The Allocation Game:
A Practical Look At Who Wins Under All Sums, Pro Rata
And The New ALI Restatement

I. INTRODUCTION

Coverage under commercial general liability policies for “longtail” claims, such as environmental property claims and asbestos bodily injury claims, has long been the source of bitter dispute. Because injury occurs over the course of many years, multiple policies may be triggered. Courts around the country, often looking at the same policy language, have come to very different conclusions as to how to divide the costs of defense and indemnity between the policyholder and its insurers. In reaching those conclusions, the courts consider what must take place to trigger a policy and then choose an allocation methodology. Those allocation methodologies generally fall into categories – “pro rata” and “all sums” – but even these types of allocation methodologies are not applied in precisely the same way in every state. And the law is still being made. Appellate courts around the country continue to refine these methodologies as long-tail injuries continue to reach higher and higher levels of coverage.

With the adoption of the American Law Institute’s Restatement of the Law of Liability Insurance in 2018, there is the potential for bringing some order to allocation nationwide. The ALI Restatement seems to split the baby, applying “all sums” allocation to defense and “pro rata” to indemnity. The Restatement’s reporters argue that this approach is justified by both the policy language and fundamental principles of insurance.

The common view of most coverage geeks is that “all sums” allocation is better for policyholders and “pro rata” is better for insurers, but this may not always be the case. This program will explore the practical application of the allocation methodologies of several states and the Restatement. Here we provide a brief summary of the controlling principles for that analysis under the allocation schemes established by New Jersey, Connecticut, California, New York, and the Restatement.

II. “ALL SUMS” ALLOCATION UNDER CALIFORNIA LAW

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As set forth below, California is an “all sums” jurisdiction under which each policy triggered by a continuous or progressive loss is independently responsible to pay its full limits of liability subject to a right of contribution against other triggered insurers at the same level. The insured, however, has no obligation to contribute for uninsured periods. Triggered policies may be “stacked,” effectively forming what the California Supreme Court has labeled “one giant ‘uber-policy.’” Subject to specific policy language, all triggered primary coverage must be exhausted before any excess policy is obligated to pay.

One important caveat to note regarding California case law: the “rule” stated in a particular California decision likely will not be applied in a later case if the relevant policy
language is substantively different from that at issue in the case from which the “rule” is derived.

A. TRIGGER OF COVERAGE – “Continuous trigger”

While the term “trigger of coverage” does not appear in the language of CGL insurance policies, it is used as a term of convenience “to describe that which, under the specific terms of an insurance policy, must happen in the policy period in order for the potential of coverage to arise. The issue is largely one of timing—what must take place within the policy’s effective dates for the potential of coverage to be ‘triggered’?” Montrose Chem. Corp. v. Admiral Ins. Co., 10 Cal.4th 645, 655 n.2 (1995).

Current California case law holds that, absent contrary policy provisions, a continuous injury trigger applies to claims of continuous or progressively deteriorating bodily injury or property damage. See, e.g., State of California v. Continental Ins. Co., 55 Cal.4th 186, 196 (2012) (“In Montrose, we held that in the context of a third party liability policy ‘property damage that is continuous or progressively deteriorating throughout several policy periods is potentially covered by all policies in effect during those periods’”), citing Montrose, 10 Cal.4th at 655. Thus, where successive policy periods are implicated by property damage which is continuous or progressively deteriorating through several policy periods, the loss is potentially covered by all policies in effect during those periods. Montrose, 10 Cal.4th at 689.

The timing of the accident, event, or condition causing property damage is largely immaterial in determining whether coverage is “triggered;” instead, what is relevant is when the complaining party was actually damaged. See State of California, 55 Cal.4th at 197 (“Aerojet reasoned that the insurers would be liable to indemnify the insured against all claims that resulted from some triggering harm during the respective policy periods, even if the claims arose after the policy period expired” (emphasis in original); Montrose, 10 Cal.4th at 670 (“The general rule is that the time of the occurrence of an accident within the meaning of an indemnity policy is not the time the wrongful act was committed, but the time when the complaining party was actually damaged”) (citations omitted); Safeco Ins. Co. of America v. Fireman’s Fund Ins. Co., 148 Cal. App.4th 620, 632 (2007) (“As defined in the policies, an ‘occurrence’ of ‘property damage’ triggered coverage based on when the damage took place, not when the wrongful act was committed”). As a corollary to this rule, there can be no coverage for bodily injury or property damage that begins after a policy expired. See Aerojet-General Corp. v. Transport Indem. Co., 17 Cal.4th 38, 71 (1997) (“there is no coverage under a comprehensive general liability policy as to acts or omissions that caused specified harm of any kind only after the policy expired”); Buena Vista Mines, Inc. v. Industrial Indem. Co., 87 Cal. App.4th 482, 487 (2001) (a “complete factual predicate must exist during the policy period [ ] [because] it is neither reasonable nor consonant with the terms of general liability policies to require insurers to cover liabilities based upon facts that did not occur until after the policy expired”), citing FMC Corp. v. Plaisted & Cos., 61 Cal. App.4th 1132, 1152, 1154-55 (1998).

B. ALLOCATION – “All Sums”

California is an “all sums” state – meaning that the insured may elect from which of several triggered policies to seek indemnity, up to the policy limits of the selected policy. Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co., 45 Cal. App. 4th 1 (1996).
In *Armstrong*, the court ruled that “[t]he insurance policies obligate the insurers to pay on behalf of the policyholder ‘all sums’ that the policyholder becomes legally obligated to pay as damages because of bodily injury during the policy period. We interpret this language to mean that once coverage is triggered, the insurer’s obligation to the policyholder is to cover the policyholder’s liability ‘in full’ up to the policy limits. In other words, the insured is covered (up to the policy limits) for the full extent of its liability and need not pay a pro rata share.”

Thus, subject to policy terms and conditions, each policy triggered by a particular claim may have the duty to defend such claim completely and to indemnify the entire judgment obtained by the claimant. *See State of California v. Continental Ins. Co.*, 55 Cal.4th at 200 (“We therefore conclude that the policies at issue obligate the insurers to pay all sums for property damage . . ., up to their policy limits, if applicable, as long as some of the continuous property damage occurred while each policy was ‘on the loss.’ The coverage extends to the entirety of the ensuing damage or injury”). In such circumstances, a policyholder may select just one of many triggered policies to provide defense and indemnity (if available under the policy terms) for a particular claim or group of claims. As one decision recently explained: “When a continuous loss is covered by multiple policies, the insured may elect to seek indemnity under a single policy with adequate policy limits. If that policy covers ‘all sums’ for which the insured is liable, as most CGL policies do, that insurer may be held liable for the entire loss.” *Stonelight Tile, Inc. v. California Ins. Guar. Ass’n*, 150 Cal. App.4th 19, 37 (2007).

1. **STACKING – Stacking is permitted**

In 2012, *State of California v. Continental Ins. Co.*, 55 Cal. 4th 186 (2012), approved stacking of policy limits. Thus, absent an anti-stacking provision in the policy, when the policy limits of a given insurer are exhausted, the insured is then entitled to seek indemnification from any of the remaining triggered insurers. The court said that “[t]he all-sums-with-stacking indemnity principle properly incorporates the *Montrose* continuous injury trigger of coverage rule and the *Aerojet* all sums rule, and ‘effectively stacks the insurance coverage from different policy periods to form one giant ‘uber-policy’ with a coverage limit equal to the sum of all purchased insurance policies.’” *Id.* at 201.

However, an insurer called upon to pay a loss cannot reduce its liability by stacking deductibles or SIRs under other policies that covered the risk during the continuous injury period. *See California Pac. Homes, Inc. v. Scottsdale, Ins. Co.*, 70 Cal. App.4th 1187, 1193 (1999). In other words, unless the policies provide otherwise, each insurer is liable up to its policy limit upon exhaustion of the deductible or SIR in its own policy. *See Montgomery Ward & Co. Inc. v. Imperial Cas. & Co.*, 81 Cal. App.4th 356, 370 (2000). An SIR is not the equivalent of a primary policy for purposes of horizontal exhaustion. *Id.* at 369-70.

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Absent unambiguous policy language, non-cumulation clauses will be construed against an insurer, who will generally be liable up to its policy limits during each year during successive years of coverage. *A.B.S. Clothing Collection, Inc. v. Home Ins. Co.*, 34 Cal. App.4th 1470, 1474 (1995).

2. ACCESSING EXCESS POLICIES – For now, “horizontal exhaustion” of primary coverage required (unless policy language provides otherwise)

California law generally requires “horizontal exhaustion” of all primary coverage before any excess policy is obligated to begin paying. In other words, when an insured is liable for progressive injuries that span multiple policy periods, excess insurance is not required to begin paying indemnity until after all triggered primary insurance is exhausted. *See Montgomery Ward & Co. v. Imperial Cas. & Co.*, 81 Cal. App.4th 356, 365 (2000) (“all of the primary policies in force during the period of continuous loss will be deemed primary policies to each of the excess policies covering that same period. Under the principle of horizontal exhaustion, all of the primary policies must exhaust before any excess will have coverage exposure”); *Stonewall Ins. Co. v. City of Palos Verdes Estates*, 46 Cal. App.4th 1810 (1996). This is so even if the primary insurance for the time period covered by the excess policy has been exhausted. *Id.*

In *Qualcomm, Inc. v. Certain Underwriters at Lloyd’s, London*, 161 Cal. App.4th 184 (2008), the court held, under policy language providing that the excess insurer’s obligations do not arise until the underlying policy “has paid or has been held liable to pay” its limits, that the excess policy has no duty to provide coverage where the policyholder accepted a settlement from the primary carrier of less than policy limits. Absent policy language obligating an excess insurer to provide coverage upon the exhaustion of a specifically described primary policy, an excess insurer need not contribute to defense costs until all triggered primary policies have been exhausted. *See Community Redevelopment Agency v. Aetna Cas. & Sur. Co.*, 50 Cal. App.4th 329 (1996). In *Community Redevelopment*, the umbrella policy contained language providing that it was excess to not only the immediately underlying primary policy, but was also excess to “any other valid and collectible insurance . . . whether or not described in the Schedule of Underlying Insurance.” The court held that the excess insurer had no coverage obligation because a primary policy in another year had not been exhausted. The court did note that different policy language could drive a different result, if the excess insurance promised to cover a claim when specific underlying insurance is exhausted (i.e., vertical exhaustion).” *Id.* at 340.

Later, in *Montgomery Ward & Co. v. Imperial Cas. & Indem. Co.*, 81 Cal. App.4th 356, 369 (2000), the court stated that vertical exhaustion applied with respect to policies sitting above “true self-insured retentions” (i.e., funded by the insured), because retentions should “not be deemed primary insurance.” In other words, “the principle of horizontal exhaustion does not apply to SIR’s in these circumstances.” *Id.* at 364. In 2017, the Court of Appeal in *State of California v. Continental Ins. Co.*, 15 Cal. App.4th 1017 (2017), followed *Montgomery Ward* and extended its holding to self-insured retentions for which the insured purchased insurance. The court held that, based on the policy language at issue, the insurer’s “duty to pay arose as soon as the specified retention was exhausted.” *Id.* at 1037. It reasoned that “[i]t would be paradoxical if the fact that the [policyholder] prudently decided to protect itself further
by buying insurance covering most of its retentions actually made it harder for [it] to obtain indemnity from any one insurer.” *Id.*

If a first-layer excess policy need not respond before all primary coverage is horizontally exhausted, must a second-layer excess policy respond before all first-layer excess coverage is horizontally exhausted? It is anticipated that the California Supreme Court will resolve this question in *Montrose Chemical Corp. v. Superior Court*, 14 Cal. App.5th 1306 (2017), *review granted*. The court of appeal held that, if policy language required it, all underlying excess insurance in all triggered periods must pay before the higher level excess policy can be called upon to pay. The California Supreme Court granted review to address the following issue: “When continuous property damage occurs during several periods for which an insured purchased multiple layers of excess insurance, does the rule of ‘horizontal exhaustion’ require the insured to exhaust excess insurance at lower levels for all periods before obtaining coverage from higher level excess insurance in any period?” The matter has been fully briefed; no argument date has been set.

### 3. ALLOCATION AMONG INSURERS – Contribution among insurers is permitted; no allocation to the insured for uninsured periods

Under an “all sums” regime, it is possible that an insurer will end up paying not only its fair share of a claim, but other insurers’ shares as well. California courts recognize that even though the policyholder may look to a single insurer for defense or indemnity relating to a claim, it is unfair to require the selected insurer to pay the shares of other insurers whose policies were also triggered by the claim. Thus, an insurer that defends or indemnifies a claim and pays more than its fair share may seek contribution from other insurers at the same level who also had a duty to defend or indemnify but did not do so (or did so but without paying its complete fair share). *See Scottsdale Ins. Co. v. Century Surety Co.*, 182 Cal. App.4th 1023, 1035-36 (2010) (“[a]n insurer can recover equitable contribution only when that insurer has paid more than its fair share; if it has not paid more than its fair share, it cannot recover, even against an insurer who has paid nothing”); *Reliance Nat. Indem. Co. v. General Star Indem. Co.*, 72 Cal. App.4th 1063, 1078 (1999) (“As a general rule, there is no contribution between a primary and an excess insurer”).

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3 See also *Fireman’s Fund Ins. Co. v. Maryland Cas. Co.*, 65 Cal. App.4th 1279, 1293 (1998) (“Where multiple insurance carriers insure the same insured and cover the same risk, each insurer has independent standing to assert a cause of action against its co-insurers for equitable contribution when it has undertaken the defense or indemnification of the common insured. Equitable contribution permits reimbursement to the insurer that paid on the loss for the excess it paid over its proportionate share of the obligation, on the theory that the debt it paid was equally and concurrently owed by the other insurers and should be shared by them pro rata in proportion to their respective coverage of the risk”) (emphasis in original); *State of California*, 55 Cal.4th at 200 (“each successive insurer is potentially liable for the entire loss up to its policy limits. When the entire loss is within the limits of one policy, the insured can recover from that insurer, which may then seek contribution from the other insurers on the risk during the same loss”); *In re Plant Insulation Co.*, 734 F.3d 900, 907 n.3 (9th Cir. 2013) (“In California, when insurance overlaps, every insurer is liable for the whole cost of defending any given claim. However, insurers have an equitable right to recover the ‘fair share’ of these costs from other insurers that could have been held responsible for the same claim”), citing *Fireman’s Fund*, 65 Cal. App.4th at 1293.
California case law further holds that an insured’s settlement with an insurer does not bar or otherwise limit the contribution rights of non-settled insurers against the settled insurer. Specifically, “one insurer’s settlement with the insured is not a bar to a separate action against that insurer by the other insurer or insurers for equitable contribution or indemnity.” Fireman’s Fund, 65 Cal. App.4th at 1288; see also Employers Ins. Co. of Wausau, 141 Cal. App.4th 398, 404 (2006) (ordering a settled insurer to contribute to a non-settled insurer’s cost of defending lawsuits that were filed after the settled insurer’s settlement with the policyholder).

Trial courts have broad discretion in determining which method of allocation will most “equitably” distribute the “loss” (defense and indemnity costs) among insurers on the risk. See Scottsdale Ins. Co. v. Century Sur. Co., 182 Cal. App.4th 1023, 1032 (2010). Potential methods include: time on the risk; policy limits; combined policy limits/time on the risk; premiums paid; equal shares; and equal shares up to the limits of the policy with the lowest limits, and then to the policy with the next lowest limits, etc. See also Axis Surplus Ins. Co. v. Glencoe Ins. Ltd., 204 Cal. App.4th 1214, 1231-32 (2012) (in making its determination of an equitable contribution claim, “[t]he court may consider numerous factors…, including the nature of the underlying claim, the relationship of the insured to the various insurers, the particulars of each policy, and any other equitable considerations”).

An insurer cannot, however, allocate any portion of the loss to periods during which the insured “went bare” (had no insurance coverage). See State of California v. Continental Ins. Co., 55 Cal.4th at 200 (“When the entire loss is within the limits of one policy, the insured can recover from that insurer, which may then seek contribution from the other insurers on the risk during the same loss”) (emphasis added). So long as there is adequate coverage under the policies triggered, the insured need not share in the loss. See id. (“The all-sums-with-stacking indemnity principle properly incorporates the Montrose continuous injury trigger of coverage rule and the Aerojet all sums rule, and ‘effectively stacks the insurance coverage from different policy periods to form one giant “uber-policy” with a coverage limit equal to the sum of all purchased insurance policies.”").

C. SELF-INSURED RETENTIONS, DEDUCTIBLES, AND OTHER INSURANCE CLAUSES

1. Self-Insured Retention

A self-insured retention (“SIR”), also known as a “retained limit,” is a feature of an insurance policy under which an initial portion of covered risk is borne by the policyholder, not the insurer. When a SIR is involved, an insured must pay its portion of the loss up front because that amount is not covered by the policy at all. An insurer’s coverage obligation begins and its limits come into play only after the insured satisfies this initial “retained” portion of the covered loss. Once the insured satisfies the retention, triggering the policy coverage, however, the insurer is liable up to its full limits.

California courts have compared SIRs to primary insurance in discussing an insured's own obligation to defend claims until the SIR amount is satisfied. In Forecast Homes, Inc. v. Steadfast Ins. Co., 181 Cal. App.4th 1466 (2010), the court said SIRs “are the equivalent to primary insurance, and . . . policies which are subject to self-insured retentions are 'excess policies' which have no duty to indemnify until the self-insured retention is exhausted.” But
where policies have precise language to the contrary, this rule will not be applied. See, e.g., Legacy Vulcan Corp. v. Superior Court, 185 Cal. App. 4th 677 (2010), where the court ruled that a “retained limit” provision relieved an insurer of the duty to defend from the first dollar only if the policy language expressly so provides. *Id.* at 682. In addition, a federal case applying California law ruled that “[i]t is well recognized that self-insurance retentions are the equivalent to primary liability insurance, and that policies which are subject to self-insured retentions are ‘excess policies’ which have no duty to indemnify until the self-insured retention is exhausted.” *Pacific Employers Ins. Co. v. Domino’s Pizza, Inc.*, 144 F.3d 1270, 1276-77 (9th Cir. 1998).

However, as a leading treatise on California insurance law notes, “[t]he analogy between ‘primary’ and ‘excess’ insurance should not be carried too far. An SIR is not the same as primary insurance for all purposes.” Croskey, et al., *Cal. Practice Guide: Insurance Litigation*, ¶ 7:387, p. 7A–128. For example, as discussed above, the court in *Montgomery Ward* held that an excess insurer that does not sit directly above an SIR cannot insist on satisfaction of the SIR for purposes of horizontal exhaustion. 81 Cal. App.4th at 370. The same result was reached in *State of California* with respect to SIRs that were themselves insured. 15 Cal. App.4th at 1037. Further, where policy terms either permit the use of other insurance to cover the SIR amount, or are at least ambiguous on that point, an insured can rely on other insurance to exhaust an SIR. *Von’s Cos. v. U.S. Fire Ins. Co.*, 78 Cal. App.4th 52, 62 (2000).

2. **Deductible**

A deductible is “the portion of the loss to be borne by the insured before the insurer becomes liable for payment.” Traditionally, deductibles apply to indemnity only, not the duty to defend. Under a primary policy, including one with a deductible, the insurer typically must defend a claim that is potentially within coverage from “dollar one.”

A deductible does not increase the primary layer of coverage. In these types of policies, the insured is not permitted to handle its own defense or make its own settlement decisions—a feature that some insureds find desirable. In *Nat’l Union Fire Ins. Co. of Pittsburgh, PA v. Lawyers’ Mut. Ins. Co.*, 885 F. Supp. 2d 202 (S.D. Cal. 1995), the court explained that an excess insurer’s obligations do not arise until after the amount of the self-insured retention has been paid, unlike the obligation that arises with a deductible.

3. **Other Insurance:**

“Other insurance” issues arise where both the insured’s own risk retention mechanism and one or more policies providing for true risk transfer provide concurrent coverage, or would apply to the same occurrence or claim. In this circumstance, a court will consider whether the insured’s retention mechanism qualifies as “other insurance.” In contrast, when a loss continues across multiple successive policy periods, courts must consider whether and how the loss should be allocated across multiple carriers, one or more of which may be subject to SIRs or deductibles.

California courts have addressed and enforced policy language specifying that the coverage is excess over other insurance, including a deductible portion or SIR. *Nabisco, Inc. v. Transport Indemnity Co.*, 143 Cal. App.3d 831 (1983), is one example. There the
policyholder had one primary policy with a $50,000 retention and was an additional insured under a second primary policy. The second policy contained an “other insurance” clause which rendered that second policy excess over “other insurance or self-insurance.” The insured argued that it was uninsured for the amount of the retention and that the “other insurance” clause therefore did not apply. The court disagreed and held that the decision not to purchase such coverage underlying the second policy was a business decision, that the insured could not have had any reasonable expectation of coverage for that amount, and that the insured was responsible for defense costs to the extent of its SIR.

III. PRO RATA ALLOCATION IN NEW JERSEY & CONNECTICUT

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The history of the development of the pro rata allocation method begins with the Sixth Circuit’s 1980 decision in Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc. In Forty-Eight Insulations, the court found that the terms of standard occurrence-based general liability policies were generally unhelpful in addressing the allocation of coverage for asbestos bodily injury claims.

An “occurrence-based” policy provides coverage for injuries that take place during the policy period even if the claim arising from that “occurrence” is not made until long after the policy period has ended. Injury during the policy period thus “triggers” coverage. While it is easy to determine which policy must provide coverage when there is a factory explosion, the Forty-Eight Insulations court found “bodily injury” and "occurrence" to be inherently ambiguous as applied to progressive disease. In the absence of clarity as to when an injury from asbestosis should be deemed to occur, the court applied well-established canons of policy construction to resolve doubts in favor of maximizing coverage. First, it applied the “exposure trigger,” holding that only policies on the risk during the time the underlying claimant is exposed to the policyholder’s products are triggered. Second, it required triggered policies to contribute a share to both defense and indemnity relative to the insurer’s time on the risk. To the extent the policyholder chose to be self-insured, decided to purchase insufficient insurance, or lost its policies, the policyholder would be required to contribute (referred to as “proration to the insured”).

Prior to Forty-Eight Insulations, insurers had attempted to reduce their exposure for environmental claims. In the early 1970s, they adopted pollution exclusions that only permitted coverage for “sudden and accidental” polluting events (that would present few if any allocation issues).

After *Forty-Eight Insulations*, the insurance industry transformed general liability coverage in response to a dramatic increase nationwide in the number of claims for injuries related to exposure to asbestos. First, insurers adopted exclusions to certain identified long-tail claims. For instance, in 1985, the industry introduced the absolute pollution exclusion and thereafter, coverage for environmental claims could be found, if at all, through the purchase of separate policies or endorsements. Also, by 1986, insurers nearly universally adopted an asbestos exclusion.

Second, at the same time, occurrence-based policies became generally unavailable to many companies and available limits were curtailed, as the insurance industry sought to limit its exposure to long-latency claims. Instead, these companies could only purchase claims-made policies, which only provide coverage for claims brought during the policy period (or extended reporting period). Claims-made policies provide far more limited coverage than occurrence-based policies.

A. New Jersey Employs Continuous Trigger, Weighted Pro Rata Allocation And The Unavailability Rule.

In the landmark case of *Owens-Illinois, Inc. v. United Ins. Co.*, the New Jersey Supreme Court, like *Forty-Eight Insulations*, found the standard general liability policy language and the traditional rules of interpretation to be unhelpful in settling on the proper method of allocating responsibility for asbestos claims. It concluded that, without clear insurance policy language addressing coverage, it would be guided by public policy concerns in choosing an allocation methodology. Chief among those public policy concerns was the goal of spreading the costs of the asbestos claims, as broadly and efficiently as possible. The court recognized that insurance spreads the costs of claims most efficiently.

The *Owens-Illinois* court followed the allocation methodology established in *Forty-Eight Insulations* in some respects, but it did not adopt the exposure trigger. Instead, it was the first court to combine pro rata allocation and proration to the insured with the "continuous trigger" rule. Finding that asbestos related disease was an indivisible injury and therefore that there was bodily injury at all times after first exposure to asbestos, the court maximized "resources" by holding that all policies from time of first exposure to the discovery of disease had to provide

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9 7 Couch on Ins. 3d § 102:22.
coverage for both defense and indemnity.\textsuperscript{12} Under continuous trigger, all policies that provide asbestos coverage from the date of first exposure (“DOFE”) to manifestation are triggered whether or not there is any exposure after the first exposure.

The Owens-Illinois Court also adopted proration to the insured but with a significant limitation. There would be no proration to the time period when the policyholder could no longer purchase insurance for asbestos-related claims because the carriers refused to make it available\textsuperscript{13} – a problem that did not exist at the time Forty-Eight Insulations was decided. This limitation was ultimately dubbed the “unavailability rule.” By limiting proration to the policyholder and thereby maximizing insurance coverage, the unavailability rule also served the goal to increase, not decrease, available resources.\textsuperscript{14} Together, pro rata allocation and continuous trigger with the unavailability rule have the effect of spreading the cost of defense and indemnity so as to maximize recoveries for injured underlying plaintiffs and to afford policyholders the protection which they purchased while reducing the liability to any one insurer.

Challenges to the application of the unavailability rule were most recently rebuffed by the New Jersey Supreme Court in its 2018 decision in Continental Ins. Co. v. Honeywell Int’l, Inc.\textsuperscript{15} In Honeywell, the insurers argued that the unavailability rule should not apply to the time period when the policyholder continued to manufacture asbestos friction products even though coverage for asbestos claims was no longer available. If the unavailability rule were to be applied to such sales, the insurers claimed it would encourage manufacturers to behave irresponsibly because they could transfer risk to prior insurers. In rejecting this argument, the Supreme Court explained that none of the initial asbestos exposures occurred after insurance became unavailable. From the time of those first exposures until asbestos coverage was no longer available there were triggered policies that promised coverage. An exception to the application of the unavailability rule “would retroactively deprive parties of paid-for insurance coverage due to their post-coverage-period conduct.”\textsuperscript{16} By contrast, the continued application of the unavailability rule supports the public policy objectives of the Owens-Illinois allocation methodology: “maximizing insurance resources, encouraging the spreading of risk throughout the insurance industry, promoting the purchase of insurance when available, and of simple justice....”\textsuperscript{17}

While adopting pro rata allocation, the Owens-Illinois court did not simply allocate based upon time on the risk. Instead, it found that the “better formula” was to “allocate[ ] the losses

\begin{footnotes}
\item[14] Owens-Ill., 138 N.J. at 472, 650 A.2d at 992.
\item[16] Id. at 67, 188 A.3d at 324.
\item[17] Id. at 68, 188 A.3d at 324.
\end{footnotes}
among the carriers on the basis of the extent of the risk assumed, i.e., proration on the basis of policy limits, multiplied by years of coverage.” Owens-Illinois used an illustration to explain what the court meant by an allocation scheme that took into account the degree of risk assumed. The illustration provided that 9 years were triggered, during which the policyholder had purchased $2 million per year in coverage in the first three years, $3 million per year in the second three years and no insurance for the last three years in which time, the self-insured risk was $4 million per year. To allocate proportionate to the risk undertaken by each party, insurers in years one through three would bear 6/27ths of the responsibility, insurers in years four through six would shoulder 9/27ths, and the building owners in years seven through nine would be responsible for 12/27ths. 19

In Carter-Wallace, Inc. v. Admiral Ins. Co., the New Jersey Supreme Court applied continuous trigger and pro rata allocation to an environmental claim and for the first time considered how this methodology would work to exhaust layers of coverage. 20 Rejecting the insurer’s argument that each layer of triggered policies – beginning with primary policies and advancing through layers of umbrella and excess policies – should be fully exhausted before accessing the next layer of coverage, a theory known as “horizontal exhaustion,” the Supreme Court followed the principles and methodology first expressed by Owens-Illinois, a method that “intentionally assigns a greater portion of indemnity costs to years in which greater amounts of insurance were purchased, based on the view that this measure of allocation is more consistent with the economic realities of risk retention and risk transfer.” 21

The Carter-Wallace court held that exhaustion could be determined by “simply extending the Owens-Illinois calculation to make the further assessment of the responsibility borne by each year of the continuous trigger and then policies would “vertically exhaust” based on the loss assigned to that particular year. It then provided a further illustration:

Assume that primary coverage for one year was $100,000, first-level excess insurance totaled $200,000, and second-level excess coverage was $450,000. If the loss allocated to that specific year was $325,000, the primary insurer would pay $100,000, the first-level excess policy would be responsible for $200,000, and the second-level excess policy would pay $25,000. 22

Over the years, there have been various refinements to the allocation scheme. For instance, in Benjamin Moore & Co. v. Aetna Cas. & Sur. Co, the New Jersey Supreme Court held that the full per-occurrence deductible in each triggered policy must be satisfied before the insured is entitled to indemnity. 23 In Quincy Mut. Fire Ins. Co. v. Borough of Bellmawr, it

18 Id. at 475, 650 A.2d at 1121-22.
19 Id. at 475–76, 650 A.2d 974
22 154 N.J. at 326–27, 712 A.2d at 1124.
held that the “allocation formula should reflect days rather than years on the risk when the underlying facts require that degree of precision in the allocation of liability.”\(^{24}\)

In *Farmers Mut. Fire Ins. Co. of Salem v. New Jersey Prop.-Liab. Ins. Guar. Ass’n*, the New Jersey Supreme Court ruled that the allocation methodology established in *Owens-Illinois* does not take precedence over a state law that expressly requires the exhaustion of all solvent carriers' policies before the Guaranty Association's reimbursement commitments on behalf of insolvent carriers are triggered.\(^{25}\) The Court explained that the “*Owens–Illinois* methodology is a product of this Court's equitable powers to advance public policy within the realm of the common law. The purpose of the methodology is to make insurance coverage available, to the maximum extent possible, to redress such matters as toxic contamination of property.”\(^{26}\) However, the statute that makes the Guaranty Association an insurer of last resort “also embodies an important public policy [and that] the common law must bow when in conflict with a legislative scheme.” Thus, the period of an insolvent carrier is allocated to the policyholder.\(^{27}\)

**B. Connecticut Applies Continuous Trigger, Pro Rata Allocation Based On Time On The Risk And The Unavailability Rule.**

In most respects, Connecticut has followed the trigger and allocation methodology established in New Jersey. In *Security Ins. Co. of Hartford v. Lumbermen’s Mut. Cas. Co.*\(^{28}\), the Connecticut Supreme Court agreed with the conclusion in *Owens–Illinois* that standard commercial general liability policies do not clearly dictate an allocation methodology for long-tail claims and embraced the public policy principles that supported the conclusion that prorated allocation of both defense and indemnity was appropriate, at least with regard to asbestos bodily injury claims. However, the court in *Security* described allocation as only based upon time on the risk and did not adopt the weighted allocation scheme embraced in New Jersey.

Although the Supreme Court in *Security* noted with approval that the trial court had applied continuous trigger and the unavailability rule, the Connecticut Appellate Court has since specifically adopted these principles in *R.T. Vanderbilt Co., Inc. v. Hartford Accident & Indem. Co.*\(^{29}\). *Vanderbilt* concerned coverage for asbestos-related bodily injury claims allegedly resulting from exposure to the policyholder's talc. The insurers in *Vanderbilt*, like the insurers in *Honeywell*, argued that the availability rule should not be adopted but, even if it were adopted, it should not apply to that period when asbestos coverage was no longer


\(^{26}\) *Id.* at 528, 74 A.3d at 863.


\(^{29}\) 171 Conn. App. 61 (2017). *Vanderbilt* is currently on appeal before the Connecticut Supreme Court where disputes over the application of continuous trigger and the unavailability rule will be addressed.

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available but the policyholder continued to sell its talc. Like *Honeywell*, the *Vanderbilt* court rejected these arguments.

First, as to whether adopt the unavailability rule, the court explained:

pro rata, continuous trigger allocation is an artificial judicial construct designed to allocate costs between the various insurance policies that are on the risk during the time over which a single, indivisible injury develops. To our minds, the question of how to allocate uninsurable portions of the allocation block is not so much one of fairness but, rather, of which party should bear the risk that the insurance pool will be terminated if substantial new long-tail risks are identified after significant liabilities already have accrued.\(^{30}\)

The *Vanderbilt* court cited various reasons identified by courts and commentators for adopting the rule, including that it “has the desirable effect of maximizing the resources available to respond to the multitude of claims facing” the policyholder, that it “best comports with the reasonable expectations of the insured,” and that “insurers have a better ability to manage this sort of risk.”\(^{31}\)

Second, while not foreclosing the possibility of an equitable exception in another case, the Appellate Court concluded it was not appropriate to do so in *Vanderbilt*. The trial court had found that

Vanderbilt had a long-standing and good faith belief that its talc did not contain asbestos and that the underlying actions were groundless. That belief appeared to be validated by federal regulators, who exempted talc from asbestos regulations; ... and by certain insurers, who agreed to insure Vanderbilt after 1993 on the basis of its representations that its talc did not contain asbestos.\(^{32}\)

The *Vanderbilt* court found that this record gave it no basis to conclude that “Vanderbilt’s continued sale of talc after 1985 did or will in fact increase the financial burdens on any of its pre-1986 insurers” or “afford Vanderbilt an undeserved windfall” and therefore refused to apply an equitable exception to the unavailability rule.\(^{33}\)

The *Vanderbilt* case provided several additional rulings worthy of note. First, the trial court concluded that, in addition to periods when the policyholder chose to be uninsured or lost the policy, periods of insolvency also would be allocated to the policyholder.\(^{34}\) Second, the Appellate Court concluded that neither the standard pollution exclusion in general liability policies nor the non-standard pollution exclusions involved in the *Vanderbilt* case would bar

\(^{30}\) 171 Conn. App. at 133-34, 156 A.3d at 579.

\(^{31}\) 171 Conn. App. at 136-38, 156 A.3d at 581.

\(^{32}\) 171 Conn. App. at 149, 156 A.3d at 587.

\(^{33}\) 171 Conn. App. at 149-50, 156 A.3d at 587-88.

coverage for asbestos-related bodily injury claims.\textsuperscript{35} Finally, the Appellate Court held that exclusions for “Occupational Disease” that did not specifically limit the exclusion to the “occupational disease” of the policyholder’s employees (as many policies do), would be construed to preclude coverage in claims where asbestos exposures are alleged to have taken place at the workplace or during the course of employment.\textsuperscript{36} The Connecticut Supreme Court has agreed to hear challenges to the Appellate Court’s rulings on continuous trigger, the unavailability rule, the pollution exclusion and the occupational disease exclusion, so stay tuned.\textsuperscript{37}

IV. ALLOCATION UNDER NEW YORK LAW: IT’S COMPLICATED

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Prior to the landmark 2016 New York Court of Appeals’ In re Viking Pump, Inc. & Warren Pumps, LLC, Insurance Appeals (“Viking Pump”)\textsuperscript{38} decision, insurers and policyholders understood that, per the Court’s prior Consolidated Edison Co. v. Allstate Ins. Co.\textsuperscript{39} decision, “pro rata” applied for purposes of allocating settlement and judgment costs for asbestos-related losses and environmental-related property damage claims.\textsuperscript{40} The Viking Pump decision upended that understanding, at least\textsuperscript{41} for policies that contain or follow form to

\textsuperscript{35} 171 Conn. App. at 216–55, 156 A.3d at 623-44.
\textsuperscript{36} 171 Conn. App. at 255-70, 156 A.3d at 644-52.
\textsuperscript{38} 27 N.Y. 3d 244 (N.Y. 2016).
\textsuperscript{39} 98 N.Y. 2d 208 (N.Y. 2002).

\textsuperscript{40} With respect to defense costs, a debate continues to play out in case law as to whether a “pro rata” share of defense costs should be allocated to the policyholder or whether the broad nature of the duty to defend, as long as the underlying claim alleges claims that potentially trigger policies, requires insurers to bear 100% of such defense costs. The New York Court of Appeals held in Continental Cas. Co. v. Rapid-American Corp. that “pro rata sharing of defense costs” among insurers “may be ordered” but that there was “no error or unfairness in declining to order such sharing, with the understanding that the insurer may later obtain contribution from other applicable policies” and also holding that the question as to whether an insured should at a later date share in paying defense costs was to be deferred until such time as the underlying claims were shown to involve “occurrences” during self-insured periods. 80 N.Y. 2d 640, 655-56 (1993). Often disputes concerning defense costs under New York law are resolved with no policyholder participation in the sharing of such defense costs, however, not always and it remains a contested issue.

\textsuperscript{41} From the policyholder perspective, as discussed herein, the Viking Pump court stumbled partly onto a truth that these standardized conditions reflect a standardized intent for historic occurrence-based policies to extend protections not just for injury that takes place during the policy period (pro rata) but also beyond it (all sums). The London Market Insurers’ LRD 60 umbrella form was the first umbrella policy to include a non cumulation condition. It had two paragraphs. The second paragraph was a “continuing coverage” clause which the Viking Pump court observed “reinforced” its conclusion that all sums, not pro rata, was intended in such policies as the clause “expressly extends a policy’s protections beyond the policy period.” Viking Pump, 27 N.Y. 3d at 262. The
standardized prior insurance and non cumulation of liability conditions ("non cumulation condition") that the Court held reflect an intent to extend coverage beyond the policy period for continuing injuries. Non cumulation conditions are ubiquitous in historic umbrella and excess insurance programs. Consequently, the Viking Pump decision radically adjusted how insurers that issued policies to New York insureds or were New York insurers perceived their potential exposure for asbestos-related and environmental-related losses.

Prior to the 2018 New York Court of Appeals' Keyspan Gas East Corp. v. Munich Reinsurance America, Inc. ("Keyspan") decision, the conventional understanding of how "pro rata" allocation would apply for continuous losses under New York law when it applied was that the losses would be allocated on a pro rata basis to periods when the damages were deemed to have taken place that were insured or during uninsured periods when insurance for such losses was generally available. See Olin Corp. v. Insurance Co. of North America, 221 F. 3d 307, 325-27 (2d Cir. 2000); see also Stonewall Ins. Co. v. Asbestos Claims *322 Management Corp., 73 F. 3d 1178, 1192 (2d Cir. 1995), modified on denial of reh’g, 85 F. 3d 49 (2d Cir. 1996) ("a fair method of allocation appears to be one that is related both to time on the risk and the degree of risk assumed. When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable."). For asbestos-related personal injury and property damage and environmental-related property damage losses, such coverage was not generally available after 1985 when the insurance industry inserted

drafters of the London '71 umbrella form dropped the continuing clause finding it to be "redundant" as the "whole intent of the policy is that if you have a loss that is in progress, it's not the intention to cut the assured off and say, oh, the policy is expired and we are not going to deal with the third-party damage or injury that is being caused." See Transcript of Peter S. Wilson at 129:7-136:17 (Jan. 24, 2017), Cannon Elec., Inc. v. ACE Prop. & Cas. Co., Case No. BC 209354 (Los Angeles Cty. Cal. Super Ct.) [hereinafter Wilson ITT Deposition] (testifying using the example of an explosion resulting in fire that causes property damage both during and after a policy period that "[b]ecause it started during the period of the policy, that is a loss occurrence that is in progress, and we would be responding to all the damage resulting from that explosion.") (emphases added) (a copy of this transcript is on file with Jay Konkel). Most of the drafters of historic general liability policies are deceased or no longer are testifying. Peter Wilson, a drafter of the London '71 umbrella and excess umbrella forms, however, testified at deposition in January 2017 and at trial in November 2018 in a longstanding coverage litigation with respect to asbestos losses for claims that continue to be brought against ITT LLC, formerly known as ITT Corporation and International Telephone and Telegraph Corporation.

Non cumulation conditions are found in many historic umbrella and excess insurance policies because domestic insurers essentially copied many of the terms of the LRD 60 umbrella form for their standard umbrella and excess umbrella policy forms, changing only a handful of words such as "Underwriters" to "Company" and "Assured" to "Insured." Transcript of Trial Testimony of Peter S. Wilson at 175:7-22, (Nov. 13, 2018 PM), Cannon Elec., Inc. v. ACE Prop. and Cas. Co., Case No. BC 290354 (Los Angeles Cty. Cal. Super Ct.) [Wilson ITT Trial Testimony (Afternoon)] (a copy of this transcript is on file with Jay Konkel).

As discussed herein, these insurers are advancing arguments in courts across the country that although the condition may support a ruling that "all sums" applies to their policies, the application of the condition itself actually shrinks the insurers' overall exposure to such liabilities.

31 N.Y. 3d 51 (N.Y. 2018).
standardized exclusions for such losses and also moved to claims-made policy forms. The Keyspan decision rejected the “unavailability” rule for time-on-the-risk pro rata allocation, holding that when pro rata applies, shares for such a loss are spread to all periods during which the damage takes place including to the insured for uninsured years regardless of the reason they are uninsured. Since thirty-three years have passed since asbestos and absolute asbestos exclusions were uniformly included in policies, the perceived change in how pro rata shares are now calculated in the wake of Keyspan under New York law when pro rata applies with a shifting of shares to insureds for more than three decades of non-insurance, has impacted negatively how certain policyholders perceive the value of the insurance they historically bought for such losses.

A. New York Law: “All Sums” Just Limited To Policies With Non Cumulation Conditions?

The insurer view and, perhaps, the conventional wisdom is that after Viking Pump and Keyspan, under “New York law,” “all sums” only applies for continuous losses under policies with non cumulation conditions. If the policy lacks such a condition, pro rata applies. This view is supported by passages in the Keyspan decision and the fact that the New York Court of Appeals in Consolidated Edison Co. of N.Y. v. Allstate Ins. Co. considered policies with standardized insuring agreements and (sort of) standardized definitions of “occurrence” that are in most historic insurance policies and held that pro rata allocation applies.

Policyholders point to the fact that the Keyspan decision rests, in part, on the fact that the policyholder conceded that pro rata applied. See Keyspan, 31 N.Y.3d at 57. Policyholders also argue that the Viking Pump court stumbled onto a truth about the intention of standardized general liability policies that have non cumulation conditions that the condition “contemplates” an intention in occurrence-based policies that were being issued at the time that they respond on an all sums basis. Standardized “conditions” in a policy, here the non cumulation condition, cannot “turn on” a dormant insuring agreement promise that already promises to cover the insured for “all sums” for damages for losses arising out of an occurrence, and with respect to personal injuries claims, damages including for “death at any time resulting” from personal injuries.\textsuperscript{45} Conditions in policies do not grant or expand coverage in the policy.\textsuperscript{46} The insuring agreement in a policy sets forth the policy’s scope of coverage.\textsuperscript{47} The insuring agreement promise in these policies to cover consequential damages and to cover claims for personal injuries including for “death at any time resulting therefrom” expressly extends the protections

\textsuperscript{45} For a discussion of the CGL drafting history of the term “bodily injury” including its inclusion of the phrase “death at any time resulting therefrom” and “damages.” See David Cox, Gerald Konkel ALI Restatement Misstates Law On Long-Tail Harm Claims, Law 360, Insurance (March 29, 2018) available at https://www.morganlewis.com/pubs/ali-restatement-misstates-law-on-long-tail-harm-claims

\textsuperscript{46} The Viking Pump court did not hold that the standardized non cumulation “conditions” granted “all sums” coverage in the policies, only that the conditions “contemplated” that was how the occurrence-based policies from the period were intended to work. Viking Pump, 27 N.Y. 3d at 260-61.

\textsuperscript{47} \textbf{RESTATEMENT OF THE LAW LIABILITY INSURANCE}, §3 cmt. b.
of the policy to injuries beyond the policy period. The standardized conditions were included to grapple with that broad coverage promise, not expand or activate it.

Notwithstanding policyholder arguments for a further expansion of applying the Viking Pump court’s reasoning to language beyond non cumulation conditions, insurers often, and rightly, point to Keyspan as posing significant headwinds for such arguments, particularly for environmental-related property damage coverage claims.

B. New York Law: Unresolved Issues For “Hybrid” Programs Where Some Policies Have Non Cumulation Conditions And Some Do Not

In a given case where the parties accept or a court rules in favor of the insurer view that under New York law only policies with non cumulation conditions respond on an all sums basis, since most historic insurance programs have policies that have the condition and policies that lack them, questions remain concerning how to allocate losses among those policies including for purposes of umbrella and excess policies coverage “attaching” upon underlying exhaustion. Since most historic primary policies lack the condition even though many umbrella and excess policies contain or incorporate such conditions, insurers often argue that for purposes of accessing that excess coverage, the insured has to allocate losses to itself in accord with Keyspan for uninsured “triggered” periods, even reallocating losses that primary insurers paid under their policies if portions of those amounts “should” have been allocated to its insured for uninsured-but-triggered periods, to determine whether enough is “properly” allocable to the underlying policy year for an excess policy’s coverage to attach.

In a scenario where primary insurers policies lack non cumulation conditions and the primary insurers assert that they should only pay their strict pro rata share of settlement and

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48 Policyholders have found some traction on opening the door to “all sums” under New York law further (in the context of asbestos-related bodily injury claims) by pointing to policy language beyond the non cumulation condition language. The Consolidated Edison and Keyspan courts which were dealing with coverage for property damage losses, did not consider the application of policy language to bodily injury claims. Two courts after Viking Pump have held that under New York law in asbestos-related bodily injury coverage cases this “death at any time” language in the policies means that all sums applies: Cannon, Elec. Inc. v. ACE Property & Casualty Co., No. BC 290354 (Los Angeles Cty., Cal. Super. Ct. Aug. 17, 2017) (“ITT I”) (trial order, on file with Jay Konkel) and Polar-Mohr Maschin-envertribsgesellschaft GMBH, Co. KG. v. Zurich American Insurance Co., 2018 WL 1335880 (N.D. Cal. Mar. 15, 2018) (citing ITT I).

49 Peter Wilson, a drafter of the London ’71 umbrella form, certainly understood that the condition did not “make” a policy an “all sums” policy but rather that the “whole intent” of the policy—and all policies—was to extend protection not just for the pro rata share of loss taking place during the policy period from an occurrence but for all of the loss for the occurrence beyond it. See Wilson ITT Deposition at 129:7-136:17; Wilson ITT Trial Testimony (Afternoon) at 174:12-19. Because courts could construe such policies in a way to permit an insured to collect “loss” from an occurrence under multiple policies the London Market Insurers kept the non cumulation conditions in their policies many years after the move from event-based to occurrence-based policies. See Transcript of Trial Testimony of Peter S. Wilson at 28:23 to 29:17, (Nov. 13, 2018 AM), Cannon Elec., Inc. v. ACE Prop. and Cas. Co., Case No. BC 290354 (Los Angeles Cty. Cal. Super Ct.) [Wilson ITT Trial Testimony (Morning)] (a copy of this transcript is on file with Jay Konkel).
judgment costs in accord with Keyspan, assuming the policyholder cannot make any traction that other policy language dictates an all sums result, the insurers will prevail on their arguments under New York law. The insured will be responsible for paying losses allocable to uninsured years.

In a scenario where the policyholder is seeking access to excess policies that have non cumulation conditions, particularly where the primary insurers have paid their limits, policyholders assert (at least) two arguments that turn on a distinction between “exhaustion” and “allocation.” Policyholders argue that under New York law, per the Second Circuit’s decision in Olin Corp. v. OneBeacon America Insurance Co., a hybrid “allocation/exhaustion” scheme is incorrect and “all sums” applies to the underlying policies for determining exhaustion pursuant to Viking Pump’s vertical exhaustion rule. Olin Corp., 864 F.3d 130, 144 (2d Cir. 2017). Policyholders also argue that under the primary insurer’s insuring agreement, that insurer has a right and a duty to defend potentially covered suits, pay settlements for such suits as it deems expedient, and stop paying such amounts (i.e. “exhaust”) once it has paid its limits. In such a scenario, policyholders argue, an excess insurer cannot contest that exhaustion without evidence of collusion to defraud an excess insurer. See United States Fid. & Guar. Co. v. Treadwell Corp., 58 F. Supp. 2d 77, 106-110 (S.D.N.Y. 1999) (holding that “treating a primary insurer’s settlement with an insured as binding for allocation purposes, at least in the absence of evidence of collusion to defraud an excess insurer, furthers the strong public interest in promoting settlement” and concluding that the primary insurer’s payment “should be allocated entirely to [its policy] period.”).

C. New York Law: Unresolved Issues As To How Non Cumulation of Liability Conditions “Reduce” Coverage For Continuous Losses

Under New York law, non cumulation conditions are “anti-stacking” conditions that prevent an insured from collecting more than one year’s policy limits to respond to the same occurrence or loss. They apply in “the situation in which ‘an insured who has suffered a long term of continuous loss which has triggered coverage across more than one policy period . . . wishes to add together the maximum limits of all consecutive policies that have been in place during the period of the loss.” Viking Pump, 27 N.Y. 3d at 259. In the wake of Viking Pump, a rash of coverage litigation has ensued regarding whether and how non cumulation conditions, particularly with respect to coverage for asbestos-related product liability claims, limit an insured’s recovery.

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50 The standardized non cumulation condition in Liberty Mutual’s historic primary and umbrella policies and excess policies that followed form to it expressly applies on a same occurrence basis. The non cumulation conditions based on the London umbrella form language applies on a same “loss” basis.

51 Cases also have been decided since Viking Pump that address the application of non cumulation conditions in the context of coverage for environmental-related property damage (where aggregate limits are not in play) including whether and to what degree a non-settling insurer with policies with the condition should get a “set off” for payments a settling insurer that issued “prior insurance” made in a “buyout.”
The two variations of non cumulation conditions that have been the subject of this litigation are Liberty Mutual's language which applies on a “same occurrence” basis and the London Market Insurer language which applies on a “same loss” basis.

Liberty Mutual’s non cumulation clause:

Non-Cumulation of Liability—Same Occurrence—If the same occurrence gives rise to personal injury, property damage or advertising injury or damage which occurs partly before and partly within any annual period of this policy, the each occurrence limit and the applicable aggregate limit or limits of this policy shall be reduced by the amount of each payment made by the company with respect to such occurrence, either under a previous policy or policies of which this is a replacement, or under this policy with respect to previous annual periods thereof.

London ’71 Umbrella form non cumulation condition:

C. PRIOR INSURANCE AND NON CUMULATION OF LIABILITY –

It is agreed that if any loss covered hereunder is also covered in whole or in part under any other excess policy issued to the Assured prior to the inception date hereof the limit of liability hereon as stated in item 2 of the Declarations shall be reduced by any amounts due to the Assured on account of such loss under such prior insurance.

Item 2 of the declarations page of the London ’71 umbrella form identifies a limit for each occurrence and a limit in the aggregate for each annual period where applicable. Under the form’s Insuring Agreement II., the policy’s aggregate limit applies for each of the policy’s annual periods separately in respect of Products Liability and in respect of Personal Injury by Occupational Disease sustained by any employees of the Assured.

Insurers have argued that, under New York law, the reference to reducing “aggregate” limits when the non cumulation condition applies means that if an insurer for an earlier policy pays a settlement for a particular asbestos-related product liability claim, the aggregate limit available for different asbestos-related product liability claims under policies with non cumulation conditions covering succeeding periods will be reduced by the amounts due under the earlier policy. Courts have rejected that argument with respect to the Liberty Mutual non cumulation condition language holding that the policy language explicitly limits the clause’s application to the “same occurrence” and not additional different occurrences. See Liberty Mut. Ins. Co. v. The Fairbanks Co., 2016 WL 4203543, at *4-*5 (S.D.N.Y. Aug. 8, 2016);\(^{52}\) see __

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\(^{52}\) The Fairbanks court rejected Liberty Mutual’s summary judgment argument that indemnity payments reduce amount of aggregate limits available for recovery under subsequent policies regardless of the number of occurrences involved in asbestos suits as the plain language of the clause refers to the same occurrence. Id. at *4. Instead, the court held that Fairbanks reasonably argued that the non-cumulation clause applies only to “the same occurrence” and not a different occurrence and held that the number of occurrence issue had to be resolved before the non cumulation clause could be applied. Id. at *5.
also Hopeman Bros., Inc. v. Continental Cas. Co., 307 F. Supp. 3d 433 (E.D.Va. 2018). Under New York law, for asbestos claims “the incident that [gives] rise to liability [is] each individual plaintiff’s ‘continuous or repeated exposure’ to asbestos.” Appalachian Ins. Co. v. General Elec. Co., 8 N.Y. 3d 162,172-73 (2007). Such separate “incidents” are considered separate occurrences under New York law, unless it can be shown that the claimants’ alleged exposures to asbestos were at essentially the same time and same place. Id. at 174. Accordingly, since courts construing the Liberty Mutual non cumulation language under New York law have held the condition only applies to the same occurrence and not additional ones, insurers’ arguments that a payment of a settlement for one claim/occurrence has not gained any traction.

By contrast, insurers have had some success in arguing that the language based on the London Market Insurers’ non cumulation condition, which references “loss” without referencing “occurrence,” has a broad impact on reducing products coverage for asbestos claims. Insurers have argued that “loss” is a broader term than “occurrence” and that a “loss” is comprised of the aggregate of asbestos-related bodily injury claims for which the insured seeks coverage and not just a particular claim arising out of a particular occurrence. See e.g. Hopeman, 307 F. Supp. 3d at 458 (holding that the undefined term “loss” “is inherently broad and would include an insured’s total liability arising from a particular category of harm” and that therefore “the term ‘loss’ in the [non cumulation condition] unambiguously refers to the gross amount [the insured is seeking under each policy . . . .].”) Insurers relying on cases such as Hopeman have argued that the payment of an asbestos claim under an earlier policy constitutes an “amount due” for the singular “covered” asbestos “loss” under prior insurance that reduces the aggregate limit in later policies for different asbestos claims as those different unpaid-by-any-insurer asbestos claims constitute the “same loss.” See London ’71 Umbrella form non cumulation condition (“if any loss covered hereunder is also covered in whole or in part under any other excess policy issued to the Assured prior to the inception date hereof the limit of liability hereon . . . shall be reduced by any amounts due to the Assured on account of such loss under such prior insurance.”) (emphasis added).

Other courts, applying New York law, have rejected the notion that a “loss” under a policy is broader than an “occurrence” based on the fact that “losses” under an occurrence-based policy arise out of an occurrence” and policy language throughout the policy reflects that fact. See Cannon Elec., Inc. v. ACE Property & Casualty Co., No. BC 290354 (Los Angeles Cty., Cal. Super. Ct. January 9, 2019) (“ITT II”); Carrier Corp. v. Travelers Indem. Co.,

53 The Hopeman court, with respect to the Liberty Mutual language, granted the policyholder’s summary judgment motion, as a matter of New York contract law, holding that “the language . . . has an unambiguous meaning” and found that the language “limits its application to recoveries involving the same ‘occurrence,’ and that each individual alleging bodily injury from exposure to Hopeman asbestos-containing material presents a separate ‘occurrence.’” Id. at 455.

54 The Hopeman court, following the Second Circuit’s Olin decision, did hold that the non cumulation condition only reduces limits to the extent that the policyholder had already recovered for the same “loss” under relevant prior insurance at the same “layer” or horizontal “tier” of coverage as the policy in the later year with the non cumulation condition. Id. at 453.
Index No. 2005-EF-7032, RJI No. 33-06-4408, slip op. at 21 (N.Y. Sup. Ct. Nov. 21, 2018); see also Olin Corp. v. OneBeacon Am. Ins. Co., 864 F. 3d 130, 147, 150-151 (2d Cir. 2017) (applying New York law). The policyholder argument is that under the policy’s terms “loss” flows from an “occurrence” and, consequently, can be no larger than an occurrence. Policyholders argue that “loss” is what is paid to a claimant that has been injured from an occurrence and that there can be multiple “losses” that flow from a single occurrence (e.g. if more than one claimant worked on the same asbestos-containing product near the same time). In the standard form London umbrella policies, the policyholder argument finds support from the definition of Ultimate Net Loss, the Insuring Agreement I, Insuring Agreement II, and the Loss Payable condition. Policyholders also argue that the non cumulation condition only is implicated if the policyholder makes a definite claim for reimbursement for the same “loss” (e.g. the amount paid for the “John Doe claim”) under more than one year’s policy or policies. Policyholders support their argument by pointing to the Insuring Agreement I and the Loss Payable condition, which provide that a “loss” is only “covered” under a later policy and “amounts” for that “loss” only are “due” under a prior policy if definite claims for reimbursement for that same loss are asserted under both policies.

With respect to non cumulation conditions that only reference “loss,” if the condition is ubiquitous in a policyholder’s umbrella and excess insurance program and if an insurer’s Hopeman-like arguments prevail before a court, the impact could mean that the policyholder, essentially, only has a total of one year’s aggregate limits to respond to all of the asbestos-related product liability suits that are asserted against them. This result can reduce the aggregate limits the policyholder bought in a historic insurance program before asbestos exclusions were added to respond to product liability claims by 90 percent. Where policyholder arguments prevail, the condition is not implicated unless the policyholder seeks to recover for the same claim under more than one year’s policy and even then, because

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55 Peter Wilson, a drafter of the London ’71 umbrella form, agrees. See Wilson ITT Trial Testimony (Afternoon) at 185:19 to 186:4 (testifying that the Ultimate Net Loss definition is “all tethered” to sums “being paid as a consequence of any occurrence); id. at 186:8-19 (testifying that Ultimate Net Loss is the “total sum of losses that the underlying insurer or insured have to pay . . .”); id. at 186:20-26 (testifying that part of that “total sum” of losses in the amount of underlying limits have to be paid before the coverage under an umbrella or excess policy can attach); id. at 190:17 to 191:12 (testifying that then excess policy, if called upon to respond, pays the excess of such losses up to that policy’s limits); id. at 187:25-188:11 (testifying about the parallels in the Ultimate Net Loss definition’s reference to “total sums” and Insuring Agreement I’s reference to “all sums” means that with respect to personal injuries claims, a “loss” is a sum and “losses” are “sums” that an insured is obligated to pay by reason of settlement or adjudication for damages on account of personal injuries claims caused by or arising out of an occurrence); see also ITT II, slip op. at 26 (“Viewing the policy terms as a whole, the only reasonable reading of loss referenced in the Prior Insurance/Non Cumulation Condition is to define “loss” as tethered to “occurrence.”). 

56 Insuring Agreement I, titled “Coverage,” provides that “coverage” for the “all sums” the policy indemnifies is subject to the policy’s “conditions.”

57 Peter Wilson agrees. See Wilson ITT Trial Testimony (Afternoon) at 188:12-20, 192:6 to 193:11; see also Wilson ITT Deposition at 122:24 to 124:9.
asbestos claims almost always are settled for much less than a policy’s limit the recovery for that loss is not effected.\footnote{Where the policyholder arguments prevail, the condition, when implicated, only reduces limits (including aggregate limits) for the particular loss and not for a different loss. See \textit{ITT II}, slip op. at 26 (“The purpose of the Non Cumulation condition is if a policy holder seeks to recover for the same loss under more than one year’s policy, its recovery for that loss must be limited to the amount of one year’s limits for that loss. Its purpose is not to eradicate aggregate limits for losses no insurer has paid.”); see also \textit{Viking Pump, Inc. v. Century Indem. Co.}, 2013 WL 7098824, at *4, *12, *16-17 (Del. Super. Ct. Oct. 31, 2013) (ruling under New York law the non-cumulation conditions apply only on a “per occurrence” basis with no effect on the aggregate limits available for different claims), \textit{aff’d in part and rev’d in part on other grounds}, 148 A.3d 633 (Del. 2016); \textit{Fairbanks}, 2016 WL 4203545, at *4-5 (ruling under New York law that application of non-cumulation condition “depends on the number of occurrences” because of “the fact that the application of the non-cumulation clause is limited to ‘the same occurrence.’”).}

V. ALLOCATION UNDER THE ALI RESTATEMENT

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The ALI’s \textit{Restatement of the Law, Liability Insurance}, which was approved in final form in May 2018, is the product of eight years of iterative drafting, review, comment, and revision. One of the more hotly contested sections of the \textit{Restatement} was section 42, titled “Allocation in Long-Tail Harm Claims Covered by Occurrence-Based Policies.”

A. The \textit{Restatement} Approach to Allocation in Long-Tail Claims

The \textit{Restatement} refers to its allocation approach as “pro rata by year.” Section 42 provides as follows:

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\item Except as stated in subsection (2), when indivisible harm occurs over multiple years, the amount of any judgment entered in or settlement of any liability action arising out of that harm is subject to pro rata allocation as follows:

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\item For purposes of determining the share allocated to any occurrence-based liability insurance policy that is triggered by harm during the policy period, the amount of the judgment or settlement is allocated equally across years, beginning with the first year in which the harm occurred and ending with the last year in which the harm would trigger an occurrence-based liability insurance policy; and
\item An insurer’s obligation to pay for that pro rata share is subject to the ordinary rules governing any deductible, self-insured retention, policy limit, or exhaustion terms in the policy.
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(2) When an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy that provides coverage for the claim.

(3) Defense obligations relating to multiple triggered policies are subject to the rules in § 20.

Thus, the Restatement adopts a pro-rata allocation scheme in which the total liability—whether determined by judgment or settlement—is spread equally across the period of time beginning with the first year in which harm occurred and ending in the last year in which the harm would trigger an occurrence-based policy. The liability attributable to each policy year is then allocated among the available insurance policies for that year in accordance with their terms. Deductibles, self-insured retentions, policy limits, and exhaustion terms are given effect, and any liability allocated to a given year that exceeds the available coverage is borne by the insured. Additionally, the portion of the loss that is attributed to years when the insured elected not to purchase coverage is allocated to the insured. 59

Crucially, the pro-rata by years approach is only a default. Therefore, “[t]he default rule of pro rata allocation can be altered by contractual terms that provide an alternative method of allocation or priority.” § 42, cmt. j. However, the traditional language of the insuring agreement in the standard CGL policy, in which the insurer agrees to pay “all sums,” does not alter the default rule. As will be discussed further below, the Restatement’s default rule is itself a choice between giving effect to the “all sums” language and the “during the policy period” language in CGL policies.

Notably, the Restatement approach does not tackle the issue of unavailability. That is, how is the loss allocated in years where indivisible harm occurred, but no insurance coverage for the loss was available for purchase? There was considerable debate following the ALI’s 2016 Annual Meeting as to whether section 42 should include an “unavailability” exception to “pro rata” liability. Under the proposed exception, the denominator for calculating each party’s share of loss in asbestos cases would omit years after 1985, when asbestos exclusions became prevalent. By contrast, under a pure “pro rata” rule, the insured is responsible for all years when there is no coverage, without distinction as to exclusions, insolvency, or a simple failure to purchase insurance. Following an intense debate within the ALI, the Reporters merely note in Comment g. that “some courts” have recognized an “unavailability” exception but do not endorse this approach.

B. Analysis of the Restatement Approach

In general, the ALI’s goal in restatements of the law is to distill prevailing legal principles from cases, to indicate a trend in common law, and, occasionally, to recommend what a rule of law should be. In essence, they restate existing common law into a series of principles or rules. In section 42 of this Restatement, the ALI wades deeply into the prescriptive side of its project. As the Restatement acknowledges, it is not even entirely clear how many jurisdictions

59 See § 42, Comment e.
have adopted all sums allocation or how many have adopted some form of pro rata allocation.\textsuperscript{60}

Nonetheless, the \textit{Restatement} puts the count at 16 jurisdictions that have adopted some version of the pro rata approach for policies containing the old “all sums” and “during the policy period” language\textsuperscript{61} compared to 10 that have adopted the all sums approach.\textsuperscript{62} Among the 16 jurisdictions that the \textit{Restatement} counts as having adopted a pro rata approach, only three have found that the plain language of the policies at issue requires the \textit{Restatement}’s pro rata by years allocation.\textsuperscript{63} Others have found that the pro rata by years approach is at least consistent with or satisfies the plain meaning of the 1976 CGL policy.\textsuperscript{64} The remainder look beyond the plain language of the policy to what the \textit{Restatement} calls “their interpretation of the contracting parties’ reasonable expectations”\textsuperscript{65} or a public policy choice.\textsuperscript{66}

On the all sums side of the divide, the vast majority of the jurisdictions that have adopted all sums allocation have relied on either the plain language of the policy or traditional principles in the interpretation of insurance policies.\textsuperscript{67} In particular, some courts that have

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\item \textsuperscript{60} § 42, Comment c. ("[t]here is some disagreement over the precise number of jurisdictions that have adopted each position, in part because of variation in policy language and in part because of differing possible interpretations of the holdings in some cases.").

\item \textsuperscript{61} § 42, Note c. (Colorado, Connecticut, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, New York, South Carolina, and Utah).

\item \textsuperscript{62} \textit{Id}. (California, Delaware, District of Columbia, Illinois, Missouri, Ohio, Pennsylvania, Texas, Washington, and Wisconsin).


\item \textsuperscript{65} § 42, Comment d.


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adopted all sums allocation have relied on the traditional principle that where the terms of an insurance policy are ambiguous, the court will construe the policy in the insured’s favor.68

The Restatement recognizes the core ambiguity that has led courts to adopt all sums allocation, but it makes a policy argument for resolving that ambiguity in favor of pro rata allocation. The core ambiguity lies in the use of both “all sums” and “during the policy period” language in the insuring agreement of the standard CGL policy. The Restatement posits that the liability risks presented by the rise of mass toxic-tort suits and environmental-cleanup and property-damage causes of action were not adequately anticipated and addressed in the standard commercial general-liability (CGL) insurance policies sold before the nature and extent of those risks became apparent in the 1980s. A careful assessment of the relevant policy language in those earlier policies must acknowledge that the language is susceptible to both pro rata and all-sums interpretations.69

Thus, the Restatement rejects those decisions that hold that the plain language of a standard CGL policy requires either pro rata or all sums allocation. Rather, the Restatement relies on a policy argument concisely stated in section 42, Comment c:

This Restatement follows the pro rata by years default rule for allocation in the case of long-tail harms, because that approach is the most consistent, simplest, and fairest solution to this problem. It is consistent because it provides the same result for every triggered year. It is simple because it requires very little information to determine the pro rata percentage to be applied, and it presents the fewest complications regarding exhaustion, deductibles, and settlement. It is fair because all triggered years, including the years in which the insured did not purchase insurance, share equally in the indivisible losses. In addition, this approach reflects the best effort to accommodate the language in insurance policies that links the coverage to harm that occurs during the policy period. Of all the alternative theories, this approach comes closest to allocating to each policy only those bodily injuries or property damage that occurred during each policy period, given the indivisibility of the harms at issue.

The Restatement goes on to note the potential for unfair outcomes under the all sums approach, where an insurer may “be held responsible for a large amount of losses that did not occur during the policy period that the insurer agreed to cover.”70

However, perhaps in recognition of the split among jurisdictions and the force of the reasoning that has led many jurisdictions to adopt all sums allocation, the Restatement offers


69 § 42, Comment d.

70 § 42, Comment d.
further reasoning for attempting to account for all of the decisions reached by courts on this issue so far:

Most of the courts that have considered this issue have rejected the all-sums approach in favor of the pro rata approach. Not all these courts provide the same reasons for their choice, but their results are all consistent with the following reasoning: (a) pro rata by years is the default allocation rule for long-tail claims under occurrence policies with harm-based triggers, (b) ambiguous or uncertain terms that can be read in two ways—as consistent with the default rule or to the contrary—are insufficient to alter that default rule, and (c) the “all-sums” wording in the pre-1986 policies is, at best for policyholders, ambiguous or uncertain in that regard and, thus, insufficient to displace the default rule. It is important to note that the cases reaching the contrary, all-sums result are consistent with a pro-rata default rule, with the crucial difference that the courts in these cases differ from the majority in treating the “all-sums” language in the earlier CGL policies as sufficient to alter that default rule. 71

The one glaring problem with the Restatement’s reasoning is that, so far, it appears no court has used it. None of the courts that have come down in favor of pro rata allocation have treated pro rata allocation as the default rule, requiring unambiguous policy language to reach a contrary result. Instead, as described above, such courts have either found that the policy language unambiguously requires pro rata allocation—a conclusion the Restatement rejects as to the standard, pre-1986 CGL policy—or relied on one or more of the policy justifications mentioned in § 42, Comment c.

Thus, the Restatement approach, in which pro rata allocation is a default rule that can be overcome only by unambiguous policy language that is at least inconsistent with pro rata allocation, is aspirational rather than descriptive. It appears to be an invitation to courts rather than a synthesis of their decisions.

The Restatement points to the New York decision In re Viking Pump as an example of its approach, citing the court’s observation that “in the absence of language [other than merely the ‘all sums’ language] weighing in favor of a different conclusion, pro rata allocation [is] the preferable method of allocation in long-tail claims in light of the inherent difficulty of tying specific injuries to particular policy periods … [but that] ‘different policy language’ might compel all sums allocation.” 72 However, in the quoted portion of the decision, the Viking Pump court was describing a suggestion made in Consolidated Edison, an earlier New York case that adopted pro rata allocation. 73 The court further noted that the Consolidated Edison decision pointed to the Delaware Supreme Court’s decision in Hercules, Inc. v. AIU Ins. Co., wherein the Delaware court adopted the all sums method, as an example of interpretation of “different policy language.” 74 The policy language interpreted in Consolidated Edison and Hercules was  

71 Id.
72 § 42, Note c. (citing Viking Pump, 27 N.Y.3d at 258).
73 Viking Pump, 27 N.Y.3d at 258 (citing Consolidated Edison, 98 N.Y.2d at 223).
74 Id.
precisely the “all sums” and “during the policy period” language that the Restatement says cannot alter the pro rata default. To be sure, the non-cumulation clauses interpreted in Viking Pump were not part of the “all sums” language included in the policies’ insuring agreements. But, following the reasoning in Consolidated Edison, the “different policy language” need not fall outside the insuring agreement. Even the relatively miniscule differences between the policy language interpreted in Consolidated Edison and Hercules could be enough to mandate all sums allocation rather than pro rata allocation. Thus, while Viking Pump is consistent with the Restatement approach, it does not provide an example of the Restatement approach in action.

Thus far, courts have been much more willing to adhere to their own readings of the relevant policy language, their own interpretations of precedent in their jurisdictions, and other sources of policy arguments. For example, Ohio Governor John Kasich has signed into law Senate Bill No. 239 that states, inter alia, that the Restatement “[d]oes not constitute the public policy of this state and is not an appropriate subject of notice.”75 The Kentucky House of Representatives also passed a resolution urging the ALI to change the proposed Restatement “[s]o that it is consistent with well-established insurance law and respectful of the role of state legislatures in establishing insurance legal standards and practice.”76

However, the goal of the Restatement may not be as much to change the law in those states that have already ruled on long-tail allocation as it is to influence the decisions of those states that have not yet ruled on the issue. By the Restatement’s count, 24 states have yet to rule on the long-tail allocation issue. For example, although not addressing the long-tail allocation issue discussed in this article, Nevada appears to be the first state in which its highest Court cited to the Restatement in approval. The Supreme Court of Nevada ended up agreeing with the Restatement and adopted a minority approach over an issue that had not yet been decided in the state.77

In states where there is no governing law, where courts nationally are split, and where two prevalent schools of thought exist, the Restatement can act as a tie-breaker. Another section of the Restatement was recently used in precisely that manner in an Illinois trial court—one of the first courts to use the Restatement to find against an insurer.78 There, the court had before it an insurer’s attempt to seek reimbursement of a $7.5 million settlement payment under a D&O policy. The policy included the insurer’s express right to reimbursement of defense costs but not any indemnity payment. The court had to apply Rhode Island law, which provided no guidance. The court noted the national split among courts on the issue of an insurer’s right to recoupment of defense costs and indemnity or settlement payments. The

75 Ohio Revised Code § 3901.82.
76 Kentucky House of Representatives Resolution 18 RS BR 1943 § 2.
court went on to cite sections 21 and 25 of the Restatement for “the recent trend and default rule to disallow reimbursement absent a provision in the insurance policy or contract between the parties.” In the absence of binding precedent and the presence of persuasive authority in both directions, the court followed the Restatement.

That may be the role section 42 plays in the development of the law on long-tail allocation. The Restatement approach is not yet an accurate description of the way courts handle long-tail allocation issues, but it does follow a slim majority of jurisdictions in opting for pro rata rather than all sums allocation. If courts find the Restatement’s policy arguments persuasive enough, section 42 may one day be a true restatement of the law on this issue.