New Developments in Allocation of Long-Tail Claims, Trigger of Coverage Theories, and Exhaustion

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I. INTRODUCTION

In his speech accepting the Nobel Prize for Literature in 1962, author William Faulkner spoke of the artist's need to focus on the "verities" of life in writing about human experience: Honor, Compassion, Truth. For the coverage practitioner handling long-tail and other complex claims, this need to focus on the constants that shape the analysis of, and response to, these claims resonates with equal force. However, in coverage law, these "verities" can be boiled down to three simple (yet daunting) concepts: Trigger, Allocation and Exhaustion.

Some attorneys might refer to these concepts as the "Holy Trinity" of coverage law. Others no doubt think of them as the "Bermuda Triangle" where practitioners can be irretrievably lost at sea. But by whatever name they are referred to , having an understanding of these concepts remains an essential part of the coverage lawyer's toolbox. This paper and the presentation will explore the many ways in which these fundamental concepts continue to evolve and challenge insurers, attorneys and the courts in diverse claims situations.

II. A BRIEF REVIEW OF THE BASICS

No doubt the professionals attending this symposium are well-versed in the basics of these concepts and so this paper will not spend a great deal of time reviewing them. However, so that we are on the same page as we approach the nuances that are evident from the recent case law, the following are simplified versions of the concepts that are in play under an "occurrence" based Commercial General Liability ("CGL") Policy:

Trigger: ***What*** must happen for a claim to be potentially covered under a policy. In other words, what event, happening, injury or damage must take place during the term of the policy for there to be an "occurrence" that is potentially within the scope of coverage. How

is the trigger to be determined? This requirement has generally been broken down into the familiar "triggers" of "actual injury" (also commonly equated with "injury in fact"), "manifestation" and the policyholder's favorite, the "continuous trigger," where every policy on the risk from the beginning of time to the end of time can potentially be required to respond to a claim so long as some portion of the damage took place during the term of the policy.

Allocation: When a claim or series of claims "triggers" more than a single year of coverage, how are the policies to respond to the claim or series of claims? This issue typically boils down to the debate between the "pro rata by time on the risk" approach vs. the "all sums" approach. Under the former, which has been held in a majority of states to be the controlling rule, all insurers that are on the risk during the period when coverage is "triggered" by continuous bodily injury or property damage must share equally in paying indemnity for the loss. While this is often regarded as a pro-insurer rule, in fact it makes the policyholder's burden substantially easier in situations involving asbestos, environmental claims and other losses that occur over long periods of time. In many situations, it is nearly impossible to determine actual start and end dates for the underlying liability and the amount of injury or damage that took place in each discrete policy period. This principle is contrasted with the "all sums" approach, derived from language in the insuring agreement, which allows the policyholder to select or target a particular policy or year from which to collect the entirety of the loss. Indeed, some jurisdictions, such as California, do not limit the recovery to a single policy or year of coverage, but permit the policyholder to add together or "stack" the limits of coverage available in multiple years in order to ensure that the policyholder is able to collect the entire loss when a single tower of coverage (primary and

excess) is insufficient to provide a full recovery. This principle of allocation can, in many instances, greatly benefit the policyholder (and unfairly burden certain insurers) depending upon the specific terms, conditions, limits and exclusions that are present in a particular year of the coverage profile.

Exhaustion: While simple in concept, as will be evident in the discussion of the *Montrose Chemical* case that follows, the question of whether, when and how underlying insurance has been "exhausted" by a claim or series of claims can be enormously complex and spawn costly supplemental litigation among insurers. The fundamental question that exhaustion addresses is, in the first instance, how insurance policies in a complex coverage profile of multiple layers of policies in effect over a long period of time are to be tapped or accessed by the policyholder in collecting indemnity that is owed under the policies. For example, if a claim or series of claims triggers thirty years of coverage, can the policyholder go straight up or "spike" a single year of coverage in order to collect the claim even though lower layer policies in other years that are triggered remain available? This concept is known as "vertical" exhaustion. In the alternative, is the policyholder obligated to exhaust all available coverage "horizontally" so that the upper layers of the available coverage are reached only as a last resort based on the idea that such policies are the furthest from the risk? To what extent should the policyholder be able to manipulate the coverage to access it in a sequence that it finds to be beneficial? These challenges are at the heart of the exhaustion cases discussed in this paper.

III. WHERE TRIGGER, ALLOCATION AND EXHAUSTION MEET: *Montrose Chemical Corp. v. Superior Court*

The inherently inter-related concepts of trigger, allocation and exhaustion all converged in a very important decision by the California Supreme Court last year. *Montrose*

*Chemical Corp. v Superior Cour*t, 9 Cal. 5th 215, 460 P.3d 1201 (2020). For the purpose of this discussion, we will refer to the case as *Montrose* since, quite literally, the case has spawned so many decisions over the course of more than thirty years of litigation that it has become nearly impossible to count them all. Taken at face value, the holding of the case is deceptively simple: vertical rather than horizontal exhaustion will apply when determining which policies and in what order the policyholder can access the coverage to satisfy a loss that spans decades of alleged damage and remediation costs exceeding $`100 million and counting.

However, as will become apparent from a close reading of the decision, its practical (or perhaps impractical) effect threatens to create a morass of after-the-fact litigation among insurers battling to mitigate the impact of the ruling. No more gently rising and evenly layered bathtub where every layer is reached in order based upon its degree of removal from the risk. Instead, the decision greatly enhances the ability of a policyholder to randomly spike particular years and layers of coverage to its advantage. And, depending upon where an insurer may be sitting in the "bathtub," those sudden spikes can really hurt.

While many attendees will be familiar with the long history of the *Montrose* litigation, a brief summary is in order as it illustrates how the issues of trigger, allocation and exhaustion meet when dealing with a complex coverage profile and a long-tail injury that spans decades. Montrose was responsible for continuous environmental property damage at its facility in the Los Angeles area during the period from 1947 through 1982. Montrose entered into a series of consent decrees with USEPA and the State of California to resolve those claims. Montrose then commenced litigation against its insurers seeking to recover the costs that it had agreed to pay to resolve its environmental liabilities.

The coverage block at issue in the case extended from 1961 through 1985. In each year of the coverage block, Montrose had purchased both primary and excess insurance policies. The amount of insurance purchased in each of the annual "towers" varied over time. The decision includes a series of tables that illustrate the coverage that Montrose had available to it in selected years. In all, the case involved more than 115 excess policies issued by some 40 different insurers.

The central issue presented on appeal focused on the ***sequence*** in which Montrose could access its excess policies included in the coverage block. Montrose contended that it should be able to go straight up vertically any particular tower of insurance. That is, so long as Montrose had exhausted the insurance that was immediately underlying a particular policy, then Montrose could go on to the next level. This would create a situation in which excess policies that were in lower layers, and therefore closer to the risk, would be left intact, subject only to Montrose's decision as to which tower to access next if needed to be made whole for its loss. This is the classic definition of "vertical" exhaustion.

The insurers, on the other hand, argued that Montrose was required to exhaust a particular layer of coverage for all years available to it before it could reach policies in a higher layer. In other words, Montrose should be required to fill up the bathtub in an even fashion, rather than being able to create vertical spikes that left gaps where the lower layers in other years were not touched. The insurers contended that the approach advocated for by Montrose was inconsistent not only with the policy language governing exhaustion, but with the expectations of the parties as to how policies in the various layers would be tapped to pay a loss.

All parties agreed that the subject policies provided that Montrose was required to exhaust its underlying insurance before it could move up the towers. However, as might be expected given the number of policies and extensive time period involved, the policies defined the concept of "underlying coverage" in many different ways. For example, some of the policies had an actual schedule of insurance which listed by insurer and policy number the particular policies that had to be exhausted. Other policies referred to a particular dollar amount of coverage that must be exhausted. Other policies referred to a specific dollar amount of insurance that had to be exhausted for the particular policy period. And still other policies refereed to the combined underlying limits in a particular policy period to define the amount that had to be exhausted before the policy could have any obligation to respond. The court also noted the variety of so-called "other insurance" provisions contained in the policies that referred to the manner in which the policies purchased by Montrose were to be accessed. While this hodgepodge of provisions is not in the least bit surprising, it clearly provided a window for the court to resist claims by the insurers that their policies included a uniform approach to exhaustion.

Noting the fact that the coverage litigation had been going on for some thirty years, the court framed the issue as follows:

> The rule Montrose proposes in its amended complaint [filed in 2015] is a rule of "vertical exhaustion" or "elective stacking," whereby it may access any excess policy once it has exhausted other policies with lower attachment points in the same policy period. The insurers, in contrast, each of which has issued an excess policy to Montrose in one of the triggered policy years, argue for a rule of "horizontal exhaustion," whereby Montrose may access an excess policy only after it has exhausted other policies with

> lower attachment points from *every* policy period in which the environmental damage resulting in liability occurred. 9 Cal. 5th at 227.

Before answering the question at hand, the California Supreme Court engaged in an extensive review of the more than 25 years of coverage litigation that had preceded this decision. The prior iterations of the case illustrate how the various elements discussed in this paper constitute the "building blocks" for the analysis of which insurers are obligated to pay and in what order. Thus, in *Montrose Chemical Corp. v. Admiral Ins. Co*., 10 Cal.4th 645 (1995), the court had ruled that where damage is continuous or progressive, all policies issued during the period of such injury would be triggered. Trigger is determined not by the "***cause***" of the damage, but rather by ***when*** the damage took place. If the damage is continuous and progressive, then all policies on the risk during the period of damage are triggered.

The court then built upon this original decision to hold that California would not adopt a pro rata by time on the risk approach to the issue of allocation. Instead, as long as at least some portion of the harm takes place during the period of coverage, the insurer is on the hook for the full amount of the damage and can be required to pay "all sums" that result from that damage. *Aerojet-General Corp. v. Transport Indem. Co.*, 17 Cal. 4th 38 (1997). The insurers' obligations continue until the policyholder is made whole or the limits of coverage are exhausted. The court concluded that such a rule was necessary given the practical difficulties (if not impossibility) of determining what amount of damage took place during any particular policy period.

Given this premise, it was only a very easy logical leap for the court to conclude in . *State of California v. Continental Ins. Co.*, 55 Cal. 4th 86, 196-200 (2012) that where the

limits of any one policy were insufficient to provide full indemnity for the loss, the policyholder should be permitted to "stack" the available limits of coverage up to the full limits of all policies that were on the risk during the period of damage. This system in effect creates one "uber" policy that is available to the insured and from which it can recover its entire loss. As the court stated:

> This all-sums-with-stacking indemnity principle properly incorporates the continuous injury trigger of coverage rule and the all sums rule, and effectively stacks the insurance coverage from different policy periods to form one giant "uber-policy" with a coverage limit equal to the sum of all purchased insurance policies. This approach treats all the triggered insurance as though it were purchased in one policy period and recognizes the uniquely progressive nature of long-tail injuries that cause progressive damage throughout multiple policy periods. Importantly, the insured has immediate access to the insurance it purchased. The insurers can then sort out their proportional share through actions for equitable contribution or subrogation. 9 Cal. 5th at 228.

In light of the pro-policyholder decisions that it previously issued on the matters of trigger, allocation and stacking, it is not surprising that the court agreed with Montrose's position that it should be permitted to access any of its triggered policies so long as it could show that it had "exhausted" the policies that provided the immediately underlying insurance to the targeted policy. In doing so, the court offered a myriad of reasons for reaching this result. In the first instance, the court relied upon the lack of clarity in the insurers' policies on the question of exhaustion. In particular, the court noted that the policies did not spell out in clear terms that Montrose was required to exhaust all insurance with lower attachment points purchased for different policy periods before it could access a policy in a higher layer so long as the immediately underlying policy had been exhausted. The court also relied on the lack

of uniformity among the policies with respect to "other insurance" and similar provisions to conclude that it could not be clearly determined that the insurers intended to require horizontal exhaustion in the case of a long-tail, progressive loss that spanned decades of coverage.

The court also turned to the extensive body of case law relating to "other insurance" clauses to reinforce its conclusion. This history demonstrated that the central purpose of "other insurance" clauses was ***not*** to address a situation such as the one presented in the case at hand. Instead, these clauses were intended to prevent situations of double recovery of a loss. Thus, they had not traditionally been analyzed as creating a rule with respect to the manner of exhaustion in a progressive loss situation. Certainly, there was nothing from the context of litigation involving "other insurance" clauses which could be used to support the insurers' position that horizontal allocation was mandated by the terms of the policies. Such clauses, the court concluded, do not "speak directly" to the issue presented on appeal.

The court then looked to other indicia of intent to support its analysis. For example, the excess policies typically state their respective attachment point by referring to the amount of underlying insurance in the same policy period that must be exhausted before the policy can have an obligation to respond. The use of schedules of underlying insurance in many of the policies also supports a reading that nothing more is required than exhaustion of the successive layers of coverage in an individual tower for a specific year.

The court also noted that the insurers' argument that horizontal exhaustion is easier to administer was inconsistent with the structure of the insurance program. Because of annual variations in limits, terms, conditions, exclusions and conditions, the notion that going straight across a layer of coverage rather than straight up a particular year would be simpler

was not true. In effect, a horizontal exhaustion approach could require the policyholder to litigate all issues across its entire coverage profile, rather than focusing on the narrow issue presented by the terms of coverage in a particular year. This would only increase the already enormous cost of coverage litigation.

The decision in *Montrose* never addresses the realities of underwriting, including with respect to the specific excess policies that Montrose purchased. The idea that Montrose purchased a so-called "uber policy" covering a span of nearly thirty years is a faction created by the court, pure and simple. Can one imagine the reaction had the risk manager of Montrose called up her broker at Marsh and told her that Montrose wanted to order up an "uber policy"? There is no such thing and Montrose's program was made up of individual policies, many with idiosyncratic terms, purchased during a particular period under specific market conditions. The decision completely disregards the relevance of pricing decisions made by underwriters based upon their analysis of risk. An underwriter issuing a policy in a layer excess of $100 million can hardly have contemplated that, in a progressive loss situation, the policy excess of $100 million might have to pay out its limits before a policy excess of$5 million was tapped. Yet, this is the very world that the California Supreme Court's decision creates.

Equally facile is the court's suggestion that any unfairness experienced by the "targeted" insurer can be addressed through follow-on suits for equitable contribution from other insurers. The court stated that "the exhaustion rule does not alter the usual rules of equitable contribution between insurers. An insurer required to provide excess coverage for a long-tail injury may lessen its burden by seeking reimbursement from other insurers that issued policies during the relevant period." 9 Cal. 5th at 237. But the court never explains

how this would work in the real world or takes into consideration the costs that would be involved to proceed with such inter-insurer cases. It took the California court system some thirty years to get the *Montrose* coverage litigation to the decision in 2020. How many more decades might it take (and at what cost) to resolve every possible permutation of claims between the participants in the "uber policy." Moreover, exactly what rights to "equitable contribution" does the court think would exist among insurers since the decision creates a system of allocating loss that it has deemed to be fair? How the impacts of the *Montrose* decision will reverberate among insurers remains to be seen. However, any notion that the California Supreme Court "solved" the allocation dilemma seems wishful thinking at best.

IV. REVISITING "SETTLED" ALLOCATION ISSUES

A. Everything Old is New Again: *Rossello v. Zurich Am. Ins. Co.*, 468 Md., 92, 226 A,3d 444 (2020)

Although the battle between theories of "pro rata" or "time on the risk" allocation, as compared with the "all sums" approach, has been going on for decades, this fight has continued in courts in many regions of the United States. Indeed, even in states where insurers may have considered the question of the applicable allocation rule to be "settled," policyholders are pushing the envelope to seek reconsideration and revision of these supposedly "settled" rules, particularly in cases where recovering compensation for personal injuries arising out of asbestos exposure is at stake.

This trend is evident in a recent and comprehensive decision on allocation that was issued by the Maryland Court of Appeals last year. The court affirmed that pro rata by time on the risk allocation would apply to long-tail claims for personal injury, thereby extending the rule that it had previously announced for property damage claims. *Rossello v. Zurich Am. Ins. Co.*, 468 Md. 92, 226 A.3d 444 (2020).

The case arose in a situation that has no doubt played itself out in thousands of asbestos cases. The plaintiff, Rossello, worked on a construction project starting in 1974. During the course of his employment, he was exposed to asbestos-containing products. He was not diagnosed with mesothelioma until 20`13. Thereafter, he sued an asbestos installer, J. Mitchell Co. ("Mitchell")., which by the time of suit had ceased operations. Rossello obtained a judgment of approximately $2.8 million against Mitchell. Rossello then sought to collect the judgment through a garnishment proceeding brought against Zurich, which had only issued policies to Mitchell during a four year period in the 1970's out of the nearly forty year period from the date of first exposure through the time of diagnosis. The central question raised by the case was whether Zurich was obligated to satisfy the entire judgment, subject only to the limits of its four policies, or whether the loss should be allocated over a much longer period of time. The case also presented a complicated issue of how any allocation period would be defined since Mitchell had both elected not to buy insurance during certain periods of time, but was also operating during periods when commercial insurance for asbestos-related exposures was not available in the commercial market.

Before tackling the allocation issue, the court thoroughly reviewed Maryland law on trigger of coverage in the context of long-tail claims. The importance of this discussion is that it demonstrates how closely tied the trigger analysis is to the question of allocation. In other words, the allocation problem arises because jurisdictions such as Maryland do not limit the policies that are triggered by an injury to only the policy on the risk when the initial exposure to the injurious substance commences. Nor is coverage limited solely to the year in which the injury becomes manifest or is discovered. Instead, in light of the long latency period between the date of first exposure and when a diagnosis of asbestos-related disease

becomes practical, the courts have determined that there is some form of "bodily injury" that takes place in each year from the date of first exposure through the date of diagnosis. In such circumstances, the "actual injury" trigger becomes a "continuous" trigger that implicates all periods of time during which the disease process is progressing. This, in turn, leads to the question of whether a claimant such as Rossello can look to any one insurer during the forty year period to obtain recovery of the judgment or, in the alternative, whether an insurer can only be required to provide indemnity for the portion of the injury period that it agreed to cover. Throughout the analysis undertaken by the court, it was very careful to reiterate the direct link between trigger of coverage and the rules relating to allocation.

After reviewing the law of Maryland and other jurisdictions with respect to trigger of coverage in the context of asbestos claims, the Court of Appeals then turned to the allocation issue. Given the long period of time during which the claimant's injuries continued and progressed before a diagnosis of mesothelioma was obtained, coupled with the lack of available insurance during a substantial portion of the triggered period, the Court recognized that the fundamental issue was how the judgment obtained by Rossello should be allocated between Zurich and its policyholder. In other words, this was not a situation where there was available coverage in all years triggered by the claim such that the loss could be allocated among a large number of insurance companies.

The court was not writing on a blank slate. Some two decades earlier, the intermediate appellate court had considered the allocation issue in *Mayor and City Council of Baltimore v. Utica Mut. Ins. Co.*, 145 Md. App. 256, 802 A. 2nd 1070 (2002) ("*Utica*"). *Utica* involved asbestos in building claims for property damage, rather than claims for bodily injury to an individual. Zurich urged that the *Utica* decision and rationale was fully

applicable to the bodily injury context. In contrast, Rossello asked the court to reconsider the holding in *Utica* and instead apply the "joint and several" or "all sums" approach that would permit the claimant to recover the entire judgment from any triggered insurer on the risk.

The court declined to revisit the holding in *Utica* and instead ruled that it applied with full force and effect to the allocation dilemma presented by the case at bar. The court reviewed the fact that the groundwork for the *Utica* decision in 2002 was laid by its decision in *Bausch & Lomb, Inc. v. Utica Mut. Ins. Co.*, 355 Md. 566, 735 A.2d 1081 (1999), where the court had declined to apply the "joint and several" approach to environmental liabilities arising from thirty years of operations at the insured's facility. Notably, the insured in *Bausch & Lomb* had only purchased coverage that applied to the type of liability at issue for a period of four years. The policyholder nevertheless sought to hold the insurer liable for all of the environmental harm, contending that so long as any portion of the property damage occurred during the period of coverage, the insurer was on the hook for the entire loss because the insurer agreed to pay "all sums". In *Bausch & Lomb*, the court ruled that pro rata allocation was consistent with the policy language specifying that the insurer was only required to pay for property damage that occurred during the policy period. Notable is the fact that. in *Bausch & Lomb*, the court had remanded the matter with instructions to receive evidence concerning the amount of environmental property damage that took place during particular time periods.

Similarly in the *Utica/Baltimore City* litigation, the dispute centered on how the City's recovery of a judgment for asbestos in building claims should be apportioned among the insurers. Baltimore contended that it could collect the entirety of the settlement from any

insurer whose policy was triggered during the period when asbestos was present in the buildings. The Court of Special Appeals disagreed, ruling that the language of the policies was most consistent with allocating the loss on a pro rata by time on the risk method. This approach would best match the policy language limiting "property damage" to the damage which occurs during the policy period. The continuous trigger theory was used to define the policies that were on the risk. For periods when the policyholder did not have coverage, it would be responsible for the shares allocated to that period except insofar as coverage was shown not to be "available" (e.g., when coverage could not be purchased due to mandatory asbestos exclusions).

After reviewing these prior decisions, the court in *Rossello* declined to adopt the approach argued for by the injured claimant and instead applied the pro rata by time on the risk allocation rule to claims for bodily injury. The court addressed head on Rossello's challenge (which is typically made by the policyholder) that, once a policy is triggered, each policy becomes obligated to pay "all sums" that result from the triggering event. While the point may be accurate as far as it goes, the fundamental problem is that the argument ignores the balance of the relevant policy provisions, which state that coverage is provided only for bodily injury that occurs "during the policy period." Thus, the interpretation argued for by Rossello fails to take into account the full breadth of the policy language. The court noted that the argument conflates the "occurrence" definition with the definition of "bodily injury," which very clearly specifies that the "bodily injury" must take place during the period of the policy. As the court concluded, "there is no logic to support the notion that one single insurance policy among 20 or 30 year's worth of policies could be expected to be held liable for the entire time period." 468 Md. at 119, *quoting Utica*, 145 Md. App. at 311. The court

further rejected the contention that a different rule should apply to claims for bodily injury since the policy language was the same without regard to whether the underlying claim was for bodily injury or property damage. This is so, the court reasoned, because claims for asbestos exposure and similar events also involve imprecision as to what actual "injury" occurred during any particular twelve month period of time. Accordingly, it would be unfair to saddle any one insurer with the entire liability associated with an ongoing and progressive disease process.

Finally, the court dispensed with arguments advanced by amici on behalf of Rossello contending that the pro rata approach is "unfair, unworkable and causes unnecessary complications." On the contrary, quoting cases from several other jurisdictions, the Maryland court noted that the joint and several allocation approach produces additional and costly litigation as the targeted insurers seek contribution from other insurers in the triggered block. *See e.g., Energy North Nat. Gas Inc. v. Certain Underwriters at Lloyd's*, 156 N.H. 333, 934 A.2d 517 (2007). At the end of the day, Zurich only issued policies that insured a portion of the plaintiff's injury and the Maryland Court of Appeals affirmed that it was only required to pay its proportionate share of the judgment.

B. The Divide Between Pro Rata Allocation vs. "All sums"

1. Decisions Adopting Pro Rata Allocation

The clear trend over the past twenty years is firmly in the direction of allocating long-tail claims using the pro rata by time on the risk approach. Jurisdictions that have adopted pro-rata allocation include Colorado, Connecticut, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York (with an important limitation), South Carolina, Utah, and Vermont. *See Public Serv. Co. v. Wallis &*

Cos., 986 P.2d 924, 935 (Colo. 1999); *Sec. Ins. Co. v. Lumbermens Mut. Cas. Co.*, 264 Conn. 688, 826 A.2d 107, 121 (Conn. 2003); *Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co.*, 275 Kan. 698, 71 P.3d 1097, 1134 (Kan. 2003); *Aetna Cas. & Sur. Co. v. Commonwealth*, 179 S.W.3d 830, 842 (Ky. 2005); *Arceneaux v. Amstar Corp.*, 200 So.3d 277, 286 (La. 2016); *Bos. Gas Co. v. Century Indem. Co.*, 454 Mass. 337, 910 N.E.2d 290, 311-16 (Mass. 2009); *N. States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 664 (Minn. 1994); *Dutton-Lainson Co. v. Cont'l Ins. Co.*, 279 Neb. 365, 778 N.W.2d 433, 445 (Neb. 2009); *EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyd's*, 156 N.H. 333, 934 A.2d 517, 526 (N.H. 2007); *Owens-Illinois v. United Ins. Co.*, 138 N.J. 437, 650 A.2d 974 (N.J. 1994); *Consol. Edison Co. of N.Y., Inc. v. Allstate Ins. Co.*, 98 N.Y.2d 208, 774 N.E.2d 687, 695-96, 746 N.Y.S.2d 622 (N.Y. 2002)(severely limited by the decision in *Viking Pump* below) ; *Crossmann Cmtys. of N.C. v. Harleysville Mut. Ins. Co.*, 395 S.C. 40, 717 S.E.2d 589, 599-601 (S.C. 2011*); Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127, 140-42 (Utah 1997); *Towns v. N. Sec. Ins. Co.*, 184 Vt. 322, 964 A.2d 1150, 1167 (Vt. 2008).

2. Decisions Adopting "All Sums"

Notwithstanding the trend in the direction of pro rata allocation, there are several states (notably California and, where certain language is present, New York) that have adopted the "joint and several" or "all sums" approach. In the case of New York, the Court of Appeals relied upon the non-cumulation of liability provisions in the policies at issue to support its rationale. *Matter of Viking Pump*, 27 N.Y.3d 244, 255, 52 N.E.3d 1144 (2016). Other states following some form of joint and several or "all sums" liability include California, Delaware, Indiana, Ohio, Oregon, Pennsylvania, Washington, and Wisconsin. *See*

Armstrong World Indus. v. Aetna Cas. & Sur. Co., 45 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690, 708 (Cal. 1996); *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481, 494 (Del. 2001); *Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049, 1058 (Ind. 2001); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 95 Ohio St. 3d 512, 2002- Ohio 2842, 769 N.E.2d 835, 841 (Ohio 2002); J.H. *France Refractories Co. v. Allstate Ins. Co.*, 534 Pa. 29, 626 A.2d 502, 507 (Pa. 1993); *Am. Nat'l Fire Ins. Co. v. B&L Trucking & Constr. Co.*, 134 Wn.2d 413, 951 P.2d 250, 256-57 (Wash. 1998); *Plastics Eng'g Co. v. Liberty Mut. Ins. Co.*, 2009 WI 13, 315 Wis. 2d 556, 759 N.W.2d 613, 616 (Wis. 2009); *see also Or. Rev. Stat.* §465.480(3)(a) (providing joint and several allocation for environmental claims).

V. MODERN PROBLEMS WITH TRIGGER OF COVERAGE

The problems faced by Insurers, Policyholders and Courts alike derive from the need to apply the basic trigger "concepts" to a variety of disparate factual settings and claims. Accordingly, it would be a mistake for a claims professional handling a matter that involves the law of a particular state to rely too heavily on the "labels" that have emerged from decades of coverage litigation over trigger in the asbestos, environmental or the myriad of other categories of claims in which the applicable trigger is an issue. This point was succinctly noted by the Maryland Court of Appeals in the *Rossello* case, discussed above. As the court there stated: " Although this discussion has referred to various trigger theories by name, we must stress that courts and litigants should be careful when referring to such delineated theories. The nomenclature and reference of specific trigger models can be deceiving 'because a court must apply policy language to the factual context before it.'" 468 Md. at 112, *quoting Utica*, 145 Md. App. at 299. The inherently fact-driven nature of the

trigger question is underscored by a pair of cases arising in different states and involving different types of underlying injuries.

A. Asbestos: *Carrier Corp. v. Allstate Ins. Co.*

The decision late last year by the Fourth Department in *Carrier Corp. v. Allstate Ins. Co.*, 187 A.D.3d 1616, 133 N.Y.S. 3d 697 (4th Dept. 2020) is a stunning example of how seemingly settled expectations concerning trigger law can be quickly upended. The case is a typical large-scale coverage action in which Carrier Corp. and a related entity sought coverage for thousands of personal injury lawsuits arising out of exposure to asbestos-containing products that they manufactured. The policies at issue were standard follow form excess policies to an underlying umbrella policy which contained the typical definition of "occurrence." Carrier had obtained a series of partial summary judgment rulings in its favor on a number of issues. With respect to the trigger of coverage, the trial court held, ***as a matter of law*** and applying New York's "injury-in-fact" trigger, the "injury-in-fact" in an asbestos action occurs from the date of first claimed exposure through death or the filing of suit, thereby triggering each policy in effect from the date of first claimed exposure." *Id.* at 1618.

On appeal, the insurer (Fireman's Fund) contended that this central issue was ***not*** capable of resolution on a summary judgment record as there were disputed issues of fact as to when such injury first occurs. The Fourth Department went all the way back to the decision in *Continental Cas. Co. v. Rapid American Corp.*, 80 N.Y.2d 640, 651, 609 N.E.2d 506 (1993), which held that the injury-in-fact trigger "rests on when the injury, sickness, disease or disability actually began." *Id.* at 1619. The insurer's position was that injury-in-

fact only occurs when a threshold level of asbestos fiber or particle burden is reached that overturns the body's defense mechanisms.

The Fourth Department agreed that the question of "when" injury begins presented a question of fact, not an issue that could be decided as a pure matter of law. In distinguishing numerous other cases where precisely such a determination had been made, the court noted that in those cases the parties had either stipulated that injury begins on the date of first exposure or the issue was not litigated. *See e.g., Pacific Employers Ins. Co. v. Troy Belting & Supply Co.*, 2015 US Dist. LEXIS 130681 (N.D. N.Y. 2015); *United States Fid. & Guar. Co. v. Treadwell Corp.*, 58 F.Supp.2d 95 (S.D.N.Y. 1999).

In contrast, the insurer had introduced evidence in the form of affidavits of two medical experts which contradicted the policyholder's claim that injury from asbestos occurs immediately after initial exposure. The affidavits of the insurer's experts (which, unfortunately are not available because the record in the case is sealed) offered opinions that harm occurs only when a threshold particle burden reaches a level that is sufficient to overtake the body's defense mechanisms. The Fourth Department concluded that this evidence created a triable issue of fact on the trigger issue such that the grant of partial summary judgment should be reversed. The court also rejected Carrier's argument that the insurer should be estopped from denying that injury begins on the date of first exposure based upon the position it had taken in other cases. Of note with respect to the other issues addressed in this paper, the court rejected the insurer's argument on allocation, reiterating that an "all sums" vertical exhaustion methodology should apply based upon the holding in *Matter of Viking Pump, Inc.*, 27 N.Y.3d 244, 255, 52 N.E.3d 1144 (2016).

On its face, the decision in *Carrier Corp*. is deceptively simple. The direct holding of the case is that the trial court's grant of summary judgment on the trigger of coverage issue was improvident. However, in ruling that the issue could not be decided as a matter of law due to conflicting medical experts, the Fourth Department opened the door to increasing the complexity of coverage litigation in the asbestos arena. Some experts utilized by insurers in this area have offered opinions attempting to "standardize" the trigger issue by opining that exposure plus a certain number of years should be used as a paradigm. The goal of such a position is to push the trigger point to later years in a policyholder's insurance program. However, the scenario presented in *Carrier Corp*. leads to the potential for having to litigate the facts of trigger as to each claimant since it cannot be presumed as a matter of law that initial exposure equates with "bodily injury" for the purpose of triggering coverage. Such a case-by-case approach to the trigger issue in matters involving large insureds who have experienced hundreds of thousands of claims could, in fact, serve to reduce the likelihood of resolving such claims. How the Fourth Department's ruling will play out in the specific litigation remains to be seen. But the decision is a clear reminder that, in the world of trigger, nothing is truly carved in stone.

B. PFAS: *Crum & Forster v. Chemicals, Inc.*

Litigation arising out of the historical use of PFAS and PFOS-the so-called "forever chemicals"-has exploded in the past several years. The suits involving these chemicals involve products as diverse as "Scotchguard" fabric protector and fire-fighting foam used by municipal fire departments throughout the United States, as well as at military installations. The range of suits is equally broad, from personal injury cases brought on behalf of allegedly exposed individuals, to suits by state governments seeking to compel the remediation of

sites where these chemicals were manufactured or discharged. Several major corporations, notably 3M, have paid hundreds of millions of dollars to resolve some of these cases. More recently, many states have adopted standards for the regulation of these chemicals which have resulted in a large number of enforcement actions by state environmental authorities arising out of the contamination of public water supplies.

While coverage litigation arising out of PFAS claims remains in a very undeveloped state, at least one recent decision has tackled the issue of trigger of coverage for these claims. *Crum & Forster Specialty Ins. Co. v. Chemicals, Inc.*, 2021 U.S. Dist. LEXIS 146702 (S.D. Tex., Aug, 5, 2021). The action sought a declaration with respect to the duty to defend in connection with the several hundred personal injury lawsuits consolidated in the *In re Aqueous Fire-fighting Foams Prods. Liability Litigation* pending in the United States District Court for the District of South Carolina. Aptly named Chemicals, Inc. is one of the many corporate defendants named in the South Carolina consolidated cases as an alleged manufacturer, designer, marketer or distributor of the fire-fighting foam products.

Of significance for the trigger of coverage analysis, the complaints in the underlying cases did not allege either dates when the firefighters were first exposed to the products or when they first manifested symptoms of injury from the products. The policies issued to Chemicals, Inc. by Crum & Forster required that the bodily injury "first occurs during the policy period." The particular policies at issue contained another provision, however, which stated that if the date of the injury could not be determined, then it would be deemed to have occurred before the policy period. Based upon this language, Crum & Forster contended that since the dates of alleged first exposure or injury could not be determined, it did not have a duty to defend the claims. The policyholder argued that the insurance policies do not

require that the dates of injury actually have been determined, but only that the dates of loss "can" be determined.

Applying Texas' traditional "eight corners" rule, the district court held that summary judgment in favor of the insurer was not appropriate. The court noted that the insurer had the burden to demonstrate that the dates of injury could not be determined or that the claims were otherwise outside the scope of coverage provided by the policies. So long as the date of injury "could" potentially be determined in future proceedings and "could" fall within the terms of the policies' coverage, the insurer was obligated to defend. The court found the provisions before it to be ambiguous to the extent that the insurer had failed to specify "who" was entitled to make the determination of whether the dates of loss "could" be determined or upon what evidence. The policy did not foreclose the possibility of an evidentiary hearing to establish the date of loss. Accordingly, since the plaintiffs in the underlying cases alleged dates of employment during the periods of the insurance policies at issue, the district court ruled that a defense was owed.

Insofar as the *Chemicals, Inc.* case was limited to the issue of the duty to defend, it does not answer the broader issue of what trigger of coverage is likely to be applied to such claims. Unlike asbestos, at this point the science related to PFAS and PFOS claims in the personal injury context is relatively undeveloped. Accordingly, whether a date of first exposure through date of manifestation of injury or suit is appropriate for such claims remains very uncertain. As with other toxic chemical claims, determining the trigger of coverage will necessarily have to follow the science as it is developed.

VI. EXHAUSTION DISPUTES

The discussion of the *Montrose Chemical* decision above provides an outline of the contours and complexities of how exhaustion works in the context of a corporate insurance program that spans decades. As noted, *Montrose Chemical* does not answer the exhaustion question, but instead effectively postpones it to follow-on litigation among the insurers. However, disputes relating to principles of exhaustion can arise in a variety of contexts as illustrated by a pair of cases decided by the Ninth Circuit Court of Appeals last year.

First, in *Axis Reinsurance Co. v. Northrop Grumman Corp.*, 976 F.3d 840 (9th Cir. 2020), the Court of Appeals rejected the attempt by an excess insurer to claim that the underlying insurance had been "improperly eroded" by the settlement decisions made by the underlying insurer. Axis, the excess insurer, sought to recover a payment it had made to the policyholder after being advised that the underlying insurance was exhausted. Axis contended that the underlying insurer had agreed to pay a claim that was not covered by the policy and, therefore, its payment of an uncovered claim could not properly exhaust the coverage and trigger Axis' obligations. The district court had accepted Axis' position and held that it was entitled to seek reimbursement of the payment from the policyholder.

The Ninth Circuit reversed, noting that there is little in the way of developed case law for a claim of "improper erosion," "improper exhaustion" or "wrongful exhaustion," as Axis' theory was variously called. Axis, which had paid its portion of the settlement of the underlying ERISA claims when called upon to do so by the primary and first layer excess insurer, contended that the settlement was not for "covered loss" and therefore its duty to indemnify had been improperly triggered. The Ninth Circuit rejected the concept that an excess insurer may "second-guess" the decision of the underlying insurers and thereby avoid

its obligations on the grounds that the policies were not properly exhausted. The policies at issue did not provide for such a contractual right to second-guess claims determinations of underlying insurers. Apart from the absence of contractual language permitting such second-guessing, the Court of Appeals noted that allowing higher layer excess insurers to challenge such decisions would undermine settled expectations concerning the manner in which claims are to be resolved. However, the court declined to rule that an excess insurer such as Axis could never have recourse to challenge payments that allegedly exhausted the underlying coverage. Relying on the decision in *Costco Wholesale Corp. v. Arrowood Indem. Co.*, 387 F.Supp.3d 1165 (W.D. Wash. 2019), the court carved out an exception to this general rule in cases where the excess insurer could establish that the settlement or payment that exhausted the underlying insurance was made in bad faith or involved fraud. The court declined to assume that any insurer was likely to pay out a claim that was not covered in order to erode limits and trigger the obligations of an excess insurer. Since Axis had not reserved a contractual right to make such a challenge to the decisions of the underlying insurer and had not specifically alleged that the underlying insurer acted fraudulently or in bad faith, for all practical purposes the Ninth Circuit rejected Axis' claim.

The *Axis* case was followed shortly thereafter by the decision in *Scottsdale Ins. Co. v. Certain Underwriters at Lloyd's*, 836 Fed.Appx. 105 (9th Cir. 2020). Scottsdale filed a declaratory judgment action against Underwriters contending that a settlement entered into by the Underwriters did not erode the limits of a professional liability policy issued to the Dickstein Shapiro law firm. The underlying claims involved a series of malpractice cases brought against the law firm. On motions for summary judgment, the district court had

concluded that Scottsdale could not challenge the settlement payment made by Underwriters and its erosion of the underlying limits.

The complicating factor here was that the settlement at issue involved not only the resolution of the underlying professional liability claims, but also the law firm's separate claims against Underwriters that they had improperly denied coverage and were therefore liable for bad faith damages. Scottsdale's primary argument was that the claim against the insurer-the London Underwriters-is not a "covered loss" under the policy issued to the law firm. The Ninth Circuit viewed this distinction as critical, since it did not involve a challenge by the excess insurer to the decision of Underwriters to settle the direct claim against the policyholder. Thus, permitting Scottsdale to challenge the ability of Underwriters to use the settlement to exhaust underlying coverage when it was also for the claims against Underwriters, did not involve the same concern regarding upsetting settled expectations of loss adjustment that was present in the *Axis* case. In particular, the court saw no reason not to permit Scottsdale to challenge how the settlement had been apportioned between the direct claim against the policyholder and the claims for bad faith asserted against Underwriters. The court therefore vacated the district court's order and remanded the matter for a determination of how the settlement should be apportioned between the two buckets of claims.

VII. CONCLUSION

As noted at the outset of this discussion, the concepts of trigger of coverage, allocation and exhaustion lie at the heart of modern disputes concerning the availability, extent and timing of coverage for disputes arising out of long-trial or progressive injury claims. While the concepts themselves are not new, how they are being applied to new and

evolving claims situations reflects that these concepts are in a continual state of evolution. For the coverage attorneys and claims professionals who must wrestle with these concepts every day, an important piece of practical advice is not to get caught up in or hung up on the labels used or how these concepts have been applied in prior claims situations. Ultimately, these concepts are inherently fact-driven and can be adapted to the particular claim being addressed. In a word, recognize that these concepts are flexible tools, not immutable rules etched in stone. Recognizing the flexibility that these concepts provide and using them in a creative way to address new categories and permutations of claims can be a winning strategy.