id.* at 1203-04.

238. Hatco Corp. v. W.R. Grace & Co. v. Allstate Ins. Co., 801 F. Supp. 1334, 1373 n.25 (D.N.J. 1992).

239. *See Stonewall*, 73 F.3d at 1191.

"triggered" at all.[240] It would be paradoxical for a court to now use that judicially created presumption to reduce the insured's already "triggered" coverage annually, following the switch in insurance forms. If, indeed, the insurer established that there were a new intervening cause, accompanied by new intervening injury, following the switch in policy forms, that would be a different case. The *Stonewall* approach[241] is not, then, inconsistent with recognition of the right of the insurer to change the policy format to "claims-made" with respect to risks that first attached after the inception of such "claims-made" policy.[242] It gives appropriate effect to an insurer decision to exclude liability for pollution, or require assertion of a claim during the policy term as the "trigger" of coverage, but it does not allow the insurer to attempt to change, retrospectively, the nature and extent of the liability that had already attached under the old "occurrence" policy form.

The trial court's approach suggests possible confusion between two very different processes: (1) the allocation pursuant to the "other insurance" condition, between insurers who are all on the risk, or (2) the proration against the insured in situations where that insured had no opportunity to purchase potentially allocable insurance in the later years of a continuing injury.[243] Proration against the insured, based on "time on the risk" measured from the date of "escape" to the date of the claim, produces a remarkable anomaly when applied across the transition from "occurrence" to "claims-made" coverage. That anomaly consists in the ratable reduction of the insured's recovery by each year of delay in the assertion of the claim by the plaintiff following the switch in policy forms. Any such result would be unique in the realm of insurance law—the creation of "disappearing coverage."

A. How Should the Solution of These Problems Caused by the Switch in Policy Forms Be Affected by Traditional Basic Concepts of Insurance Law?

As one court summarized more than a decade ago:

General principles of insurance policy interpretation are:

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240. *See* Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1216-17, 1224 (6th Cir. 1980) (adopting the exposure theory which argues that injury takes place at time of exposure. All insurance policies in effect during any period of exposure are, then, triggered.

241. *See Stonewall*, 73 F.3d at 1191-92.

242. *See id.* at 1203.

243. *See id.*

> (1) the objective in construing the policies' coverage of liability must be to give effect to the policies' dominant purpose of indemnity; (2) ambiguity in an insurance contract must be construed in favor of the insured; (3) the Court should ordinarily strive to give effect to the objectively reasonable expectations of the insured.[244]

B. The Continuing Vitality of Contra Proferentem

Although insurance policies are like other contracts,[245] in that clear language is enforced if it does not run counter to the insured's reasonable expectations and is not unconscionable,[246] the mass standardization of the CGL policy, its language, and its application to a host of varying situations frequently creates ambiguity in the process of application. As a result, the principle of construing ambiguous contract language against the drafter is frequently relied on in insurance cases construing this form.[247]

This principle, while clearly documented in a leading decision of the Minnesota Supreme Court,[248] has come under attack by some scholars as too simplistic and anti-insurer.[249] However, Professor Abraham, a leading scholar in the field, recently examined insurance interpretation theory and found the approach of construction against the drafter well suited to the difficult task of adjudicating insurance coverage.[250]

The first principle of insurance law is captured by the

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244. See Hancock Lab., Inc. v. Admiral Ins. Co., 777 F.2d 520, 523, n.5 (9th Cir. 1985) (applying California law) (citing GEORGE J. COUCH, COUCH ENCYCLOPEDIA OF INSURANCE LAW §§ 15:41, 15:14, 15:16, 15:74 (Anderson 2d ed. 1959)).

245. *See* COUCH, *supra* note 244, §15:4.

246. *See id.*

247. *See* STEMPEL, *supra* note 139, at §§ 3, 5. (citing Nationsbank of North Carolina, N.A. v. Variable Annuity Life Ins. Co. 513 U.S. 251 (1995)).

248. *See, e.g.*, SCSC Corp. v. Allied Mut. Ins. Co., 536 N.W.2d 305, 316 (Minn. 1995) (stating that "[a]ny ambiguity regarding coverage is resolved in favor of the insured") (citation omitted).

249. *See* David S. Miller, Note, *Insurance as Contract: The Argument for Abandoning the Ambiguity Doctrine*, 88 COLUM. L. REV. 1849, 1857 (1988) ("The protection offered by the ambiguity doctrine against overreaching by insurance companies is inappropriate when an insurance policy is the product of arms-length bargaining."); Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against the Drafter*, 30 GA. L. REV. 171, 174, 187-207 (1995) (discussing the costs imposed on insurers when ambiguities are construed against the insurer).

250. *See* Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531, 533 (1996).

> maxim *contra proferentem*. . . . [I]n addition to *contra proferentem*, policyholders may invoke such allied doctrines as waiver, estoppel, and the rule that reasonable expectations of the insured should be honored even if those expectations are unambiguously contradicted by fine-print provisions in the policy.
>
> . . . On balance, I prefer the traditional conception of *contra proferentem* and a weaker version of the expectations principle. This combination leaves the courts to do more of what they are comparatively capable of doing—interpret—and less of what they tend to do poorly—regulate. Courts treat insurance policies differently than other contracts "because of their unique characteristics such as standardization, marketing on contract of adhesion basis, complexity, policyholder reliance and vulnerability."[251]

The time-honored process of interpreting questionable insurance coverage in favor of the insured and against the insurer reflects a number of factors inherent in the underwriting and purchase of insurance.[252] The essential purpose of insurance is to provide a measure of security and protection for the insured.[253] Timely reimbursement of the insured for expense and loss, encouragement of settlement, maximum certainty of result and minimum risk, and cost of litigation to determine outcomes, are all a part of this approach.[254] An insurance policy is supposed to provide coverage, rather than be an invitation to a lawsuit.[255] The threat of the process turning into just this invitation to a lawsuit is substantially compounded where, as in both the "occurrence" and "claims-made" policies, the policy can

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251. *See id.* at 531-32, 568-69; *see generally* James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995, 999-1000 (1992) (examining common justifications for treating insurance contracts differently); Roger Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823, 827 (1990) (applying traditional principles of *contra proferentem* to the reasonable expectations doctrine); Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 OHIO ST. L.J. 1037, 1050-54 (1991) (discussing the theory that insurance contracts are not ordinary contracts); Jeffrey W. Stempel, *Reading Between the Lines: Insurance Contract Interpretation*, TRIAL, Sept. 1995, at 74.

252. *See* Fischer, *supra* note 251, at 999.

253. *See* David Tartaglio, *The Expectation of Peace of Mind: A Basis for Recovery of Damages for Mental Suffering Resulting from the Breach of First Party Insurance Contracts*, 565 CAL. L. REV. 1345, 1346, 1362 (1983).

254. *See id.* at 1345-51

255. *See id.* at 1346-47.

be, and frequently is, written as indemnity rather than liability coverage. Under this form, the insurer can simply sit back, force the insured to incur years of investigation, defense, and settlement of the underlying risk, leave the insured "twisting slowly in the wind," and then contest every facet of the insured's conduct of the defense and compliance with every nit, actual or supposed, in the policy.[256] Faced with very large claims for indemnification, some insurers consistently raise and contest every conceivable point, apparently without regard to positions they took in other cases or positions taken by other members of the ISO.[257] Recent mass tort insurance litigation suggests the difficulties caused by such behavior patterns with respect to large corporate insureds.[258] These behavior patterns are apt to have an even more serious impact on the smaller insured who lacks either the funding or the staying power to litigate for years with an insurance carrier or carriers. Respect for the interests and expectations of the smaller insured, and recognition of the impact of insurer delays on the cash flow of insureds, underlies a great deal of the judicial attitude toward interpretation of insurance policies. There is, unfortunately, an important and basic difference between automobile liability coverage, where the insurer must provide both investigation and defense, and cover reasonable settlements at the risk of being found to have acted in bad faith under well-developed law, and CGL coverage where a common insurer practice is to do nothing, make the insured investigate, settle or pay the judgment, and then come after the insurer. Such insurer behavior patterns can operate, in a substantial way, to deprive the insured of much of the benefit thought to be derived from the purchase of insurance. Insurer payment delayed, and insurer obligation to pay sometimes unreasonably contested, both lead to a serious loss of, or reduction in, the benefit contracted for.

C. Peace of Mind and Invited Reliance

Insurers sell and policyholders buy peace of mind and protection of assets. Speakers on behalf of insurers and insurer advertise-

256. *See* Veteran's Mem'l. Med. Ctr. v. Connecticut Ins. Guar. Ass'n, No. CV 940246875, 1996 WL 6734264, at *2 (Conn. Super. Ct. Oct. 23, 1996).

257. *See* Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp., 73 F.3d 1178, 1192. (2d Cir. 1995). *Stonewall* discusses the inability of insurers to agree to definitions of policy terms such as bodily injury. *See id.*

258. *See In re* Dow Corning Corp. 198 B.R. 214, 251 (Bankr. E.D. Mich. 1996).

ments reinforce these concepts.[259] "Electrifying Performance," "Spectacular Results," trumpets one. "Let us take the risks," says another; "In fact, we don't believe there's any such thing as a 'standard' risk. Instead, we believe every risk can be better served by a creative underwriting approach"; "Serve your customers imaginatively and thrive. Serve your customers or else"; "You get action with [named insurer]"; "You know insurance can cost a lot more than just premiums. That's why you need [named insurer]. We do everything we can to reduce your insurance costs in the first place, so you don't end up paying for it later."

D. Determining the Number of Occurrences—A Preference for Maximizing Coverage

The bewildering number of court decisions interpreting CGL policies might give the appearance of facial inconsistency. In some cases, for instance, multiple claims have been treated as one occurrence,[260] whereas in other cases, they have been treated as separate occurrences.[261] In almost all cases, however, consistency appears to lie, as it should, in the court's determination to maximize the use of available triggered insurance. The number of occurrences can be a matter of critical importance because it can affect whether more than one limit of liability applies, and because it also can determine the effect of a provision specifying a deductible when an insured is entitled to indemnification.[262] Most courts have used "cause" analysis to determine the number of occurrences according to the number of causes of covered loss.[263] A few courts have used an "effects" analy-

259. *See* ANDERSON ET AL., *supra* note 59, app. A, at 447 (referring to a insurer's 1966 statement about the unprecedented coverage of the "occurrence" policy)

260. *See* Michigan Chem. Corp. v. America Home Assurance Co., 728 F.2d 374, 378 (6th Cir. 1984). In that case, Michigan Chemical allegedly shipped contaminated livestock feed which was eventually distributed to unsuspecting dairy farmers throughout Michigan. *See id.* at 376. As a result, hundreds of claims were filed against Michigan Chemical which then submitted the claims to its insurer. *See id.* The court held that the accidental shipment was the sole occurrence under the policy, regardless of the number of claims. *See id.* at 379.

261. *See* Maurice Pincoffs Co. v. St. Paul Fire & Marine Ins. Co., 447 F.2d 201, 206-07 (5th Cir. 1971) (stating that the occurrence under the policy was each sale by the insured of contaminated bird feed).

262. *See* Diocese of Winona v. Interstate Fire & Cas. Co., 89 F.3d 1386, 1390 (8th Cir. 1996).

263. *See Michigan Chem.*, 728 F.2d at 379 (applying Illinois law); *Maurice Pincoffs*, 447 F.2d at 206-07 (applying Texas law); Transport Ins. Co. v. Lee Way Motor Freight, Inc., 487 F. Supp. 1325, 1330 (N.D. Tex. 1980) (applying Oklahoma

sis, which determines the number of occurrences by the number of victims or claimants impacted by the event at issue.[264] The triggered insurance, however, is generally maximized in accordance with canons of insurance policy construction.[265]

In the provision of insurance coverage for products liability there is usually a particularly strong underlying reason for choosing a "cause" analysis.[266] The complaint, after all, usually alleges a defect in design or manufacture, and/or an alleged failure to warn.[267] The alleged defect is often generic to the product line as a whole rather than specific to one particular example.[268] Nevertheless, cases such as *Michigan Chemical* and *Maurice Pincoffs*[269] illustrate the malleability of cause analysis. In both cases, the courts could have viewed the manufacture of contaminated animal food as one occurrence for which there was coverage.[270] Instead, both cases found multiple causes, and hence more available insurance, by deeming each wholesale shipment of cattle or bird feed to be the cause of damage. If, however, the courts had taken this analysis much further and, for example, found every retail sale to be an occurrence, or every animal's ingestion to be a cause (thereby metamorphasizing cause analysis into effects analysis), the policyholder would have been hard pressed to enjoy as much coverage. Although either of the two hypothetical approaches would have made more coverage available at the top, each finding of an occurrence would also have required the policy-

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law); STEMPEL, *supra* note 149, § 35.3.

264. *See* Elston-Richards Storage Co. v. Indemnity Ins. Co. of N. Am., 194 F. Supp. 673, 682 (W.D. Mich. 1960) (applying Illinois law) (noting that each injury constitutes a single occurrence, even if the result of a common cause).

265. *See id.* at 679 (setting forth well-recognized rules of insurance policy construction).

266. Three public policies underlie products liability law: "(1) to place the burden of loss on those who can spread the costs of injuries to all purchasers; (2) to promote accident prevention; and (3) to relieve injured consumers of the often impossible burden of proving a manufacturer's negligence." W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 98, at 692-93 (5th ed. 1984); *see also* Union Pump Co. v. Allbritton, 898 S.W.2d 773, 784 (Tex. 1995) ("Based on these policies, one logical limit for liability in product liability cases would be to restrict recovery to those damages caused by the use of the defective product and to those damages against which manufacturers can feasibly insure.") (emphasis in original omitted).

267. *See Elston-Richards*, 194 F. Supp. at 678.

268. *See id.* at 677-78.

269. *See supra* notes 260-61.

270. *See id.* While the court in *Michigan Chemical*, found the shipment of contaminated feed to be the "occurrence" and not the subsequent multiple resales, it noted that had there been more than one shipment, each such shipment would have been a separate "occurrence." *See* 728 F.2d 374, 383 (6th Cir. 1984).

holder to spend its own funds to satisfy the deductible or self-insured retention necessary to obtain coverage.

Similarly, in environmental pollution cases involving harms resulting from the disposal of toxic materials, courts have often concluded that for the purpose of assessing the applicability of liability insurance, there is a single occurrence for purposes of triggering each coverage period.[271]

E. Time and Cost to the Insured and Society of Delayed Coverage

When a loss occurs, a policyholder is generally in need of timely protection.[272] Once again, insurance advertisements recognize and emphasize this need. Allowing litigation to focus on insurer proration, as contrasted with allocation between insurers, often leaves the insured sitting for years while the insurers argue about respective shares.[273] Extended dispute and delay over issues of allocation rapidly impairs the reasonable expectations of the insured in purchasing insurance in the first place. It may also complicate, or even frustrate, any opportunity on the part of the insured to settle a large claim.[274] The insured, without the participation of the insurer, may simply not have the funds needed to achieve a reasonable settlement.[275] An insurer with deep pockets, able to throw almost endless dollars at a lawsuit, can exert unfair economic pressure on many insureds who lack such means.[276] Insurers are also often said to lose money on the underwriting side of the business while more than making up for this loss on the investment side. The significance of this, with respect to insurer tactics of delay and postponement, is clear. The longer the delay in payment exists, the greater the opportunity to realize investment side returns. Given the difference in spread between the applicable rates of prejudgment interest compared with investment

271. For example, the Minnesota Supreme Court decided in *Northern States Power Co.* that there had been one occurrence for purposes of each applicable policy because the covered claim—soil pollution and remediation—stemmed from one underlying cause. 523 N.W.2d 657, 664-65 (Minn. 1994).

272. *See* Spencer v. Aetna Life & Cas. Ins. Co., 611 P.2d 149, 152 (Kan. 1980) ("An insured is usually suffering from physical injury or economic loss when bargaining with the insurance company . . . .").

273. *See Northern States Power*, 523 N.W.2d at 662-63.

274. *See Spencer*, 611 P.2d at 152 (noting that one of the reasons for an independent bad faith tort against insurers is to cure the inequitable bargaining position between insurer and insured).

275. *See id.*

276. *See id.*

returns, the economic incentive for insurers to delay rather than pay is very great. Courts need to be aware of this significant imbalance of power in deciding insurance cases.

Delay in settlement or payment can have another steady, if somewhat concealed, result. Current inflation rates, are relatively benign. But 3 to 4% a year, compounded annually, quickly makes a significant difference in the ultimate payment to the insured where that payment is delayed by five years or more of wrangling in the courts—and the typical ultimate payment is not adjusted for inflationary effect.

Promoting and encouraging settlement of litigation is a crucial part of our civil justice process.[277] Judge Weinstein, for example, spoke effectively of the importance of public policy in favor of settlement in the "Agent Orange" case.[278] The prospect of insurers arguing among themselves over their respective obligations to the policyholder tends to stifle the settlement of underlying claims.[279] A policyholder may often have no source for settlement payment other than its insurance proceeds. If those proceeds are held up because insurers are arguing over allocation, a policyholder may have no choice but to proceed to trial even in cases that should be settled.

F. Creating Incentives for Appropriate Behavior by Insurers

Because of the untenable position in which a policyholder is placed when an insurer fails to fulfill its commitments,[280] courts have responded with a number of rules to deter insurer misconduct and rectify the consequences in a relatively streamlined, effective manner.[281] If an insurer fails to perform its defense obligations, either before the fact or after the fact (by failing to make prompt payment of such expenses), or otherwise takes unfair advantage of its insured which is faced with a claim situation, additional damages should be

277. *See* Pierce v. Atchison, Topeka & Santa Fe Ry. Co., 65 F.3d 562, 572 (7th Cir. 1995) (stating that the encouragement of voluntary settlement of civil claims is an important federal policy).

278. *See In re* Agent Orange Prod. Liab. Litig., 597 F. Supp. 740, 747 (E.D.N.Y. 1984).

279. *See Northern States Power*, 523 N.W.2d at 663 (noting the unlikelihood of settlement when insurers are embroiled in allocation disputes).

280. *See Spencer*, 611 P.2d at 158 ("The legislature has recognized the public interest nature of the insurance industry and has also recognized policy holders require protection because of their inequitable bargaining position.").

281. *See* KEETON & WIDISS, *supra* note 37, § 7.8, at 877.

considered.[282] One obvious remedy is to find bad faith against the insurer.[283] A majority of jurisdictions treat insurer bad faith as a tort subjecting the insurer to possible punitive damages.[284] A significant minority of states, however, treat insurer bad faith as akin to a super-breach of contract and provide only contract-based remedies for the policyholder.[285] Although incidental and consequential damages for insurer bad faith can be substantial, they still pose significantly less deterrence for insurer bad faith than the tort action.[286]

Even in a state with a strong array of tort remedies available for insurer bad faith,[287] insurers may not be adequately deterred from breaching their obligations. So long as the insurer can articulate a seemingly reasonable basis for its actions disputing coverage, it has a chance of avoiding bad faith liability, particularly punitive damages, which must ordinarily be demonstrated by clear and convincing evidence.[288] As a result, bad faith exposure alone will ordinarily not be sufficient to protect policyholders if an insurer wrongfully fails to defend, defends in a conflict-of-interest situation, mishandles the defense, fails to pay costs of investigation, defense and settlement promptly, or otherwise takes unfair advantage of its insured.

Consequently, a number of jurisdictions provide that if the in-

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282. *See id.* at 878. *See also* Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724 (Minn. 1997) where the Minnesota Supreme Court affirmed an award of defense costs as damages together with an award of legal costs incurred in pursuing recovery from the insurer.

283. *See* STEMPEL, *supra* note 139, § 19; *see* KEETON & WIDISS, *supra* note 37, §7.8(b), at 881.

284. *See* KEETON & WIDISS, *supra* note 37, § 7.8(h), at 898 ("Courts in many states have now concluded that when an insurer acts in reckless disregard of its insured's rights, an award of punitive damages may be justified.").

285. *See* STEMPEL, *supra* note 139, §§ 19.2, 19.3; *see also* Seifert v. Farmers Union Mut. Ins. Co., 497 N.W.2d 694, 697 (N.D. 1993) (declining to extend the tort concept of negligence to acts or omissions of insurers).

286. "[C]haracterizing the cause of action as a tort claim [as opposed to a contract claim] may broaden the measure of damages available to a claimant." KEETON & WIDISS, *supra* note 37, § 7.8, at 878.

287. *See, e.g.*, Crisci v. Security Ins. Co., 426 P.2d 173, 179 (Cal. 1967) (recognizing tort remedies for mental suffering against an insurer who wrongfully refused to settle a third party claim); Fletcher v. Western Nat'l Life Ins. Co., 89 Cal. Rptr. 78, 93 (Ct. App. 1970); Farmers Group, Inc. v. Williams, 805 P.2d 419, 426 (Col. 1991) (affirming a common-law tort remedy for bad faith breach of an insurance contract); Dold v. Outrigger Hotel, 501 P.2d 368, 372 (Haw. 1972) (recognizing a cause of action for tortious breach of contract); Story v. City of Bozman, 791 P.2d 767, 773 (Mont. 1990) (recognizing that "an insurer's statutory duties create a duty of good faith and fair dealing sounding in tort and running to both the insured and third party claimants").

288. *See* KEETON & WIDISS, *supra* note 37, § 7.10, at 921-22.

surer controlling the defense rejects a reasonable settlement offer, it is liable for any resulting judgment against the policyholder, even if the judgment exceeds the policy limits.[289] Where an insurer fails to defend or pay defense costs, or abandons the defense in midstream, insurers are often found liable for not only policy limits but also consequential damages such as counsel fees in prosecuting the coverage action against the insurer.[290]

IV. HOW THE TRADITIONAL CANONS OF INTERPRETATION, INCLUDING THE CONCEPT OF REASONABLE EXPECTATIONS, CAN APPLY IN RESOLVING ISSUES OF "TAIL" LIABILITY UNDER THE "OCCURRENCE" POLICIES WRITTEN PRIOR TO 1986

As discussed above,[291] "occurrence" policies have been regularly construed to include later damage that resulted from an injury that occurred during the policy term.[292] The issue often litigated has been the allocation of liability under these "occurrence" policies together with the insurer-argued-for proration of part of the loss against the insured.[293]

Also as discussed above, the ISO and its member insurers must be held responsible for the ambiguities inherent in the definition of "occurrence," the conscious choice not to incorporate a meaningful allocation provision in the policy, and their representations, in or about 1986, that the new "claims-made" policy would not affect the operation of the previous "occurrence" policy. Application of either or both of the ambiguity and reasonable expectations doctrines reinforces the conclusion that once the coverage of an "occurrence" policy has been triggered with respect to an injury, the proceeds of that policy should be available to the insured without proration.[294] The

289. *See e.g.*, Johansen v. California State Auto Ass'n, Inter-Ins. Bureau, 538 P.2d 744, 746 (Cal. 1975); Crisci v. Security Ins. Co., 426 P.2d 173, 176 (Cal. 1967); *see also* Northfield Ins. Co. v. St. Paul Surplus Lines Ins. Co., 545 N.W.2d 57, 60 (Minn. Ct. App. 1996) (citing Short v. Dairyland Ins. Co., 334 N.W.2d 384, 387 (Minn. 1983) (stating that an insurer may become liable in excess of its coverage under a policy if it fails to exercise good faith in considering settlement offers for an amount within the policy limit)).

290. *See, e.g.*, Beckwith Mach. Co. v. Travelers Indem. Co., 638 F. Supp. 1179, 1186 (W.D. Pa. 1986); Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724 (Minn. 1997).

291. *See supra* Part II.G.

292. *See* Hillman & DeYoung, *supra* note 105, at 293.

293. *See, e.g.*, Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994).

294. *See* Howard, *supra* note 162, at 626 n.6.

reasonable expectations doctrine has been adopted, clearly, as part of the Minnesota case law,[295] as well as a large number of other jurisdictions.[296]

In 1970, then Professor Robert E. Keeton, now a federal district court judge in Boston, made one of his many substantial contributions to the growth of insurance law doctrine.[297] The gist of his recommendation was that courts should go further than merely resolving ambiguities favorably to the insured.[298] According to Keeton, if an insurance buyer could reasonably understand and expect that certain benefits under the policy were thus and so, then a court should give effect to that understanding and rule for the insured despite language to the contrary found elsewhere in the policy.[299] Minnesota is one of many states that have adopted Judge Keeton's view.[300]

In *Atwater*, the Minnesota Supreme Court held that although a definition of "burglary" was included in the insurance policy, and although this definition was not ambiguous, it should be interpreted according to the reasonable expectations of the insured.[301] The policy in *Atwater* contained an "evidence of forcible entry" clause as a requirement of coverage.[302] A theft occurred at night and Atwater filed a claim.[303] The insurer denied the claim on the grounds that "there were no visible marks of physical damage to the exterior at that point of entrance or to the interior at the point of exit, as required by the definition of burglary in the policy."[304] The Supreme

295. *See* Northern States Power Co. v. Fidelity & Cas. Co. of N.Y., 523 N.W.2d 657, 661 (Minn. 1994).

296. *See* ABRAHAM, *supra* note 114, at 57; Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823, 823 n.5 (1990) (noting that 16 states have adopted the doctrine).

297. *See* Robert E. Keeton, *Insurance Law Rights at Variance With Policy Provisions*, 83 HARV. L. REV. 961 (1970).

298. *See id.* at 967 (stating that "[t]he principle of honoring reasonable expectations should be extended further, protecting the policyholders' expectations as long as they are objectively reasonable from the layman's point of view, in spite of the fact that had he made a painstaking study of the contract, he would have understood the limitation that defeats the expectations at issue.")

299. *See id.*

300. *See* Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co., 366 N.W.2d 271, 277 (Minn. 1985)

301. *See id.* at 278-79 (holding "where the technical definition of burglary in a burglary insurance policy is, in effect, an exclusion from coverage, it will not be interpreted so as to defeat the reasonable expectations of the purchaser of the policy.")

302. *See id.* at 274.

303. *See id.*

304. *Id.*

Court declined to decide the case on the basis of an ambiguity in the policy.[305] The court in a landmark pronouncement of the doctrine stated:

> Some courts and commentators have recognized that the burglary definition at issue in this case constitutes a rather hidden exclusion from coverage. Exclusions in insurance contracts are read narrowly against the insurer. Running through the many court opinions refusing to literally enforce this burglary definition is the concept that the definition is surprisingly restrictive, that no one purchasing something called burglary insurance would expect coverage to exclude skilled burglaries that leave no visible marks of forcible entry or exit. Professor Robert E. Keeton, in analyzing these and other insurance cases where the results often do not follow from the rules stated, found there to be two general principles underlying many decisions. These principles are the reasonable expectations of the insured and the unconscionability of the clause itself or as applied to the facts of a specific case. Keeton's article and subsequent book, *Basic Text on Insurance Law*, (1971), have had significant impact on the construction of insurance contracts.
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> The doctrine of protecting the reasonable expectations of the insured is closely related to the doctrine of contracts of adhesion. Where there is unequal bargaining power between the parties so that one party controls all of the terms and offers the contract on a take-it-or-leave-it basis, the contract will be strictly construed against the party who drafted it. Most courts recognize the great disparity in bargaining power between insurance companies and those who seek insurance. Further, they recognize that, in the majority of cases, a lay person lacks the necessary skills to read and understand insurance policies, which are typically long, set out in very small type and written from a legalistic or insurance expert's perspective. Finally, courts recognize that people purchase insurance relying on others, the agent or company, to provide a policy that meets their needs. The result of the lack of insurance expertise on the part of insureds and the recognized marketing techniques of insurance companies is that "[t]he objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insur-

305. *See id.* at 276.

> ance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations."[306]

The court continued:

> The reasonable-expectations doctrine gives the court a standard by which to construe insurance contracts without having to rely on arbitrary rules which do not reflect real-life situations and without having to bend and stretch those rules to do justice in individual cases. As Professor Keeton points out, ambiguity in the language of the contract is not irrelevant under this standard but becomes a factor in determining the reasonable expectations of the insured, along with such factors as whether the insured was told of important, but obscure, conditions or exclusions and whether the particular provision in the contract at issue is an item known by the public generally. The doctrine does not automatically remove from the insured a responsibility to read the policy. It does, however, recognize that in certain instances, such as where major exclusions are hidden in the definitions section, the insured should be held only to reasonable knowledge of the literal terms and conditions. The insured may show what actual expectations he or she had, but the factfinder should determine whether those expectations were reasonable under the circumstances.[307]

In *Minnesota Mining and Manufacturing Co. v. Travelers Indemnity Co.*, the Minnesota Supreme Court addressed a problem arising out of environmental pollution under the CGL "occurrence based" policy form.[308] The question at issue was whether "response costs," that is to say costs of remedying a contaminated site, required by the Minnesota Pollution Control Agency, were damages within the meaning of the CGL policy.[309] The insurers argued that the CGL policies indemnify the insureds only when the insureds are legally obligated to pay damages to a third party.[310] The court held that the word "damages," as used in the policy, was ambiguous as it was sus-

306. *Id.* at 276-77 (quoting Keeton, *supra* note 297, at 967).

307. *Id.*

308. 457 N.W.2d 175, 177 (Minn. 1990).

309. *See id.* at 177-78 (bringing motions for summary judgment, the insurance companies sought "declarations that claims for environmental cleanup costs mandated by the MPCA are not covered 'damages' within the meaning of the CGL policies.")

310. *See id.* at 178.

ceptible to more than one reasonable interpretation.[311] The court then continued with a holding as to the insured's reasonable expectations:

> It is consistent with the reasonable expectations of the insureds under these policies that the clean up costs be covered. Another court, reaching the same conclusion, noted that "[i]t would come as an unexpected, if not incomprehensible, shock to the insureds to discover that their insurance coverage was being denied because plaintiff chose to frame his complaint in equity rather than in law." If a narrow, technical definition of the term "damages" was intended by the insurance companies, it was their duty to make that intention clear. The insureds purchased these "comprehensive general liability" policies expecting coverage against most legal liabilities which could arise out of their own acts or omissions, including liabilities which were unknown at the time. The standard language used in the policy is broad. The insurers agreed that they "will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies caused by an occurrence." The utility of the policy would be seriously called into question if coverage is permitted to hinge on such a fortuitous event as whether a plaintiff bringing an action against the insured has framed his complaint in equity rather than in law. Clearly the insureds under these policies contemplated greater certainty when they purchased the policies. They could reasonably expect the policy to provide coverage for any economic outlay compelled by law to rectify or mitigate damage caused by the insured's acts or omissions.[312]

In *Board of Regents of the University of Minnesota v. Royal Insurance Co. of America*, the Minnesota Supreme Court had occasion to revisit the subject of the doctrine of reasonable expectations.[313] From 1969 until 1972, the University had installed asbestos-containing fireproofing material in some of its buildings.[314] The University later incurred

311. *See id.* at 179 (relying on the "rules of insurance contract interpretation which require that undefined terms be given their 'plain, ordinary, and popular meaning'").

312. *Id.* at 181-82 (citation omitted).

313. 517 N.W.2d 888, 891 (Minn. 1994).

314. *See id.* at 889.

significant cost in removing the asbestos. Having settled with the manufacturer, the University sued its insurer.[315] The court of appeals held that coverage was excluded by a "pollution exclusion" in both primary and excess policies.[316] The primary and excess policies at issue were in the CGL "occurrence based" format.[317] The Supreme Court, in this case, gave the *Atwater* decision a narrower interpretation.[318]

In interpreting the language of the exclusion clause in the primary policies, however, the court held that the words "discharge, dispersal, release or escape of . . . pollutants into or upon land, the atmosphere, or any water course or body of water" did not apply to an escape of pollutants within a building.[319] The air of a building was held to be something other than the "atmosphere."[320] In contrast, the exclusion in the excess policies referred to "pollution of land, water, air or real or personal property. . . ."[321] This wording, the court held, was effective to exclude liability for pollutants escaping inside a building.[322]

In *Northern States Power v. Fidelity & Casualty Company of New York*, the Minnesota Supreme Court once again, and without the more restrictive reading of the *Board of Regents* decision, indicated that the reasonable expectations doctrine is part of Minnesota insurance law.[323]

In *Eiynk v. Sabrowsky*, the insurer issued a liability policy to the insured.[324] Three years later the insurer renewed the policy but added a new exclusion for bodily injury to family members.[325] The insurer did not notify the insured of the newly added term.[326] The policy was subsequently renewed multiple times without reference to

315. *See id.* at 889-90.
316. *See id.* at 890.
317. *See id.*
318. *See id.* at 891 (holding that where an exclusion of coverage is plainly designated in a CGL policy, and a claim of ambiguity is raised, the *Atwater* reasonable expectation test does not apply, as "[t]he reasonable expectation test is not a license to ignore the pollution exclusion in this case nor to rewrite the exclusion solely to conform to a result that the insured might prefer.").
319. *See Board of Regents*, 517 N.W.2d at 893.
320. *See id.*
321. *See id.* at 893 n.7.
322. *See id.* at 893-94.
323. 523 N.W.2d 657, 661 (Minn. 1994).
324. 524 N.W.2d 297, 298 (Minn. Ct. App. 1994).
325. *See id.*
326. *See id.*

the added exclusion.[327] The court of appeals concluded that when an insurer substantially reduces coverage through a renewal or endorsement, it must notify the insured of the change in writing.[328] Commenting on the basis of this decision the court stated:

> The holding in *Canadian Universal* was explained by reference to contracts of adhesion. Later supreme court analysis suggests that *Canadian Universal* was based on the reasonable expectations of the insured. Under the reasonable expectations doctrine, an insured would reasonably expect each renewal or subsequent policy to be on the same terms as the original unless the insured had notice of any change in coverage.[329]

From the above cases, it is clear that the doctrine of reasonable expectations is a material part of Minnesota insurance law, and in particular, hidden coverage exclusions will be ignored if inconsistent with the insured's reasonable expectations.

When speaking of "reasonable expectations," one must use some care. Commentators have referred to a range of uses of the doctrine.[330] For simplicity's sake, one might speak of a "strong" or "pure" version of the doctrine, as identified by Judge Keeton, that the reasonable expectations of the policyholder will be honored even where the policy language clearly precludes coverage.[331] It is important to remember that Judge Keeton limited this principle to cases where the policyholder's expectations were objectively reasonable.[332] One might also posit a "weak" version of the doctrine that protects the reasonable expectations of the insured only when the

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327. *See id.*

328. *See id.* at 298 (citing Canadian Universal Ins. Co., v. Fire Watch, Inc., 258 N.W.2d 570, 575 (Minn. 1977) (holding that insurers must notify the insured when an insurer by renewal, notification, or endorsement substantially changes the insured's prior coverage)).

329. *Eiynk*, 524 N.W.2d at 299 (citing Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co., 366 N.W.2d 271, 278 (Minn. 1985)).

330. *See, e.g.*, JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS § 11.4.5 (1994) (finding as many as six different variations in state court approaches to reasonable expectations, ranging from total rejection of the doctrine to adoption of a "pure" form of doctrine to override even explicit policy language); Mark C. Rahdert, *Reasonable Expectations Reconsidered*, 18 CONN. L. REV. 323, 354 (1986) (noting that reasonable expectations analysis is reserved by most states for ambiguous policy language and not applied where language is clear even if surprising and adverse to the policyholder).

331. *See* Rahdert, *supra* note 330, at 354.

332. *See id.* at 334-36.

policy language is ambiguous.[333] Minnesota could be described as employing a "moderate" version of reasonable expectations analysis that will override clear policy language, where the court views the language as operating in the nature of a hidden exclusion.[334] But in a case like *Atwater*, which refused to apply the "visible marks" definition in a burglary policy, the court was arguably straining to label the visible marks definition as hidden merely because it was contained as a definition rather than as an exclusion.[335] Without doubt, however, Minnesota courts have been receptive to protecting the reasonable expectations of the policyholder where the policy language at issue is ambiguous.[336]

The insurers' argument, rejected in *Stonewall, Owens-Illinois,* and *Hatco*[337] that the insured must prorate with "occurrence" carriers for years when it could not purchase occurrence coverage for the risk (either because of exclusion or change in form to claims-made policies) does not fit with the insured's reasonable expectations.[338] Allocation by "time on the risk" should not be allowed to have the effect of reducing coverage under an occurrence policy once that coverage has attached. There is no known doctrine of insurance law or canon of construction stating that once coverage has attached in a particular coverage year, it can be reduced or eroded by events that happen in following years in the manner urged by the insurers in these cases. If the issue is proration between multiple insurers, each on the risk, that is one matter. But progressive reduction of the insured's coverage is another.

The inequity of allocating, as the insurers argue, by "time on the risk" down to the date of claim across "occurrence" and "claims-made" policies[339] can be illustrated as follows. Clearly the date of filing the claim is largely fortuitous. Assuming "occurrence" coverage for 1981-85, and "claims-made" coverage for years 1986-90, a claim referencing the "occurrence" policies might

333. *See Atwater*, 366 N.W.2d at 275.

334. *See id.* at 276.

335. *See id.*

336. *See id.* at 277-78.

337. *See* Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp., 73 F.3d 1178, 1178 (2d Cir. 1995); Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 995 (N.J. 1994); Hatco Corp. v. W.R. Grace & Co., v. Allstate Ins. Co., 801 F. Supp. 1334, 1373 (D.N.J. 1992).

338. *See* ROBERT E. KEETON, INSURANCE LAW § 6.1, at 341 (1971) (detailing the fairness policies associated with the doctrine of reasonable expectation).

339. *See* Frame, *supra* note 2, at 169-78 (discussing the history and development of "occurrence" and "claims-made" policies).

be brought in 1986, 1987, 1988, 1989, 1990 or thereafter. Applying the insurers' argument, the insured's available coverage would erode progressively with each year of delay by the plaintiff in bringing the claim. Thus, if the claim were brought in 1985, the insured would be fully covered under the "occurrence" policies. If the claim were brought in 1986, the insurer would, under this theory, be responsible for 5/6ths of the loss. If the claim were brought in 1987, the insurer would be responsible for 5/7ths of the loss. If the claim were brought in 1988, the insurer would be responsible for 5/8ths of the loss. If the claim were brought in 1989, the insurer would be responsible for 5/9ths of the loss. If the claim were brought in 1990, the insurer would be responsible for 5/10ths of the loss, and so on. Any such progressive reduction of triggered occurrence insurance coverage that would result from such a wholly arbitrary circumstance, extrinsic to the procurement of the occurrence insurance coverage, and the initial triggering of that coverage, cannot be supported logically.[340]

The policies involved all deal with the issue of availability of other insurance and apportionment of loss with that other insurance through the device of the "other insurance" clauses. This process assumes two or more available policies and proration between the two—the insured is preserved whole but the triggered insurers share. As suggested above, those clauses cannot result, on the face of their language, in the taking away of coverage from the insured once that coverage has attached. [341] These clauses are the express terms of the insurance coverage inserted in the policies to deal with the issues of allocation of liability among insurers, albeit ineffectively in the case of the CGL policies.[342] If time on the risk allocation on the present facts were to involve proration across all years between attachment of coverage and the commencement of suit, such a process would be tantamount to implying an additional insurance provision, flatly inconsistent with the express provision, and resulting in the progressive removal of coverage from the insured.[343] Minnesota law is clear—insurance policies are contracts and are to be interpreted as such under the traditional canons of interpretation.[344] One primary canon is that no term should be im-

340. *See id.*
341. *See supra* note 155 and accompanying text.
342. *See Stonewall*, 73 F.3d at 1218.
343. *See supra* note 341 and accompanying text.
344. *See* Minnesota Mining & Mfg. Co. v. Travelers Indem. Co., 457 N.W.2d

plied in a contract where such an implied term would contradict and derogate from an existing express term.[345]

Sound public policy supports the same conclusion. In many situations, insurance may be the only resource from which injured plaintiffs can ultimately be cared for. A proration system which progressively reduces coverage, as argued by insurers, however, can act as a counter to the indemnity characteristics of insurance, thus reducing the fund to which plaintiffs may have access.[346]

Any such progressive reduction in coverage, once it has attached, must run contrary to the expectations of the insured.[347] A manufacturer who makes and sells widgets over a five year period of 1978 through 1982, when purchasing products liability coverage in each of those years, expects protection against claims, based on faulty widgets, to be covered with respect to injuries that occur between 1978 and 1982. The manufacturer would never dream that coverage which attached during those years, would be *reduced* by circumstances occurring beyond 1982, or that its insurers could argue that they would not cover ongoing problems of claimants who were injured during these years.

Any other approach would leave the manufacturer severely underinsured with respect to claims for injuries which manifested later. The manufacturer would have no forewarning that coverage for injuries that occurred and attached during the policy periods would be *reduced* because the resulting injury continued after the policy period. Nothing in the policy language warns of any such arbitrary and unanticipated result.

Moreover, the insurer's approach would leave the manufacturer exposed to the annual insurer's choice to withdraw or change a particular coverage provision, a choice which, when exercised, would have the retroactive effect of reducing or depriving the manufacturer of previously purchased coverage. The author of a recent article notes the possibility, and the negative effect of such action under the "claims-made" form.[348]

> The practical difference between occurrence and claims-made policies shows up in delayed disaster situations such

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175,179 (Minn. 1990) (setting forth some basic rules of contract interpretation).

345. *See* First Nat'l Bank v. Thorpe Bros., 179 Minn. 574, 577, 229 N.W. 871, 873 (1930) (holding that contract provisions are not to be implied where they would take the place of express provisions).

346. *See supra* note 341 and accompanying text.

347. *See id.*

348. *See* Lynn M. LoPucki, *The Death of Liability*, 106 YALE L.J. 1, 1 (1996).

> as asbestos, toxic waste, or cigarettes. Under an occurrence policy, the insurer pays for the disaster when the claims are finally made. Under a claims-made policy, as soon as the insurer sees that massive numbers of claims will be filed over the coming years, the insurer declines to write the next year's policy. . . .[349]

The last consideration under the "reasonable expectations" doctrine is the possible argument that this doctrine should provide no help for a sophisticated insured with long experience in purchasing CGL coverage. While the Minnesota courts have indicated that the level of sophistication and understanding of the insured can be a relevant factor in considering the reasonable expectations doctrine,[350] the insurer arguments with respect to allocation are so abstruse that no insured, regardless of the level and extent of its insurance department, could reasonably be expected to foresee and understand it in advance.[351] Professional experience in corporate management and insurance practice supports this conclusion.

V. HOW MIGHT THE INSURER ARGUMENTS FOR PRORATION AGAINST THE INSURED WORK OUT IN THE CONTEXT OF INSURED RISKS OTHER THAN ENVIRONMENTAL POLLUTION AND ASBESTOSIS?

A current mass tort, of monumental proportions in terms of numbers of claims asserted, involves the allegation of injury resulting from the surgical implantation of silicone gel breast implants.[352] The claims in these cases include assertions that the surgical implantation was performed without informed consent, and that silicone gel breast implants can cause abnormal immune or auto-immune response and may lead to "atypical" auto-immune disease.[353]

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349. *Id.* at 78.

350. *See* Atwater Creamery Co. v. Western Nat'l Mutual Ins. Co., 366 N.W.2d 271, 277 (Minn. 1985) (noting lack of insurance expertise can play a role in the reasonable expectations doctrine).

351. The Minnesota Supreme Court found this doctrine applicable in the case of three sophisticated corporate insureds (three separate cases consolidated for hearing purposes) in Minnesota Mining and Manufacturing Co. v. The Travelers Indemnity Co., 457 N.W.2d 175, 181-82 (Minn. 1990). The court in that case rejected the argument that the level of sophistication of the insured should make the doctrine of reasonable expectations inapplicable.

352. *See In re* Silicone Gel Breast Implant Products Liability Litigation v. Dow Corning Corp., No. CV 92-P-10000-5, 1994 WL 114580, at *11 (N.D. Ala. Apr. 1, 1994) (noting the many similar lawsuits also pending at the time).

353. *See* Hall v. Baxter Healthcare Corp., 947 F. Supp. 1387, 1402 (D. Or. 1996). *Hall* involved atypical connective tissue disease (ACTD). The court noted

Apparently fueled by massive negative publicity in the early 1990's,[354] these cases are now showing signs of taking a remarkable turn in the opposite direction.[355] Because of the volume of both individual and class action claims on behalf of such implant recipients, these claims were ordered consolidated and transferred to Judge Sam Pointer's court in the Northern District of Alabama for pretrial purposes.[356] Judge Pointer certified the plaintiffs as a class for purposes of settlement against defendants including all of the known manufacturers of silicone gel breast implants.[357] Thereafter, Judge Pointer approved first a so-called "Global Settlement Agreement," and thereafter a "Revised Settlement Agreement" covering many of the leading manufacturers of such implants but providing for opt-out for plaintiffs so electing.[358] A group of such "opt-outs" was assigned by Judge Pointer back to Judge Robert E. Jones in Oregon for trial on the merits.[359] Pursuant to a timely request by defense counsel, Judge Jones held a Rule 702 "Daubert" hearing to determine whether the medical experts offered on behalf of the plaintiffs would be permitted to testify at the forthcoming trial.[360] Judge Jones appointed a panel of independent experts and, based on the opinions of that panel, ruled in limine that the plaintiffs would not be permitted to present their medical witnesses to the jury.[361] Judge Jones decided to suspend the effect of this ruling pending the outcome of a similar hearing now being conducted by

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that "[t]his 'disease' allegedly manifests itself through a constellation of various symptoms and is allegedly caused by an autoimmune response to silicone from breast implants." *Id.*

354. *See In re* Silicone Gel Breast Implants Products Liability Litigation, 837 F. Supp. 1128, 1130 (N.D. Ala. 1993) (noting that "[o]ver the last several years, thousands of lawsuits against numerous defendants have been filed across the country by persons claiming to have been injured from silicone breast implants").

355. *See id.*

356. *See id.*

357. *See In re* Silicone Gel Breast Implant Products Liability Litigation, No. CV 92-P-10000-S, 1994 WL 114580, at *2, 11 (N.D. Ala. Apr. 1, 1994) (certifying the plaintiffs as a non-mandatory "opt-out" plaintiff settlement class).

358. *See In re* Silicone Gel Breast Implant Products Liability Litigation, No. CV-92-P-10000-S, 1994 WL 578353, at *6, (N.D. Ala. Sept. 1, 1994) (noting that the total number of persons opting out of the class is a small fraction—less than 5%—of the total number of putative class members and that most persons opting out did so because they "believed they could recover more through individual litigation than under the settlement").

359. *See* Hall v. Baxter Healthcare Corp., 947 F. Supp. 1387, 1392 (D. Or. 1996).

360. *See id.* at 1392-93.

361. *See id.* at 1394.

Judge Pointer.[362] He also noted that two other such hearings had been held recently in New York by Judges Weinstein and Baer.[363] Judge Jones issued the following order:

> For the reasons stated above, those portions of defendants' motions in limine that seek exclusion of any expert testimony concerning a general causal link between silicone gel breast implants and ACTD or any systemic illness or syndrome are GRANTED . . . .
>
> Specifically, I will exclude as irrelevant any testimony or evidence of the following: ACTD; any systemic illness or syndrome or autoimmune disorder of any kind; any emotional distress claims arising out of any alleged fear of developing any systemic disease or injury or fear of cancer."[364]

Reassertion of any causal relationship between breast implant and injury has thus been challenged. Judge Jones' ruling is based on the absence of appropriate evidence of any causal relationship between the surgical implantation of silicone gel breast implants and systemic or autoimmune disease.[365] However, massive litigation has already occurred in the class action proceedings before Judge Pointer and substantial settlements have been approved.[366] A few individual lawsuits have already been tried to conclusion, many with a verdict for the defense, but some with substantial verdicts for the plaintiff.[367] Furthermore, additional proceedings (involving core proceedings jurisdiction pursuant to U.S. Bankruptcy Code § 157(b)(2)(A)) have gone forward in federal bankruptcy court in Michigan involving Dow Corning and other defendants joined as co-defendants with Dow Corning in particular cases.[368]

Doubtless, since the more significant volume of such breast implants were implanted during the time when "occurrence" products liability coverage was available, the insurers will once

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362. *See id.* at 1394 (noting Judge Pointer had appointed a national panel of experts and that further scientific developments could occur prior to the completion of the panel's work).

363. *See id.*

364. *See id.* at 1414.

365. *See id.* at 1414-15 (holding absent proof of general causation).

366. *See In re* Silicone Gel Breast Implant Products Liability Litigation, No. CV-92-P-10000-S, 1994 WL 578353, at *1 (N.D. Ala. Sept. 1, 1994) (approving a settlement awarding plaintiffs in excess of $4 billion).

367. *See id.* at *6.

368. *See, e.g., In re* Dow Corning Corp., 198 B.R. 214 (Bankr. E.D. Mich. 1996).

again litigate coverage for silicone gel breast implant claims under these policies.

While under the *Stonewall* court approach the differences do not matter, significant factual differences exist between the circumstances of the alleged breast implant injury and those of the environmental pollution and asbestos cases. As discussed earlier, the key to the allocation of environmental pollution insurance coverage has been the evidentiary presumption that, in the absence of discrete and identifiable events, the injury is to be presumed to occur in equal increments across each year between the "escape" and the claim.[369] In the asbestos cases, the courts have adopted medical testimony establishing that the disease is a continuing and progressive one, thus affected by successive exposures to inhalation of asbestos fibers over a period of years.[370] By way of contrast, in the breast implant cases, a key initial feature of some of the complaint assertions is the tort of battery—namely, that the surgical implantation was undertaken without adequate notice or warning of the dangers involved.[371] Again, along with the complaints, the allegations apparently allege that injury followed almost immediately after the surgical implantation and continued to be present for periods of years thereafter. On the facts, do these cases state an injury that is crisply related to the time of the surgery, and therefore trigger the policy in effect as of that date? Or, assuming that the plaintiffs allege continuing injury through subsequent years, are "occurrence" policies for those later years also triggered? And, if so, what shall be said of allocation?

As discussed above,[372] the insurance policy in effect at the time of the surgical implantation is clearly "triggered" by that event and must respond not only for the injury alleged to have occurred in that year, but also for any injury alleged to have occurred in subsequent years.[373] Likewise, assuming a basis for the allegations of con-

369. *See supra* notes 206, 223 and accompanying text.

370. *See* Hancock Lab., Inc. v. Admiral Ins. Co., 777 F.2d 520, 525 (9th Cir. 1985).

371. *See supra* note 353 and accompanying text.

372. *See supra* Part II.G.1-4 (discussing generally when policies triggered).

373. *See Hancock Lab.*, 777 F.2d at 524 (applying California law). In this case the insured, an aortic heart valve manufacturer, provided a porcine heart valve that had been contaminated and the contaminated valve was surgically implanted in the claimant who then suffered progressive resultant disease. *See id.* at 521-22. The court said, "The infectious disease process resulting from the contaminated Hancock heart valve is similar to a cumulative progressive type of disease rather than a common type of disease or ordinary accident." *See id.* at 524. The court

tinuing injuries in subsequent "occurrence" years, there can be little question that those policies are also "triggered." The respective "occurrence" insurers may fight, if they wish, about allocation between the respective insurers, but under the doctrine of *Stonewall*, *Owens-Illinois*, and *Hatco*,[374] there should be no issue in these cases of proration against the insured. Unlike the environmental cases, there is no new "external event" each policy year, either proven or, as a result of the evidentiary presumption, presumed.[375]

VI. CONCLUSION

The "occurrence" based CGL policy enjoyed a checkered history and generated enormous litigation. The problems were self-inflicted by the general commercial liability industry and the ISO. The industry deserves the right to rethink and regroup, through the introduction and provision of the now only relatively new "claims-made" policy. The industry should not be permitted to change retroactively, through a novel and very recent policy interpretation assertion, the coverage due to insureds who purchased "occurrence" coverage in good faith and who have been called upon to defend or pay claims relating to injury that occurred, initially, during the period of those policies. There never has been a concept of "progressively vanishing insurance coverage," and no such concept should now be created through an extremely strained construction of an ambiguous insurance policy provision.

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held that the insurer on the risk at the time of surgical implantation of the valve was completely obligated. *See id.* at 525; *see also* Eljer Mfg., Inc. v. Liberty Mut. Ins. Co., 972 F.2d 805, 813-14 (7th Cir. 1992) (holding that the insurer on the risk at the time of installation of a plumbing system was held liable for the subsequent failure of that system causing physical damage to the structure).

374. *See supra* note 337 and accompanying text.

375. *See* Hancock Lab. Inc. v. Admiral Ins. Co., 777 F.2d 520, 525 (9th Cir. 1985).