Can You Climb the Excess Tower and Enjoy the View From Up There?

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TABLE OF CONTENTS

The challenges to obtaining coverage under umbrella and excess insurance are many and fraught. First and foremost is the challenge of establishing the proper exhaustion of all applicable underlying insurance. The dispute over what constitutes proper exhaustion is not simply between policyholders and excess carriers; it is often joined by primary and umbrella carriers who disagree with their excess brethren regarding the correct interpretation of their coverage obligations.

This paper serves to outline some of the most common of these challenges: When does an excess carrier get to dissect the settlement or the claims handling decisions of the underlying carriers? How can exhaustion be established when a policyholder enters into a below-limits settlement with the underlying carrier? If multiple underlying carriers have coverage obligations, which ones have to be exhausted?

I. Challenges to Amount of/Timing of Settlement of Underlying Claim Or Proportion of Claim to be Covered

It is axiomatic that an excess insurer has no obligation until the primary or underlying insurer exhausts, and that a primary insurer owes no further defense or indemnity after it exhausts. *See, e.g., Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049, 1062 (Ind. 2001) (although finding a fact issue as to whether aggregate limits applied); *N. River Ins. Co. v. Am. Home Assurance Co.*, 210 Cal. App. 3d 108, 112, 257 Cal. Rptr. 129, 131 (Cal. Ct. App. 1989; *Godur v. Travelers Indem. Co.*, 567 So. 2d 1028, 1030 (Fla. App. 1990). But what it means to exhaust, when exhaustion occurs, and whether the payments that lead to exhaustion can be questioned, have led to myriad disputes among primary insurers, excess insurers, and policyholders.[1] While there are splits in the jurisdictions as to many of the issues, policy language is also paramount, and many of the cases turn on the specific terms at issue.

A. Primary Insurer's Payment of Potentially Uncovered Claims

A question often arises as to whether an excess/umbrella carrier is bound by a primary insurer's exhaustion by settlement where there are potential uncovered claims. This issue can arise from any insuring agreement or exclusion issue, but may also arise based on trigger.

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[1] States also differ on whether a primary insurer can exhaust its limits, and trigger excess coverage, by a settlement for less than limits. *See, e.g., Zeig v. Massachusetts Bonding & Insurance Co*., 23 F.2d 665 (2d Cir. 1928); *Pfizer Inc. v. United States Specialty Ins. Co.***,** 2020 Del. Super. LEXIS 2759 (Del Super. Sept. 1, 2020) ("*Stargatt* rule") (citing *Stargatt v. Fidelity and Cas. Co. of New York*, 67 F.R.D. 689, 691 (D. Del. 1975)); *Gasquet v. Commercial Union Ins. Co.*, 391 So. 2d. 466 (La. App. 1980); *Anile v. Liberty Mut. Ins. Co***.,** 2015 Mass. App. Unpub. LEXIS 856 (Mass. App., Aug. 20, 2015), allowing settlement for less than limits; *see also Aggreko, L.L.C. v. Chartis Specialty Ins. Co.*, 942 F.3d 682 (5th Cir. 2019) (covenant not to execute was equivalent of settlement); *but compare Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 161 Cal. App. 4th 184, 73 Cal. Rptr 3d 770, 778-79 (Cal. Ct. App. 2008); *Citigroup Inc. v. Fed. Ins. Co.,* 649 F.3d 367 (5th Cir. 2011), requiring actual payment of limits. Even where such settlements are allowed, the excess insurer is usually liable for indemnity only above the primary limits.

From the excess/umbrella insurer's standpoint, if the carrier was not a party to the settlement, it should be able to contest the settlement and force the primary insurer, or insured, to establish that the full limits can be allocated to covered claims. From the primary insurer's standpoint, and often the insured's, a reasonable settlement that includes a compromise of unsettled coverage issues is sufficient.

There is no clearly recognized cause of action for wrongful or premature exhaustion. In *Amerisure Mut. Ins. Co. v. Arch Specialty Ins. Co.*, 784 F.3d 270, 275 (5th Cir. 2015), the court noted the dilemma of a "wrongful exhaustion" claim, since the insured initially sought coverage but the subrogated excess insurer now argued some claims paid by the primary were not covered. Ultimately, the court held the claims were covered, so it did not need to address whether such a cause of action existed.

In *Axis Reinsurance Co. v. Northrop Grumman Corp.*, 975 F.3d 840 (9th Cir. 2020), the second-layer excess insurer, Axis, asserted the underlying insurers had improperly eroded their limits and prematurely exhausted by payment of non-covered claims. The district court agreed, and allowed a claim for reimbursement against the insured. In a case of first impression, the Ninth Circuit concluded that, absent express language in the policy, the payments could be contested only if the excess insurer could establish the payments were made in bad faith.

After investigation by the Department of Labor the insured, Northrop, entered into several settlement agreements, and then submitted the claims to its insurers for reimbursement. The first settlement was with DOL. AIG, the primary insurer, concluded the claims were covered and paid its limits. CNA, the first-layer excess, also concluded the claims were covered and made payments, although the payments did not exhaust its limits. CNA then contributed to a subsequent settlement, on behalf of several Plans, exhausting its limits and implicating the Axis policy. The Axis policy had language providing it would "drop down," where primary layers were exhausted by payment of covered claims. *Id.* at 843. Axis did not contest the second settlement was covered, but did contest coverage for the DOL settlement, arguing it was disgorgement and uninsurable under California law. *Id.* at 844.

The court first noted that no jurisdiction had adopted the theory of "improper erosion" espoused by Axis, under which an insured effectively bears the risk of its insurer's coverage determinations. *Id.* Northrop argued, and the court agreed, that the excess insurer should bear the risk that it will disagree with an underlying insurer's coverage determination. *Id.*

The court noted the limited caselaw in this area, but reasoned that it supported a rule that "that excess insurers generally may not avoid or reduce their own liability by contesting payments made at prior levels of insurance, unless there is an indication that the payments were motivated by fraud or bad faith."

The court in *Northrop* distinguished a prior Ninth Circuit case, *Shy v. Insurance Company of the State of Pennsylvania*, 528 F. App'x 752 (9th Cir. 2013), in which the excess insurer successfully challenged a primary insurer's coverage decision. In *Shy*,

the primary and excess insurers reached different coverage determinations as to a single claim. The court concluded the primary carrier exhausted, but the excess insurer was entitled to contest coverage for its portion. A similar result was reached in *Allmerica Fin. Corp. v. Certain Underwriters at Lloyd's,* 871 N.E.2d 418 (2007), in which the court held that, despite following form language, an excess insurer was not bound by the primary insurer's coverage determination in regard to a class action settlement. In *Allmerica*, the court emphasized that each layer, and each policy, was a separate and distinct contract. *Id*. at 428. The court did not specifically address whether the excess insurer could challenge only coverage under the excess, or could also challenge exhaustion of the primary.

In *Costco Wholesale Corp. v. Arrowood Indem. Co.*, 387 F. Supp. 3d 1165 (W.D. Wash. 2019), a case upon which the court in *Northrop* relied, a third layer excess insurer contested various administrative payments, included within coverage by underlying insurers in conjunction with a class action settlement between Costco and its employees. Essentially, the insurer argued that it could have held the covered costs down and would never have been triggered. Again, the court balked at requiring that in insured bear the burden of establishing that every payment by every insurer was covered. Instead, it concluded that an excess insurer is not bound by an underlying insurer's application of policy provisions, as to its own policy, but may not second-guess determinations by underlying insurers, absent an express contractual right to "interfere in their adjustment processes." Discussing whether "loss" allowed an excess carrier to review payments and require proof that all underlying payments were covered, the court concluded that "the weight of authority" holds that "an excess insurer is bound by the fact of payment and cannot contest the soundness of the underlying insurer's decision to pay unless there is an indication that the payments were motivated by fraud or bad faith." *Id.* at 1174.

Addressing concerns of the District Court, that the *Costco* rule provided no protection to excess insurers, the court in *Northrop* also reasoned:

> The district court's perspective presumes that underlying insurers are motivated to pay uncovered claims even in the absence of fraud or bad faith. While such a possibility may exist, we do not think that there are many instances where an insurance company will pay out claims—let alone its policy's limit—when it is not obligated to do so (at least in cases not involving fraud or bad faith). But even if AXIS were correct that insurers sometimes choose to settle claims that fall outside their scope of coverage "for what they perceive[] as legitimate business reasons," nothing prevents AXIS or any other excess insurer from raising and leveraging this concern during contractual negotiations with their policyholders. For example, the excess insurer could request higher premiums to account for this contingency, or it could insert specific policy language reserving its right to contest "improper erosion" by the underlying insurers under certain conditions—so long as the provision does not conflict with applicable law or public policy.

Id. at 846-847.

Turning to the Axis policy language, the court also held that the language regarding “covered loss” did not include any right or reservation to challenge payments by a primary insurer. *Id*. at 848. In *Costco*, the court concluded the policy language was ambiguous.

The court in *Northrop* also noted that excess insurers could contract around the general rule by including language in the policy reserving the right to challenge payments—at least where that provision was not contrary to applicable law. It noted language in another case involving Axis, *AXIS Surplus Ins. Co. v. Innisfree Hotels, Inc.*, No. CIV.A. 05-0527-WS-C, 2006 U.S. Dist. LEXIS 73230, 2006 WL 2882373, at *9 n.22 (S.D. Ala. Oct. 6, 2006) in which the policy stated that "[o]nly losses which, except for the amount thereof, would have been payable under this Policy contribute to the satisfaction, reduction or exhaustion of underlying limits or deductibles." In that case, Axis was second layer excess on hurricane claims involving wind and flood damage. The Axis policy excluded flood. The court therefore concluded that amounts paid by underlying insurance for flood losses that would not have been payable under the Axis Excess Policy did not count towards the underlying liability limit, and that, "[a]s a result, any amounts that the Primary Policy paid for flood losses do not erode the $10 million threshold, creating a possibility of a gap in coverage between layers for which [the insured] itself would be responsible.”

The opinions in *Northrop* and *Costco* appear to reflect the general rule. In *Edward E. Gillen Co. v. Ins. Co. of the State of Pa.*, No. 10-C-564, 2011 U.S. Dist. LEXIS 48119, at *4 (E.D. Wis. May 3, 2011), the excess insurer contended most of arbitration award was for project delay and was economic loss, not covered under primary or following form excess. The policyholder sought indemnification and the primary insurers sought a declaration that it had exhausted. The court held that payment of the limits discharged the primary insurer’s obligation. *Id.* at *11. The court concluded that an excess liability insurer was not required to adjust a claim in the same manner as the primary, despite following form language, and was free to contest coverage under its own policy, but assumed the risk of the primary insurer’s adjustment. Citing *Allmerica*, the court emphasized that individual insurers, absent specific policy provision, did not act as coinsurers of the entire risk, but each contracted to cover a particular portion of the risk. *Id.* at *14-15.

In *ARM Props. Mgmt. Group v. RSUI Indem. Co.*, 2008 U.S. Dist. LEXIS 108624 (W.D. Tex., Aug. 25, 2008), RSUI contended the underlying insurers had overpaid property claims arising from Hurricane Katrina, and had failed to deduct a flood exemption, which impacted ultimate net loss. ARM contended RSUI could not challenge the adjustments, and the RSUI policy attached when the underlying insurers paid their limits. The court agreed, finding no policy language allowed RSUI to review the payments and coverage determinations of the underlying insurers.

Other courts have allowed some level of review of how payments are allocated between policy years, and the exhaustion of individual primary policies. *See, e.g., LSG Techs., Inc. v. United States Fire Ins. Co.*, 2010 U.S. Dist. LEXIS 140879 (E. D. Tex. Sept. 2, 2010). In *LSG Techs*., the primary insurer contended it had exhausted multiple years of coverage paying asbestos claims, triggering the excess policies in those years. The court held that the excess policy language did not provide for an examination of the primary insurer's claims handling or the strength of the settled claims, or allow for "mini-trials." *Id.* at *36. The court nevertheless held, in part, that the insured and the primary insurer had to establish which claimants could be grouped into an occurrence, and that claims were allocated to a policy based on a link to the underlying injury. Id. at *41. *Cf. UNR Indus., Inc. v. Continental Ins. Co.,* 1988 U.S. Dist. LEXIS 12561, *35-36 (N.D. Ill. Nov. 9 1988) (other than requirement that injury fall during period of coverage, insured was not required to reallocate primary insurer's payment to establish exhaustion).

What if the excess contends the payments leading to exhaustion are not merely improper but are fraudulent? The court in *Ins. Co. of N. Am. v. Kayser-Roth Corp.*, 770 A.2d 403 (R.I. 2001), noted the trial judge's conclusion that "*absent fraud* between the insured and the primary carrier, 'the insured does not carry the burden of proving the soundness of the primary carrier's decision to pay.'" *Id.* at 416 (emphasis added). The court of appeals further concluded the policyholder's burden was to establish coverage under the excess policy, which included exhaustion, not that the primary insurer's payments were valid. *Id.* at 417. Of course, this begs the question of whether a cause of action would exist if fraud could be established, but insinuates that it would.

Even where the excess policy follows form, exclusions may apply to the excess that did not impact the primary. In *ContraVest Inc. v. Mt. Hawley Ins. Co.*, 2020 U.S. Dist. LEXIS 31976 (D. S.C. Feb 25, 2020) (appeal filed) the court held, *inter alia,* that Mt. Hawley was entitled to rely on an exclusion in the primary policy where the primary had exhausted by payment of claims that did not implicate the exclusion.

While some states require a primary insurer to continue defending, even after exhaustion, an excess insurer's defense obligation is also usually governed by policy language, regardless of proper exhaustion. *Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 15 P.3d 115, 134 -135 (Wash. 2000). While many excess policies follow form, and assume defense after exhaustion, some provide only a right, but no duty, to defend. In an unusual turn, in one case a court held the excess insurer owed a defense *because* it was excess. *BDR Clyde Hill VII LLC v. Cont'l Western Ins. Co.*, 478 F. Supp. 3d 1097 (W.D. Wash. 2020). In *BDR Clyde Hill*, Continental Western contended it owed no defense because an SIR and underlying policy were not exhausted. The court disagreed, relying on policy language stating that:

> When this insurance is excess, we will have no duty under Coverages A or B to defend the insured against any "suit" if any other insurer has a duty to defend the insured against that "suit." If no other insurer defends, we will undertake to do so, but we will be entitled to the insured's rights against all those other insurers.

Id. at 1101.

Continental Western contended it was excess of an Amtrust policy with an SIR, both of which had to exhaust before it owed defense. But, the Amtrust policy included only a right, and not a duty to defend. Since no other insure was defending, the policy language required Continental Western to do so.

B. Settling to Avoid Attorneys' Fees

An issue often arises when an excess insurer contends the primary has attempted to exhaust by overpayment, premature settlement, or payment despite strong liability defenses, just to avoid the ongoing costs of defense. An excess insurer may have a claim if the primary fails to settle, and the judgment exceeds primary limits. Does it have a claim for premature or wrongful settlement?

In *Pareti v. Sentry Indemnity Company*, 536 So. 2d 417 (La. 1988), the court held that the policy language supported exhaustion upon payment. It also discussed a split in the case law, where such language was not present, as to whether settlement terminated the duty to defend. The court acknowledged a potentially legitimate concern over an insurer attempting to circumvent its defense obligation by an "early escape" from the litigation.

There is little established case law recognizing or defining a claim for wrongful settlement. Since the excess insurer's claims typically arise from subrogation, the existence of a claim depends, in part, on the scope of extracontractual claims that can be asserted, and whether there is any limitation on extracontractual claims between insurers. *See, e.g., Steadfast Ins. Co. v. Agric. Ins. Co.*, 304 P.3d 747 (Okla. 2013).

In *Steadfast,* on certified questions from Tenth Circuit, the court held a second-level excess insurer could assert an equitable subrogation claim against first-level excess insurer for improperly allocating claims to policy year—even though the insured agreed that the first-level excess insurer had properly exhausted. The court rejected a "strict derivative rule" that would ignore the excess insurer's expectations and the insured's own obligations to deal with its insurer in good faith.

Other courts have suggested that a settlement that exhausts the primary layer must be reasonable, or in good faith, and that a settlement that is merely designed to terminate any further obligations may not relieve the primary insurer of its defense obligation. *E.g., Pareti,536 So.2d at 423; In re E. 51st St. Crane Collapse Litig.*, 2010 N.Y. Misc. LEXIS 6310 (N.Y. Sup. 2010), aff'd, 84 A.D.3d 512 (N.Y. App. 2011) (primary insurer could exhaust by payment of settlement of less than all claims if it did so in good faith); *Maguire v. Ohio Casualty Ins. Co.,* 602 A. 2d 893 (Pa. Super. Ct. 1992); *Great West Cas. Co. v. Panebianco*, 2020 U.S. Dist. LEXIS 248440 (M.D. Fla. Nov. 19, 2020).

The answer may also depend on whether there is a demand that could trigger exposure for a judgment in excess of limits. *See, e.g.*, *Pride Transp. v. Cont'l Cas. Co*., 511 Fed. Appx. 347 (5th Cir. 2013) (refusing to recognize a cause of action based on primary insurer's acceptance of a policy limits demand). In *Pride,* one insured, Pride, sued over the primary insurer's settlement of claims against another insured, leaving Pride exposed. While it involved a policyholder claim, it still potentially impacts excess insurers' rights, to the extent they arise through subrogation. In *Pride*, the court noted the insurer's "*Stowers"* duty to settle within limits, when other requirements are met, that gives rise to a cause of action if there is an excess judgment. It also noted that there was no recognized cause of action for premature or wrongful settlement.
There are few cases dealing with allegations of premature exhaustion, absent other coverage issues. Even in states that recognize a cause of action, an excess insurer may have a difficult time establishing that a primary insurer settled and exhausted its limits just to avoid defense costs and expenses, and not for other legitimate reasons within the contractual right to control defense and settlement, or the extracontractual considerations that arise from a duty to defend or settle.

C. Questions of Timing

Most primary policies include language requiring the insurer to continue defending until the policy is exhausted by judgment or settlement. Some specify by payment of judgment or settlement. Most excess policies provide that coverage does not attach until all underlying insurance is exhausted. But, what does that mean? When does exhaustion attach—when funds are committed through a memorandum of settlement? When a check is issued? What if there are conditions on settlement?

Generally, at a minimum, a primary insurer can exhaust only by virtue of a settlement or judgment. A tender of primary limits to the excess in a vacuum, or to the claimant without a release, is neither, and will typically not constitute exhaustion, or relieve the primary insurer of a duty to defend. *E.g., Continental Casualty Co. v. North American Capacity Insurance Co.*, 683 F.3d 79 (5th Cir. 2012); *BBL-McCarthy, LLC v. Baldwin Paving Co.,* 285 Ga. App. 494, 499-500 (Ga. App. 2007) *see also Pareti*, 523 So. 2d at 424. Nor will a deposit into the court's registry suffice. *In re 51st St. Crane Collapse Litig.*, 2010 N.Y. Misc. LEXIS 6310 (Sup. Ct. N.Y. 2010), ***aff'd,*** 84 A.D. 3d 512 (N.Y. App. 2011).

The limited case law is also clear that, even when there is a negotiated settlement, it is the *payment* that constitutes exhaustion. *See, e.g., Mid-Continent Cas. Co. v. Eland Energy, Inc.*, 2009 U.S. Dist. LEXIS 89359 at *40-41 (N.D. Tex. Mar. 30, 2009), ***aff'd***, 709 F.3d 515 (5th Cir. 2013) (policy limits exhausted and duty to defend ended when check tendered); *Amerisure Mut. Ins. Co. v. Arch Specialty Ins. Co.*, 784 F.3d 270, 275 (5th Cir. 2015) (under policy with eroding limits, duty to defend ended when combined defense and indemnity payments exhausted limits, unlike standard policy in which duty to defend ends upon indemnity payment that exhausts limits). S*ee also Allied Prop. & Cas. Ins. Co. v. Bed Bath & Beyond, Inc.,* 2014 U.S. Dist. LEXIS 42977, *27 (N.D. Ga. Mar. 31, 2014) (citing *BBL-McCarthy, LLC,* 285 Ga. App. at 499)

("exhaust" means payment of a judgment which depletes policy amount); *Nat'l Beef Packing Co., L.L.C. v. Zurich Am. Ins. Co.,* 336 S.W.3d 181, 185-187 (Mo. App. 2011) (payment of limits in settlement terminated duty to defend); *Godur v. Travelers Indem. Co.,* 567 So. 2d 1028, 1030-1031 (Fla. App. 1990) (insurer's duty to defend claim ended when it paid policy limits in settlement); *California Cas. Ins. Co. v. State Farm Mut. Auto Ins. Co.,* 913 P. 2d 505, 510 (Ariz. App. 1996) (duty to defend terminated when insurer obtained release for insured after paying policy limits). Because payment is the determining event, other acts that may be incidental to settlement, such as the distribution of the payment or the dismissal of the lawsuit, not referenced in the policy, are not the determining factors.

Similarly, the majority rule is that an excess insurer's duty to defend begins when the underlying insurance has been exhausted by payment. *See Schneider Nat'l Transp. v. Ford Motor Co.*, 280 F. 3d 532, 538-39 (5th Cir. 2002) (citing *Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 20 S.W.3d 692, 700 (Tex. 2000)); *but cf. Cambridge Mut. Fire Ins. Co. v. Metchum*, 2012 U.S Dist. LEXIS 115618 (D. Conn., Aug. 16, 2012) (collecting cases but adopting minority rule that excess insurer's duty to defend is triggered when there is reasonable possibility the claim will exceed the primary limit).

The Fifth Circuit has also rejected a claim, under Texas law, for alleged premature payment of remaining primary limits, where coverage was not contested. *Tex. Disposal Sys. v. FCCI Ins. Co.*, 2021 U.S. App. LEXIS 13394 (5th Cir., May 5, 2021). In *Texas Disposal Systems*, a settlement was reached that exhausted several layers of insurance. Unlike the underlying layers, the final excess policy had a right, but no duty, to defend. The insured argued, among other things, that the primary insurer paid its limits under the mediated settlement agreement prematurely—before all conditions of the settlement were resolved and before the last date for payment. *Id.* at *9-10. The Fifth Circuit rejected the argument, recognizing the payment was in settlement of the claims and exhausted the policy, terminating the defense obligation. *Id.* at *10.

While a commitment of funds to a settlement is not sufficient, there is no clear rule as to the insurer's obligation to "wrap up" a settlement, once payment is issued. In most instances, however, it seems fair to assume that the insurers' interest in seeing the settlement fully executed will prevail, and that there will be some amicable arrangement between primary and excess insurers. *Cf. Pareti*, 523 So. 2d at 424. In *Pareti,* the court stated that, "If in fact an insurer enters into a good faith settlement for policy limits and thereby terminates its defense obligations under the express terms of the policy, the insurer must make every effort to avoid prejudicing the insured by the timing of its withdrawal from the litigation. The insurer should make allowances for the time that the insured will need to retain new counsel, and should continue to represent the insured after the settlement, if necessary, until new counsel can be retained." *Id*. at 423, citing 8 Appleman, Insurance Law and Practice § 4685 (1962).

In *Eland*, which involved covered cleanup costs, payment was reimbursed to the insured. *Id.* at *33-34. The court reasoned the insured could not extend the defense obligation by refusing to accept the check. *Id*. at *34. Presumably, under the same reasoning, an excess insurer could not unreasonably delay consummation of settlement to forestall its own defense obligation.

D. Defense Within or Outside Limits and the Impact on Settlement

Many policyholders are not adequately insured, often because they are unaware of the amount of money both litigation and resolution or judgment may entail. Inadequacy of policy limits often presents a significant hurdle to resolving a case. Legal costs regularly exhaust primary policy limits leaving policyholders to pay out of pocket for claim expenses and settlement, if they can, unless they have significant excess coverage available. This is a major issue that becomes more prevalent with the rising costs of litigation where the primary policy provides for defense within the limits of liability, i.e. where defense costs erode the available limits, versus where defense is outside the coverage limit. For example, let's say a company has a $1 million employment practices liability policy which is eroded by payment of defense costs. The company gets sued for sexual harassment and the jury awards $500,000. However, the defense costs total $900,000. The company is on the hook for $400,000 out of pocket. If the defense costs were outside of the limits of liability, the entire amount could have been covered. Admittedly, policyholders do not always have a choice regarding whether defense coverage is inside or outside the policy limits.

Defense within limits policies may raise other issues and considerations for insurers and policyholders. While there is not a lot of case law directly addressing conflicts presented by defense within limits policies, some scholars believe that insurance policies providing for defense within limits present inherent conflicts of interest between insurers and policyholders in the selection of counsel, the defense of a case and in settlement. See Jordan S. Stanzler, *Defense-Within-Limits Policy Presents Conflicts Minefield*, Focus Column, Insurance Law, https://stanzlerlawgroup.com/publications/pub26.htm, The Daily Journal Corporation (December 8, 2004). Due to the competing interests of defending and settling, policyholders and insurers may be at odds over fundamental decisions like choice of defense counsel, defense rates, whether to settle, and the amount to be spent on defense or settlement. This is so because the amount of defense costs and liability exposure combined often has the potential to exceed the available limits of liability. See Celia M. Jackson, *The Settlement Dilemma: When a Policyholder and Insurer Disagree on Settlement*, https://www.orrick.com/en/Insights/2012/06/The-Settlement-Dilemma-When-a-Policyholder-and-Insurer-Disagree-on-Settlement, Orrick (June 13, 2012). If there is truly a conflict, the policyholder will, in most jurisdictions, be entitled to independent counsel who will control decisions about the defense of a case.

While the typical general liability (GL) policy provides for unlimited defense expenditures that are separate from and in addition to the limits of the policy (defense outside limits), professional liability policies and D&O policies most often provide for the erosion of limits by payment of defense costs (defense within limits). In policies that erode

through payment of defense costs it is clear when the obligation ends – when the limits are exhausted. However, exactly when an insurer's defense obligation ceases is less clear when defense costs are paid outside of limits. This can significantly impact settlement negotiations, a policyholder's desire to settle, and the involvement of excess insurers in the settlement process.

If defense is paid outside the limits and the primary insurer's defense obligation ceases only upon exhaustion of its limits, the excess insurers may be hesitant to settle if there appear to be viable liability defenses. If defense costs erode the primary limits and the excess or umbrella insurer does not have a duty to defend, the excess insurer again may not be in a rush to resolve the matter. Where the excess insurer has the right but not the duty to defend and defense costs erode limits, an assessment of actual liability and exposure and the insurer's interest in controlling the defense may impact resolution and defense decisions. If the excess or umbrella insurer has a duty to defend after exhaustion of the primary limits, the excess insurer might be more inclined to move the case toward early resolution and pressure the primary insurer to settle within its limits.

Looking to the primary insurer, in evaluating the case and determining that the combined exposure exceeds the available limits, and where defense costs erode the limits, the primary insurer might not have a strong opinion about where to spend the money unless there is room for a savings of a portion of the limits. Alternatively, the primary insurer may desire to spend everything on defense to send a message to other potential claimants and discourage other lawsuits, especially if the policy has an aggregate limit greater than the per claim limit. This may not sit well with the policyholder or excess insurers. In fact, the policyholder who realizes that defense costs will eat away at the policy limits may want to settle early while there is still significant money left to contribute toward settlement. We also see the reverse – where the policyholder wants to fight but, in the interest of protecting the policyholder's personal assets and cap exposure, the insurer wants to settle. This becomes even more complicated where some portions of a case are likely covered and other allegations or damages are not. And the factors, analysis and interests can greatly differ when defense costs do not erode the limits. Who is right, and who gets to decide?

When there is an actual conflict, the insurer must let the policyholder control the defense and must provide "independent counsel" in most jurisdictions. See, e.g., ILLINOIS; *San Diego Federal Credit Union v. Cumis Insurance Society*, 162 Cal.App.3d 358 (1984). Not doing so could create major problems and exposure for the insurer. If the insurer makes the decisions through counsel of its selection, where the policy is eroded by defense costs, that insurer will be blamed if there is not enough money left to settle the case or pay a judgment. If the policyholder tells the defense attorney not to waste limits but the insurer directs defense counsel to keep defending, defense counsel becomes conflicted and cannot represent both interests. Under defense within limits policies, every dollar spent by insurer appointed counsel on defense is one dollar less for indemnity, deciding to some degree what the indemnity limits of the policy will be.

Even when “independent counsel” is appointed, there may be conflicts when settlement offers are made. In fact, a risk-averse policyholder may insist that any settlement demand up to the limits of the primary policy (and sometimes excess policies) be paid. Even if the insured is certain of a victory at trial, the prospect of running out of money to fund the defense is chilling. On the other hand, the insurer must weigh the merits of the case AND the cost of continued litigation and the prospect that refusing a settlement offer will lead to continued litigation and continued depletion of the available insurance coverage. These issues are compounded by higher potential exposure, more complicated cases that may involve covered and non-covered amounts, and the involvement of excess insurers who may or may not have a duty to defend once the primary policy limits are exhausted.

Insurers must give the insured at least as much consideration as they do their own interests, and when there is great risk of recovery beyond the available limits so that the most reasonable manner of disposing of the claim is a settlement which can be made within those limits, a consideration in good faith of the insured's interest requires the insurers to attempt to settle the claim. Depending upon the exposure, the primary insurer will also experience pressure to settle within its limits from the policyholder and excess insurers. Such concerns are magnified by the added complexity of the defense within limits policy. The very nature of the self-consuming policy puts a premium on considering how the continued prospect of litigation will diminish the limits available for defense or settlement.

E. Defense Costs Coverage Only for Covered Claims

Whether an insurance policy provides coverage for only some or all of the defense costs incurred on behalf of an insured with respect to a claim can have a great impact on the ability to resolve a case. An insurance company’s obligation to pay defense costs incurred by its insured in response to a claim generally falls into one of two categories - a duty to defend or a duty to advance defense costs. The duty to defend is most often included in GL and errors & omissions (E&O) policies while the duty to advance is more likely to be included in D&O policies. Policy terms do vary, so any type of policy could contain either type of obligation.

With respect to the duty to defend, although case law varies somewhat from jurisdiction to jurisdiction, in the majority of states the duty to defend is considered broader than the duty to advance and the defense obligation is broader than an insurer’s duty to indemnify for loss under a policy. The duty to defend is typically triggered whenever the allegations in a complaint against the insured potentially fall within the scope of risks undertaken by the insurer, even if the allegations are false or groundless. Moreover, even where some allegations or claims would not be covered, as long as something is potentially covered the insurer typically has a duty to defend. And that duty generally applies to all of the allegations/claims against the insured, even those for which there would be no indemnity coverage.

The duty to defend also gives the insurer control over the defense of the claim including the right to appoint defense counsel. An exception to this rule in most jurisdictions, mentioned above, is that where there is a conflict of interest between the insured and the insurer, the insured is entitled to select independent counsel. In the case of a conflict, the insurer is responsible for payment of the reasonable defense fees of independent counsel. Some jurisdictions also allow the insurer to cap rates consistent with what the insurer typically pays to counsel in the jurisdiction for a similar action.

Where the insurer is paying all defense costs and a case presents major defense cost and indemnity exposure, there is often a likelihood of significant erosion of policy limits through the payment of defense costs. In that scenario, an insurer may have a greater incentive to seek an early settlement, even if there are coverage issues, in the attempt to cap exposure and save some of its limits.

But what happens when an insurance policy expressly provides that defense costs are only covered if they are incurred with respect to a covered claim? Such a restriction is often found in policies setting forth a duty to advance. The duty to advance generally only requires the insurer to advance defense costs incurred in the defense of covered claims. In those policies, the insurer is regularly allowed to allocate defense costs to covered and non-covered claims and often provides a basis for the insurer to advance only a percentage of the defense costs. The duty to advance is also conditional. In other words, if it is subsequently determined that there is no coverage for the claims, the insurer may have a right to stop paying and seek recoupment of the already advanced defense costs from the insured. The insured, on the other hand, generally gets to select its own defense counsel, often subject to insurer approval, and has control of the defense and the responsibility to defend the claim and to keep the insurer informed.

Where the insured is defending and the insurance company can allocate, there is a greater likelihood of out of pocket exposure to the policyholder for both defense and indemnity. Also, where there is the ability to allocate and the policyholder may be anxious to settle to avoid paying significant amounts out of pocket, an insurer may not have the same incentive to enter into an early settlement or a cost of defense settlement, unless the amount of the settlement expressly accounts for the insurer's coverage and allocation positions.

We note that there are also policies written on a duty to defend basis that allow for allocation. Such policies provide that the insurance company has the right and duty to defend, including the selection of defense counsel, but may allocate costs of defense and indemnity where there are allegations and damages sought for which the policy does not provide coverage. While on its face, that type of provision might appear reasonable and allocation may seem possible, there are jurisdictions which do not allow for an insurer to allocate defense costs if the policy imposes a duty to defend upon the insurer. In those jurisdictions, the existence of the duty to defend requires an insurer to pay all defense costs if the defense obligation is triggered at all. However, while the jurisdiction may require payment of all defense costs up front, the majority of jurisdictions allow for the insurer to seek reimbursement of defense costs for claims that

were not even potentially covered. See, e.g., *Travelers Prop. & Cas. Co. of America v. Hillerich*, 598 F.3d 257, 265-66 (6th Cir. 2010); *Cotter Corp. v. American Empire Surplus Lines Ins. Co.*, 90 P.3d 814, 828 (Colo. 2004); *Buss v. Superior Ct.*, 939 P.2d 766 (Cal. 1997). The minority of jurisdictions do not even allow for reimbursement unless that right is set forth in the applicable insurance policy. See, e.g., *Blue Cross of Idaho Health Service Inc. v. Atlantic Mut. Ins. Co.*, 2010 U.S. Dist. LEXIS 86737, *16-19 (Aug. 23, 2010); *American and Foreign Ins. Co. v. Jerry's Sport Center Inc.*, 2010 Pa. LEXIS 1803, *45-47 (Aug. 17, 2010); *Westchester Fire Ins. Co. v. Wallerich*, 527 F.Supp.2d 896, 907-08 (D. Minn. 2007). The minority approach often serves as an incentive for insurers to seek early resolution so as not to pay significant amounts toward the defense of non-covered allegations.

F. Exclusions in Excess Not in Primary Policy

There are different types of "excess" coverage available to policyholders and the specific terms in those policies could have a significant impact on the availability of limits and the ability to settle a claim. On the broadest level, we can divide the options into umbrella policies and excess policies. Umbrella policies provide liability coverage in addition to that of the primary policy. They can be written to restrict or broaden coverage from the underlying policy and often serve to fill coverage gaps. Umbrella policies can cover multiple underlying policies concurrently. Excess policies, like umbrella policies, provide additional liability coverage. Unlike an umbrella policy, an excess policy often provides no broader protections than the underlying policy and often are written to be more restrictive. Excess policies often only apply to one underlying policy at a time. Both umbrella policies and excess policies can be follow form, adopting most of the terms, provisions, exclusions and conditions of the primary policy, or stand alone, setting forth their own terms which can differ from the underlying policies in material ways.

Stand-alone excess policies frequently set forth their insuring agreements, definitions, exclusions, conditions and other terms without incorporating any of the elements of underlying coverage or incorporating some but not all of the provisions of the underlying policy. The scope of coverage of such a stand-alone policy may be ascertained from the four corners of the policy itself. Excess insurers may also come onto risks later, without tracking the exact policy period set forth in the primary or underlying policies. This is in contrast to following-form policies, which are intended to be read in connection with their respective underlying "followed" policies. Other excess policies with differing terms include Side A policies which provide added protection to directors & officers only, where they are not indemnified by the policyholder entity, and DIC (difference in condition) policies which provide coverage for a limited risk that the primary insurer is unwilling or unable to bear (such as coverage for investigations that may not qualify as civil complaints or other covered claims in the underlying). However, it is different exclusionary language in excess policies that often poses the biggest problem for policyholders and settlement.

Where an excess insurance policy contains different exclusions or restrictive terms, a policyholder's resolution of a high value claim with the insurance tower may be

tricky. Some of the exclusionary language seen in excess policies that may not be found in primary policies, especially if the excess insurer came on the risk later, include more restrictive retroactive dates or retroactive date exclusions, prior knowledge exclusions, specific matter or circumstance exclusions, specific litigation exclusions, and bankruptcy/insolvency exclusions.

Differing terms in a primary policy and the applicable excess policies cause the need for a creative approach to settlement with members of an insurance tower who are not completely aligned. Where excess insurers raise certain policy terms as defenses to coverage which do not exist in the primary policy, or where the primary policy provides coverage for things excluded by the excess policies, the settlement terms with the primary and excess insurers may need to differ. In fact, a policyholder and its counsel may seek to have the primary insurer designated as specifically paying for things for which the excess insurance policies do not provide coverage in an attempt to tap into the excess policy limits for claims and amounts they do not exclude. Excess insurers, however, may take issue with such creative bargaining in negotiations or wordsmithing in settlement agreements.

In addition, in instances where terms differ between the primary and excess policies, a policyholder may be more accepting of responsibility for the non-covered allegations and more willing to make a personal contribution toward a portion of the loss in order to satisfy the excess insurer and gain access to the excess policy limits. In such instances, an excess insurer seeing a policyholder in a difficult situation could also agree to contribute a greater percentage toward settlement, above the amount it believes represents covered exposure, for a release from further policy limits exposure.

II. Practical Considerations and Challenges to Settlements Involving Multiple Insurers

Many of us handle cases with severity that has the potential to exhaust a tower of insurance but where there are coverage issues preventing the insurers from paying the entire loss. Such situations are complicated by differences of opinion regarding liability, case value, defense strategy, and coverage and policy language interpretation. The issues arise in general liability and all types of professional liability and specialty exposures. Some of the factors that complicate the ability to settle with multiple insurers include variations in settlement or policy terms among the triggered layers of insurance, whether the primary policy involved contains a duty to defend and provides for defense within or outside of limits, the availability of defense costs coverage only for covered claims, and existence of exclusions in excess or umbrella policies that do not appear in lower layers of insurance.

A. Shaving of Limits – Difference in Settlement Terms

Facing a large loss, a policyholder may find itself in a coverage dispute with multiple layers of its tower of insurance. The policyholder may desire to reach a settlement with one or more of the insurance companies, accepting less than the full limits of a layer as a compromise of the parties' dispute over coverage rather than get

into a contract fight with multiple insurers. This most often occurs in big dollar scenarios such as securities class actions or matters involving governmental agencies such as HUD and the DOJ.

Shaving of limits settlements are popular in the United States, particularly when it comes to directors and officers (D&O) liability. Frequency, volume and value of D&O claims, coupled with a soft insurance market, continues to put significant business pressure on D&O insurers. Shaving of limits settlements involve the policyholder agreeing to a number with a claimant in a situation where the claimant's alleged damages far exceed all available limits in the tower of insurance. The policyholder seeks consent from the insurers, or that the insurers will not raise lack of consent as a bar to coverage, to get the matter resolved in principal. The policyholder and its broker then approach each insurer, often negotiating different percentages (that decrease up the tower) to get each insurer to participate in the settlement to some degree. The overall settlement could also involve a payment by the policyholder, which may account for some portion of non-covered loss or uninsurable amounts, but that is not always the case.

Typically, if the policyholder writes a check to infill for shaved primary policy limits, it may presume that the excess insurance is available. However, that may not work, depending upon the particular policy terms involved. Policyholders who enter into these settlements with a lower coverage layer have historically faced arguments from excess insurers that the settlement does not properly exhaust the lower layer of coverage, even if the policyholder is willing to make up the difference by itself bearing the remaining amount of loss within the settled layer. The excess insurers argue that the failure to properly exhaust the underlying layer through payment of limits by the underlying insurer excuses the excess policies from any payment obligations, even if the loss is covered and would reach the excess layers. [A different issue arises where demands for settlement contributions are made to excess insurers where the actual number might not have reached one or more of the excess insurers but for the limits shaving approach.]

For instance, if there is a $15 million loss and the primary insurer has a $5 million limit but only pays $4 million for a release from the policyholder, the excess insurer might refuse to contribute. Unless the underlying insurer paid every penny of that limit, the excess insurer might not have to pay depending upon the policy terms at issue and the jurisdiction in which it is challenged. Although many courts have rejected those exhaustion arguments, some have accepted them and held that an insured's settlement with an underlying insurer for less than limits releases the excess coverage from liability, under certain variations of excess policy language. See Michael T. Sharkey, "Settlements With Underlying Layers Satisfy Exhaustion Conditions in Excess Policies," 2013 LexisNexis Emerging Issues Analysis 7108 (Nov. 2013) (discussing cases); Bert Wells, *Excess Insurance, Umbrella Insurance and Multi-Insurer Coverage Programs*, Covington & Burling LLP (Jan. 4, 2010); and see, e.g., *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 161 Cal. App. 4th 184 (Cal. Ct. App. 2008) (California Court of Appeal affirmed dismissal of excess insurer where insured had settled with its primary insurer for an amount less than the primary policy's limit and "absorb[ed] the

resulting gap" between the settlement amount and the primary policy's limit. Court rejected insured's public policy arguments regarding the encouragement of settlements, instead relying on the "literal language" of the excess policy requiring the primary insurer to pay the "full amount" of its limit); *Goodyear Tire & Rubber Co. v. Nat'l Union Fire Insurance Company of Pittsburgh, PA*, 694 F.3d 781 (6th Cir. 2012) (coverage dispute led to partial settlement by underlying insurer for amount less than policy limit and court ruled excess coverage was not available); *Preferred Construction, Inc., v. Illinois Nat. Ins. Co*., No. 11-4339-cv, 2012 WL 3735056 (2d. Cir. Aug. 30, 2012) (exhaustion of underlying limits ruled a condition precedent if excess coverage was to apply).

On the surface, the outcome seems somewhat unfair. If a policyholder is willing to pay out of its pocket to facilitate a settlement, should it not be rewarded? See Eric Silverstein, *Shaving of Limits Has Limits of Its Own, Lockton Companies*, https://www.lockton.com/Resource_/PageResource/MKT/Shaving%20of%20Limits.pdf (May 2013). The answer to this is both yes and no. Insurers have historically been concerned about the impact of the removal of clauses requiring complete limits payment by an underlying insurer, although much more liberal language has been the trend in recent years. Today, most insurers who refuse to provide shaving of limits wording in their excess liability policies generally include it in some form in their D&O – or allow for payment by anyone equaling the underlying limits. In practice, large claims often include multiple claimants and multiple insurers and a single claimant or insurer may refuse and attempt to derail a settlement. On occasion, an insured may decide to settle, regardless of a particular insurer's position, in order to facilitate the most effective settlement for everyone involved. In such circumstances, a limits shaving provision or provision allowing for payment of a sum equal to the underlying limits could mean the difference between resolving the case with no further disputes or a failed settlement and protracted coverage litigation.

Limits shaving settlements most often combine settlement of the liability case and any coverage issues. Without the participation of the excess insurers there would be little incentive for the primary to attempt settlement but rather test the outcome on liability and/or coverage. Even if the insurers agree in principal, the individual allocation is typically not straight forward and often requires consideration of other factors, from the primary insurer's obligation to advance defense costs to different premium rates and other factors.

Settlement terms with the excess insurers may differ as well. This is often dependent upon particular policy language if the excess layers are more restrictive, such as where higher layers of coverage were purchased later – mid-term – and bear different policy periods than lower layers. Differences in settlement terms are not particularly concerning the higher up the tower one goes. However, more favorable terms for lower levels of insurance, closer to the risk, will not be looked upon favorably by excess insurers, and will provide grounds for objection that could derail or delay effectuating settlement.

B. *Qualcomm v. Zeig* – Who loses if the policyholder cannot pay the balance of the layer?

Settling with a primary insurance carrier for an amount below policy limits may place excess coverage at risk. Historically, an excess insurer could not "refuse to contribute to a settlement even when a primary insurer resolves its indemnity duty by paying less than its policy limits." K. Pasich, *Triggering Excess Insurer Duties Without Full Payments by Primary Insurers*, Ins. Cov. L. Bull. (June 2004). Legal support for policy holders "filling the gap" to reach the attachment point of a policy was largely the legacy of *Zeig v. Massachusetts Bonding & Ins. Co.*, an influential 1928 Augustus Hand decision. *See* Jeffrey W. Stempel*, An Analytic "Gap": The Perils of Relentless Enforcement of Payment-by-Underlying-Insurer-Only Language in Excess Insurance Policies*, 52 Tort Trial & Ins. Prac. L.J. 807, 807–08 (2017) (citing *Zeig v. Massachusetts Bonding & Ins. Co.,* 23 F.2d 665 (2d Cir. 1928)). *See also id.* at 871, n. 37 (collecting cases).

Today, courts are split, with some courts finding no exhaustion unless the underlying insurers have paid out the full extent of the primary coverage limits. Courts either focus on the terms of the excess policy, assessing whether it requires the underlying insurer pay the underlying limits in full as a condition precedent to excess coverage, or the public policy considerations, which favor below-limit settlements. However, courts ruling on public policy grounds generally must first find ambiguity in the policy language.[2] Jurisdiction then plays a role as some courts are more willing than others to find ambiguity in policy terms and consider policy rationales.[3]

1. *Zeig* & Public Policy Considerations

In *Zeig*, the excess insurer had issued the insured a $5,000 burglary insurance policy to sit above three other insurance policies totaling $15,000 in coverage. *Zeig*, 23 F.2d at 665. The excess insurance policy provided it would "apply and cover only after all other insurance herein referred to shall have been exhausted in the payment of claims to the full amount of the expressed limits of such other insurance." *Id.* The insured had settled with the underlying insurers for $6,000 and sought coverage for

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[2] The American Law Institute views recovery from excess insurers following gap-filling by insureds "merely a default rule" that can be contracted around. *See* Restatement of the Law of Liability Insurance § 39 (2019) (June 2021 Update). *See, e.g., Great Am. Ins. Co. v. Bally Total Fitness Holding Corp.*, No. 06-CV-04554, 2010 WL 2542191, at *1, 5 (N.D. Ill. June 22, 2010) (holding third excess policy language clearly required actual payment by insurer of total underlying limits for exhaustion, where clause read: "[i]t is expressly agreed that liability for any covered Loss shall attach to the Insurer only after the insurers of the Underlying Policies shall have paid, in the applicable legal currency, the full amount of the Underlying Limit and the Insureds shall have paid the full amount of the uninsured retention, if any, applicable to the primary Underlying Policy.")

[3] For example, the Fifth Circuit and the Eastern District of Virginia considered identical policy language but reached opposite conclusions. *Compare Martin Res. Mgmt. Corp. v. AXIS Ins. Co.*, 803 F.3d 766, 770 (5th Cir. 2015) (applying Texas law) ("The word 'all' makes clear that, under the AXIS policy, a settlement does not exhaust the Zurich policy when it is for less than the limit of liability.") *with Maximus, Inc. v. Twin City Fire Ins. Co.*, 856 F. Supp. 2d 797, 802 (E.D. Va. 2012) (applying Virginia law) *(*"[N]othing in the exhaustion provision of the Axis Policy requires actual payment of the policy limit *by the insurance carrier*.") (emphasis in original).

losses above the $15,000 limits. *Id.* The excess insurer argued that the excess insurance did not attach because the insured's settlement with the underlying insurers meant those polices were not exhausted. *Id.* at 666.

The Second Circuit "saw no reason for a construction so burdensome to the insured" and called the insurer's "construction of the policy sued on . . . unnecessarily stringent" *Id.* Reasoning that the parties could have included "such a condition precedent to the liability… if they chose to do so," the court found the excess policy did not explicitly require "collection" of the total underlying limits. *Id*. The court defined "payment" more broadly than "payment in cash" as "[i]t often is used as meaning the satisfaction of a claim by compromise, or in other ways." *Id.* Thus, the underlying policies were exhausted and the excess layer attached where the claims were paid to the full amount of the underlying insurance, regardless of whether the insured filled the gap.

Holding otherwise, the court cautioned, would "involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable." *Id*. In the Second Circuit's view, such a "harmful result to the insured" with "no rational advantage to the insurer, ought only to be reached when the terms of the contract demand it." *Id.* at 666. Subsequent court rulings on exhaustion of underlying layers took these policy rationales into account as well as the fact that releasing excess insurances from their coverage responsibilities would result in forfeiture to insureds and an undue windfall to excess insurers. *See, e.g., Koppers Co. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440, 1454 (3d Cir. 1996) ("Courts have adopted this rule because it encourages settlement and allows the insured to obtain the benefit of its bargain with the excess insurer . . ."); *Pereira v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. 04 CIV. 1134 (LTS), 2006 WL 1982789, at *7 (S.D.N.Y. July 12, 2006).

Despite these apparent costs to insureds, the court system, and society on a larger scale, courts have moved away from *Zeig*, declining to hold excess insurers liable where underlying limits were not fully paid by underlying insurers. This split was largely inspired by *Qualcomm, Inc. v. Certain Underwriters at Lloyd's London* and *Comerica Inc. v. Zurich Am. In. Co.*

2. *Qualcomm/Comerica* Approach: A Shift to Policy Language

In more recent years, courts have departed from *Zeig*, emphasizing policy language over public policy concerns. For example, in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, the California Court of Appeals held the exhaustion clause was unambiguous and precluded liability against Lloyd's, where the insured, Qualcomm, settled with its underlying insurer short of the $20 million underlying limit.[4] 161 Cal. App. 4th 184, 189-90 (2008). The court held that phrases like "have paid . . . the full amount of [$20 million]," particularly when read in the context of the entire

[4] The Lloyd's excess policy provisions stated, in relevant part, that "Underwriters shall be liable only after the insurers under each of the Underlying Policies [the National Union policy] have paid or have been held liable to pay the full amount of the Underlying Limit of Liability." *Id*.

excess policy, could not have any reasonable meaning other than requiring actual payment of no less than the $20 million underlying limit. *Id.* at 197-198 (2008). In so holding, the *Qualcomm* court rejected decisions from other jurisdictions which "appeared to place policy considerations (*i.e*., the promotion of convenient settlement or adjustment of disputes) above the plain meaning of the terms of the excess policy." *Id*. This included rejection of cases with "the policy rationale favoring the efficient settlement of disputes between insurers and insureds…a rationale that … cannot supersede plain and unambiguous policy language." *Id*. at 199.

The Eastern District of Michigan held similarly in *Comerica Inc. v. Zurich Am. In. Co.*, concluding the excess policy terms unambiguously required the primary insurance be exhausted or depleted by actual payment of losses by the underlying insurer. 498 F. Supp. 2d 1019, 1032 (E.D. Mich. 2007) (applying Michigan law).[5] The court distinguished decisions following *Zeig*, noting those decisions "generally rely on an ambiguity in the definition of 'exhaustion' or lack of specificity in the excess contract as to how the primary insurance is to be discharged." *Id.* at 1030.

Other jurisdictions have followed the reasoning in these cases, finding policy language unambiguous as to exhaustion and declining to consider policy rationales. *See Intel Corp. v. Am. Guarantee & Liab. Ins. Co.*, 51 A.3d 442, 450 (Del. 2012) (applying California law) ("Plain policy language on exhaustion ... will control despite competing public policy concerns" even though "some courts' decisions, including those of Delaware trial courts, could be read to suggest that [Zeig] requires a different result."); *Forest Lab'ys, Inc. v. Arch Ins. Co.*, 953 N.Y.S.2d 460, 465 (Sup. Ct. 2012), *aff'd*, 116 A.D.3d 628, 984 N.Y.S.2d 361 (2014) (applying New York law) (finding the policy language that exhaustion of the underlying policies "solely as a result of actual payment of a Covered Claim pursuant to the terms and conditions of the Underlying Insurance thereunder ..." was unambiguous in requirement of full payment up to the limits of underlying policies); *Citigroup Inc. v. Fed. Ins. Co.,* 649 F.3d 367, 372-73 (5th Cir. 2011) (applying Texas law) (relying on *Comerica* and *Qualcomm* to determine that various excess insurance policies were not triggered by plain language of those policies, which stated attachment occurs after: (1) "[payment of the] full amount of the underlying insurer's limit of liability" (Federal policy); (2) the "total amount of the Underlying limit has been paid in legal currency by the insurers of the Underlying Insurance" (St. Paul policy); (3) "any [underlying] insurer . . . shall have agreed to pay or have been held liable to pay the full amount of its respective limits of liability" (SR policy); and (4) "exhaustion of all of the limit(s) of liability of such 'Underlying Insurance' solely as a result of payment of loss thereunder" (Steadfast policy)).

[5] The Zurich policy stated that coverage "shall attach only after all such 'Underlying Insurance' has been reduced or exhaustion by payments for losses," and that depletion of the underlying insurance could occur "solely as a result of actual payment of loss thereunder by the applicable insurers." *Id.* at 1021-22. The policy additionally provided that it "does not provide coverage for any loss not covered by the 'Underlying Insurance' solely by reason of the reduction or exhaustion of the available 'Underlying Insurance' through payments of loss thereunder." *Id.*

Policy rationale that has been cited for precluding excess coverage where an insured settles beneath coverage limits is that excess insurers rely upon underlying insurers to vigorously defend coverage issues and defenses. *See, e.g.*, *Mills Ltd. P'ship v. Liberty Mut. Ins. Co.*, No. CIV.A. 09C-11174 FSS, 2010 WL 8250837, at *9 (Del. Super. Ct. Nov. 5, 2010) (quoting insurer's argument for requiring underlying insurers payment of underlying limits before triggering excess layers). However, this rationale rings "hollow" where insurers are unable to describe "a coverage issue or defense that an underlying carrier might have used to reduce [the excess insurer]'s exposure." *Id.* at *10. After all, even where settlement occurs with underlying insurers, the excess insurer's burden is not increased —the insured fills the gap to the attachment point. Weighed against the impacts of denying coverage for lower-than-limit settlements espoused in *Zeig* demonstrates the insured, the court system, and society at large, lose when excess insurers escape liability by virtue of the technicality of who pays underlying limits.

C. Conclusion – Excess Policy Language & Jurisdiction Matter

Case law following *Qualcomm*/*Comerica* decisions demonstrates that policy language matters and modern cases relying on the policy rationales discussed in *Zeig* have recognized ambiguity in policy terms as an essential prerequisite to finding that coverage is owed to insureds. *See, e.g., Cincinnati Ins. Co. v. Franck*, 644 N.W.2d 471, 473 (Minn. Ct. App. 2002) (determining below-limits exhaustion was permitted but stating "[w]here there is no ambiguity in an insurance policy, there is no room for construction."). Thus, coverage counsel should be aware of policy terms specifically requiring payment by the underlying insurer up to the insurance limits as they may serve as a roadblock to coverage. Exhaustion conditions of excess policies should always be reviewed and analyzed with care prior to counseling clients in negotiations with underlying carriers.

III. Exhaustion of General Liability Policies in the Context of Long-Tail Claims

Coverage for "long-tail" 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 policyholders and 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 two categories – "pro rata" and "all sums." Appellate Courts continue to refine these methodologies as long-tail injuries reach higher and higher levels of coverage but the methodologies are not applied in precisely the same way in every state.

Not surprisingly, the different allocation methodologies impact the ability of policyholders to access their umbrella and excess general liability policies in different ways. To illustrate the differences in approach in establishing the impairment (and ultimately the exhaustion) of primary and underlying umbrella and excess policies in the

context of long-tail claims, the following is a brief summary of the allocation schemes adopted in two pro rata states – New Jersey and Connecticut – and one "all sums" state – California.

A. Long-Tail Claims Generally Trigger Occurrence-Based Pre-1986 Policies

Before delving into the allocation methodologies, it is important to understand the policies generally at issue in long-tail claims. They are predominantly older (pre-1986), "occurrence-based" general liability policies issued before the absolute pollution exclusion and the asbestos exclusion were adopted throughout the insurance market. These policies typically provide coverage for bodily injury or property damage caused by an "occurrence" or accident. When an occurrence is a discrete event (like a fire), it is easy to determine which policy will provide coverage for those damages (i.e. the policy in place on the date of the fire). By contrast, long-tail injuries typically involve progressive damage that takes place over the course of many years and often those damages are not discovered for many years. *See State of California v. Cont'l Ins. Co.,* 55 Cal.4th 186*,* 281 P.3d 1000, 1005 (2012), *as modified* (Sept. 19, 2012) ("Continental")*.*

The term "trigger" is "used 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." *Montrose Chem. Corp. v. Admiral Ins. Co.*, 10 Cal. 4th 645, 655, 913 P.2d 878, 8880, n. 2 (1995), *as modified on denial of reh'g* (Aug. 31, 1995). General liability policies typical define their coverage to make clear that it "is not the time the wrongful act was committed, but the time when the complaining party was actually damaged" that triggers coverage. *Id.* at 890. For instance, an "occurrence" is commonly defined as "an accident, including continuous or repeated exposure to conditions, which results in … property damage neither expected nor intended from the standpoint of the insured." *Id.* Bodily injury and "property damage that is continuous or progressively deteriorating throughout several policy periods is potentially covered by all policies in effect during those periods." *Id.* at 880. This is referred to as "continuous trigger."

The transformation of the insurance market to reduce and ultimately eliminate coverage for long-tail claims began in the early 1970s when insurers adopted pollution exclusions that only permitted coverage for "sudden and accidental" polluting events (that would present few if any allocation issues). 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. 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-tail claims. These companies could only purchase "claims-made" policies that limited coverage to claims brought during the policy period (or extended reporting period). Claims-made policies provide far less coverage than occurrence-based policies.

B. Pro Rata Allocation Is Applied in New Jersey and Connecticut

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., 633 F.2d 1212 (6th Cir. 1980).* 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. While it is easy to determine which policy must provide coverage when there is 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 asbestos 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").

1. 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.*, 138 N.J. 437, 650 A.2d 974 (1994), 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[6] 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 coverage for both defense and indemnity. 650 A.2d at 995. Under continuous trigger, all policies that provide asbestos coverage from the date of first exposure to manifestation are triggered whether or not there is any exposure after the first exposure.

[6] *Owens-Illinois* rejected the alternative "all sums" allocation discussed *infra* under California law.

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[7] – a problem that did not exist in 1980, at the time *Forty-Eight Insulations* was decided. This limitation was ultimately dubbed the "unavailability rule."[8] 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.[9]

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 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." 650 A.2d at 1121-22. *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. *Id.* at 994.

In *Carter-Wallace, Inc. v. Admiral Ins. Co.*, the New Jersey Supreme 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. 154 N.J.

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[7] Coverage became unavailable for asbestos-related bodily injury claims with the industry-wide adoption of the asbestos exclusion. New Jersey courts have rejected arguments that standard pollution exclusions would preclude asbestos claims. *See Scottsdale Ins. Co. v. Woolsulate Corp.*, No. A-4815-06T1, 2008 WL 5233662, at *7 (N.J. Super. Ct. App. Div. Dec. 17, 2008).

[8] 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.,* 234 N.J. 23,188 A.3d 297 (2018). 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." 188 A.3d at 324. 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…." *Id.*

[9] Some states have rejected the "unavailability" rule for time-on-the-risk pro rata allocation. See *Keyspan Gas East Corp. v. Munich Reinsurance America, Inc.,* 31 N.Y.3d 51, 60, 96 N.E.3d 209 (2018); *Boston Gas Co. v Century Indem. Co.,* 454 Mass. 337, 370, 910 N.E.2d 290, 315 (2009).

312, 712 A.2d 1116 (1998). 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." 712 A.2d at 1123 (internal quotes omitted) (quoting *Chemical Leaman Tank Lines, Inc. v. Aetna Casualty & Surety Co.*, 978 F. Supp. 589, 605 (D.N.J.1997)).

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.

712 A.2d at 1124. Although the example provided by *Carter-Wallace* concerned an allocation that was significant enough so that coverage was provided in several layers of excess, a New Jersey federal court has concluded that even where the allocation is not likely to exhaust any of the primaries, the *Owens-Illinois* calculation requires a weighted allocation that considers all of the layers of insurance (and not just differences in limits of primary policies) in every triggered year. *Travelers Indem. Co. v. Thomas & Betts Corp.*, No. CV136187MASLHG, 2017 WL 3187217, at *4 (D.N.J. July 26, 2017).

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. 179 N.J. 87, 91, 843 A.2d 1094, 1096 (2004). In *Quincy Mutual Fire Insurance Co. v. Borough of Bellmawr*, it 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." 172 N.J. 409, 437, 799 A.2d 499 (2002).

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 carrier's policies before the Guaranty Association's reimbursement commitments on behalf of insolvent carriers are triggered. 215 N.J. 522,

527–28, 74 A.3d 860, 863 (2013). 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." However, the statute that makes the Guaranty Association as an insurer of last resort "also embodies an important public policy [and t]he common law must bow when in conflict with a legislative scheme." Thus, the period of an insolvent carrier is allocated to the policyholder. *Ward Sand & Materials Co. v. Transamerica Ins. Co.*, No. A-1479-13T1, 2016 WL 237781, at *1 (N.J. Super. Ct. App. Div. Jan. 12, 2016).

2. 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*., 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 prorate allocation of both defense and indemnity was appropriate, at least with regard to asbestos bodily injury claims. 264 Conn. 688, 720, 826 A.2d 107 (2003). 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, these principles were specifically adopted in *R.T. Vanderbilt Co., Inc. v. Hartford Accident & Indemnity Co.*, 333 Conn. 343, 216 A.3d 629 (2019), *affirming* 171 Conn. App. 61, 156 A.3d 539 (2017).[10] *Vanderbilt* concerned coverage for asbestos-related bodily injury claims allegedly resulting from exposure to the policyholder's talc. The insurers in *Vanderbilt*, argued that the unavailability rule should not be adopted but, even if it were adopted, it should not apply to that period when asbestos coverage was no longer available but Vanderbilt continued to sell its talc. The *Vanderbilt* court rejected these arguments, explaining:

> 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

[10] The Connecticut Supreme Court specifically adopted the Appellate Court's "well-reasoned" decision on the allocation and pollution exclusion issues.

> substantial new long-tail risks are identified after significant liabilities already have accrued.

156 A.3d at 579. 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." *Id.* at 581.[11]

Although the insurers in *Vanderbilt* had also argued that horizontal allocation should apply, the Court did not address it, leaving in place the trial court's conclusion that certain policies had been vertically exhausted by pro rata allocations based simply on time on the risk (from date of first exposure to discovery of disease or 1986, whichever is earlier).

C. California Applies "Continuous Trigger" and "All Sums" Allocation to Long-Tail Claims

Like the courts in New Jersey and Connecticut, California courts have concluded that general liability policies do not directly answer the questions of (1) when does a continuous condition such as environmental damage "trigger" coverage under an insurance policy and (2) how should responsibility for coverage be allocated among multiple policies that are triggered in such long-tail claims. *See Continental,* 281 P.3d at 1005. While agreeing with those states that "continuous trigger" should apply to long-tail claims, the California Supreme Court did not adopt the pro rata methodology. Instead it looked to various provisions of those general liability policies and decided to adopt "all sums" allocation. *Aerojet-Gen. Corp. v. Transp. Indem. Co.*, 17 Cal.4th 38, 948 P.2d 909, 920 (1997), *as modified on denial of reh'g* (Mar. 11, 1998).

To reach this result, California focused on typical policy language promising to cover "all sums" to which the insured becomes liable.[12] Based on that coverage provision, the settled rule in California is that any policy that is triggered by continuous or progressively deteriorating bodily injury or property damage is responsible for indemnifying the insured not only for the damage that occurs during its policy period, but also "for the entirety of the ensuing damage or injury." *Aerojet,* 948 P.2d at 918 n.10. Because each successive insurer on the risk during continuous or progressively deteriorating property damage is "*separately and independently* obligated to indemnify the insured," "each insurer is severally liable on its own policy up to its policy limits."

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[11] While not foreclosing the possibility of an equitable exception in another case, the court concluded it was not appropriate to do so in *Vanderbilt.* It found that the 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 underserved windfall" and therefore refused to apply an equitable exception to the unavailability rule. *Id.* at 588.

[12] The "all sums" phrase is typically located in the coverage provision or the definition of ultimate net loss.

Continental, 281 P.3d at 1006-07 (citations and internal quotation marks omitted).[13] Given this separate and independent responsibility of each insurer, under "all sums" allocation, the policyholder may select any of its triggered policies to provide coverage up to the limits of that policy. *See Dart Indus., Inc. v. Commercial Union Ins. Co.*, 28 Cal.4th 1059, 52 P.3d 79, 93-94 (2002); *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690 (Cal. App. 1996) (the all sums "allocation procedure does not affect the obligation of the insurers to respond in full: 'a policyholder may obtain full indemnification and defense from one insurer, leaving the targeted insurer to seek contribution from other insurers covering the same loss.'"), *quoting Keene Corp. v. Ins. Co. of North America,* 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied,* 455 U.S. 1007 (1982).

California also permits an insured, if it so chooses, to "stack" policy limits – that is obtain coverage from multiple triggered policies – where there is no policy provision specifically prohibiting stacking. *See Continental*, 281 P.3d at 1008. However, California does not force the policyholder to seek coverage under all triggered policies and has specifically rejected the insurers' argument that pro rata allocation should be applied to long-tail claims. *Id.* at 1002, 1007-08. Instead, the California Supreme Court held that "all-sums" was justified by both the language of the policies and the reasonable expectations of the insured, assuring "that the insured has immediate access to the insurance it purchased." *Id.*at 1008-09.[14]

1. In Disputes Between Insurers for Equitable Contribution, California Pro-Rates the Obligations of Insurers and Requires Horizontal Exhaustion

California applies different allocation rules to disputes between insurers. While "all sums" requires any triggered policy selected by the insured to provide full coverage up to the policy limits, pro rata allocation applies to disputes between insurers. The basis for this different allocation approach is often derived from the doctrine of equitable contribution or "other insurance" provisions in the policies. *Dart*, 52 P.3d at 93.

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[13] *Continental* involved coverage for environmental contamination. The Supreme Court concluded "that the policies at issue obligate the insurers to pay all sums for property damage [at a single] site, 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, and best reflects the insurers' indemnity obligations under the respective policies, the insured's expectations, and the true character of the damages that flow from a long-tail injury." 281 P.3d at 1008 (internal citations omitted).

[14] Other states have also adopted all sums allocation or some combination of both methodologies. For instance, New York applies all sums allocation to policies that contain or follow form to standardized prior insurance and non-cumulation of liability conditions but otherwise applies pro rata allocation. *See Keyspan,* 31 N.Y.3d at 58-59 (explaining *In re Viking Pump, Inc. & Warren Pumps, LLC, Insurance Appeals,* 27 N.Y. 3d 244, 52 N.E.3d 1144 (2016) and *Consolidated Edison Co. v. Allstate Ins. Co.* 98 N.Y. 2d 208, 774 N.E.2d 687 (2002)). By contrast, New Jersey rejected the argument that the non-cumulation clause justified all sums allocation. *Spaulding Composites Co., Inc. v. Aetna Casualty & Surety Co.*, 176 N.J. 25, 42–45, 819 A.2d 410 (2003), *cert. denied*, 540 U.S. 1142, 124 S.Ct. 1061, 157 L.Ed.2d 953 (2004).

Equitable contribution "is the right to recover, not from the party *primarily* liable for the loss, but from a *co-obligor* who *shares* such liability with the party seeking contribution. In the insurance context, the right to contribution arises when several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss … ." *Fireman's Fund Ins. Co. v. Maryland Cas. Co.*, 65 Cal. App. 4th 1279, 1292, 77 Cal. Rptr. 2d 296, 303 (1998).

Under equitable contribution, loss is allocated among all "coinsurers" on the theory that the debt paid by one insurer "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. The purpose of this rule of equity is to accomplish substantial justice by equalizing the common burden shared by coinsurers, and to prevent one insurer from profiting at the expense of others." *Id*. at 303.

Many policies include "other insurance" provisions that attempt to address the problem of coverage when multiple policies cover the same injury. Such provisions commonly provide that where there is other valid and collectible insurance to cover the loss, the policy will either be (1) null and void as to that loss, (2) excess to the other policies covering that loss or (3) share in the loss pro rata. *See Dart*, 52 P.3d at 92. "Historically, 'other insurance' clauses were designed to prevent multiple recoveries when more than one policy provided coverage for a particular loss. On the other hand, 'other insurance' clauses that attempt to shift the burden away from one primary insurer wholly or largely to other insurers have been the objects of judicial distrust." *Id.* at 93 (internal quotation marks and citations omitted). As a result, the "modern trend" is for California courts to disregard the terms of "null and void" and "excess" other insurance provisions and "require equitable contributions on a pro rata basis from all insurers. *Id.*

In the context of disputes between insurers, under certain circumstances California courts have required "horizontal exhaustion" of the limits of all triggered underlying policies before any excess policy can be accessed. In *Community Redevelopment Agency v. Aetna Cas. & Sur. Co.*, a case involving an equitable contribution dispute among insurers, the Appellate Court described horizontal exhaustion as a "general rule;" however, it recognized that where a policy provides that it is excess only to a specific underlying policy, vertical exhaustion applies – *i.e.*, once the directly underlying policies have exhausted, the next layer of umbrella or excess coverage comes on the risk. 57 Cal. Rptr. 2d 755, 761 (Cal. App. 1996), *as modified* (Nov. 13, 1996) (horizontal exhaustion will not be applied where the "excess policy states that it is excess over a specifically described policy and will cover a claim when that specific primary policy is exhausted, [because] such language is sufficiently clear to overcome the usual presumption that all primary coverage must be exhausted").

2. Does Horizontal Exhaustion Apply to Disputes Between Insurers and Policyholders?

In *Dart Indus., Inc. v. Commercial Union Ins. Co.,* the California Supreme Court made clear that the obligations of insurers to apportion loss among triggered policies is distinct from and "has no bearing upon the insurers' obligations to the policyholder." 52

P.3d at 93.[15] The insurer is "bound by an obligation to indemnify [the insured] for the whole amount of the loss, without taking into account any contribution that [another insurer] might be obligated to make." *Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc.,* 78 Cal.App.4th 847, 93 Cal. Rptr. 2d 364, 400 (Cal. App. 2000). Thus, in the absence of any prospect of a double recovery by the policyholder, an "other insurance" clause has no effect on the policyholder's right to access its coverage.

The issue of whether horizontal exhaustion applies to disputes between policyholders and insurers was largely resolved in the recent ruling in *Montrose Chemical Corp. v. Superior Court* ("*Montrose III*"), 9 Cal.5th 215, 460 P.3d 1201 (2020). In *Montrose III*, the parties had agreed that all of the primary policies had been exhausted but disputed whether layers of umbrella and excess policies had to be horizontally exhausted. The California Supreme Court held that a policyholder has a right to coverage from its excess insurers as long as it vertically exhausted all other directly underlying excess policies. To reach that conclusion, the Court focused on its principles that, in the context of long-tail claims, general liability policies promising to cover "all sums" for which a policyholder may become liable, are to be construed to ensure that the policyholder has "immediate access" to its insurance without regard to other triggered policies in other years. 460 P.3d at 1208, 1214.

Montrose III specifically rejected the insurers' arguments for the application of horizontal exhaustion, concluding that "Other Insurance" clauses were at the very least ambiguous. The Court stated that the insurers had failed to explain why the phrase "other insurance" should be understood to mean *all* other underlying insurance, rather than simply "a requirement that the insured exhaust only excess insurance with lower attachment points from the *same* policy period." *Id.* (emphasis in original). The Court also observed that historically, Other Insurance clauses were designed to prevent multiple recoveries when more than one *concurrent* policy provided coverage for a particular loss and were "not aimed at governing the proper allocation of liability among successive insurers in cases of long-tail injury or the appropriate sequence in which a policyholder may access its insurance across several policy periods." *Id.* at 1212 (citations omitted).

Montrose III concluded that the contracts "strongly suggest" that the Other Insurance exhaustion requirements were meant to apply solely to directly underlying insurance and not to insurance purchased for other policy periods. It reasoned that (1) the excess policies contain explicit attachment points but under the insurers' horizontal exhaustion theory an insured would have to exhaust policy limits up to that attachment point *for every relevant policy period* – an amount that could greatly exceed the actual amount stated and (2) the excess policies included schedules of underlying insurance that solely referenced the same policy period – but under the insurers' view, these schedules would represent only a fraction of the insurance that must be exhausted. *Id.*

[15] *See Armstrong*, 52 Cal. Rptr. at 708 ("[A] policyholder may obtain full indemnification and defense from one insurer, leaving the targeted insurer to seek contribution from other insurers covering the same loss.") (internal quotation marks omitted); *Haskel, Inc. v. Superior Court*, 39 Cal. Rptr. 2d 520, 526 (Cal. App. 1995) (insurer's refusal to pay more than a pro rata share of defense constituted a denial of coverage).

Because *Montrose III* did not concern the exhaustion of primary policies, the Court declined to decide the question of "when or whether an insured may access excess policies before all primary insurance covering all relevant policy periods has been exhausted." *Id.* at 1206, n.4. Although the California Supreme Court has not yet addressed it, the California Appellate Court in *SantaFe Braun, Inc. v. Ins. Co. of N. Am.*, took up that issue and decided that vertical exhaustion did indeed apply to primary policies in in the context of policyholder/insurer disputes over coverage for long-tail claims. 265 Cal. Rptr. 3d 692 (2020), *review denied* (Sep 30, 2020).[16]

The *SantaFe Braun* Court rejected the insurers' argument that the qualitative differences between primary and excess policies justified horizontal exhaustion of primary policies. While acknowledging these differences – including that primary policies generally (a) attach as first dollar coverage and have an immediate obligation to defend and, as a result, (b) receive significantly higher premium and offer lower limits – the Court held that such "the differences provide little justification for construing the policy language interpreted in *Montrose III* differently." *Id.* at 700.[17] Citing the *Montrose III* example that the application of horizontal exhaustion would significantly increase the operative attachment point, the *SantaFe Braun* Court held that such variation between the policy's stated attachment point that would be applied to a claim that occurred in a single policy period and the significantly expanded the attachment point for long-tail claims under horizontal exhaustion would make the calculation of the premium speculative and unpredictable. *Id.* at 698-701. Finding no meaningful qualitative difference between primary and excess policies that would justify the choice of horizontal exhaustion, the *SantaFe Braun* Court held it must interpret the same or similar "provisions of excess policies to mean what the Supreme Court in *Montrose III* held they mean" and apply vertical exhaustion to primary policies. *Id.*

[16] *But see Cont'l Cas. Co. v. Rohr, Inc.,* 201 Conn. App. 636, 702–03, 244 A.3d 564, 603 (2020), concluding that horizontal exhaustion applies to the exhaustion of primary policies under California law in disputes between policyholders and insurers and that the Connecticut Appellate Court was not obliged to follow *SantaFe Braun.*

[17] Other states have required horizontal exhaustion of primary policies before excess policies can be accessed. *E.g., William Powell Company v. OneBeacon Insurance Company*, 2020-Ohio-5325, 162 N.E.3d 927 (Ohio Ct. App. 1st Dist. Hamilton County 2020); *Kajima Const. Services, Inc. v. St. Paul Fire and Marine Ins. Co.*, 227 Ill. 2d 102, 879 N.E.2d 305 (2007); *SwedishAmerican Hosp. Ass'n of Rockford v. Illinois State Medical Inter-Ins. Exchange*, 395 Ill. App. 3d 80, 334 Ill. Dec. 47, 916 N.E.2d 80 (2d Dist. 2009), *appeal denied*, 235 Ill. 2d 606 (2010). *See* 15 Couch on Ins. § 220:27; Allocation of Losses in Complex Insurance Coverage Claims § 10:4.