INSURANCE COVERAGE FOR MASS EXPOSURE TORT CLAIMS: THE DEBATE OVER THE APPROPRIATE TRIGGER RULE

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* Professor of Law, Southwestern University School of Law. In the interests of full disclosure, *see* Ronald K.L. Collins, *A Letter on Scholarly Ethics*, 45 J. LEGAL EDUC. 139 (1995), I note that I have been retained by insurance carriers in several matters relevant to the topic of this paper, including insurance coverage disputes which arose out of the Coordinated Breast Implant Litigation settlement. *See generally In re* Silicone Gel Breast Implant Prods. Liab. Litig., No. CV.92-P-10000-S, 1994 WL 114580 (N.D. Ala. Apr. 1, 1994) (granting preliminary approval to settlement agreement); *In re* Silicone Gel Breast Implant Prods. Liab. Litig., No. CV.92-P-10000-S, 1994 WL 578353 (N.D. Ala. Sept. 1, 1994) (approving $4.225 billion settlement of class of some, but not all, women who received breast implants before June 1, 1993, from one or more of the settling defendants). In connection with those retentions I have provided testimony as a designated insurance coverage expert witness on the issues discussed in this paper. Finally, I would like to thank Ellen Pryor and Charles Silver who provided consistently helpful comments for which I am deeply grateful.

"Litigation is the most expensive means of settling a dispute, short of warfare"[**]

I. INTRODUCTION

In the typical liability insurance coverage case the policyholder and the carrier can point to a specific event as the focal point to determine if a claim is covered by that carrier. For example, assume a motorist-policyholder purchased liability insurance coverage for calendar years 1990, 1991, and 1992 with carriers *A*, *B*, and *C*, respectively. If the policyholder is involved in a motor vehicle accident in 1990 and is sued in 1993 for bodily injuries and property damage sustained in the accident by the driver of the other car, we assign the claim to carrier *A* because, under the standard liability insurance policy, the carrier within whose policy period an accident happened is the carrier responsible for the claim.[1] The usual approach is to treat the accident as having happened when injury was sustained, which under the hypothetical facts was 1990.[2] We can complicate the problem a little by adding that the

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** Stephen Merrett, *quoted in* ADAM RAPHAEL, ULTIMATE RISK 145 (1994). Mr. Merrett has himself received critical retorts from the English legal system. *See* Louis A. Chiafullo, *The Malstrom at Lloyds of London: Is It Sink or Swim for Policyholders?*, 26 SETON HALL L. REV. 1392, 1398 n.21, 1400 n.25 (1996).

1. Standard general liability insurance provides coverage for bodily injury resulting from an occurrence; occurrences are in turn defined as: "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." INSURANCE SERVICES OFFICE COMMERCIAL GENERAL LIABILITY COVERAGE FORM (1982, 1984), *reprinted in* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES, app. J(1), at 1157 (Student ed. 1988). Liability insurance policies typically contain two promises by the carrier to the policyholder: (1) to defend the policyholder from suits alleging, or in some cases raising the potential of, claims within coverage; and (2) to indemnify the policyholder for liability to another. *See id.* at 1149.

> SECTION I—COVERAGES
>
> COVERAGE A. BODILY INJURY AND PROPERTY DAMAGE LIABILITY
>
> 1. Insuring Agreement.
>
> a. *We will pay* those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damages" to which this insurance applies. No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under SUPPLEMENTARY PAYMENTS—COVERAGES A AND B. This insurance applies only to "bodily injury" and "property damage" which occurs during the policy period. The "bodily injury" or "property damage" must be caused by an "occurrence." The "occurrence" must take place in the "coverage territory." *We will have the right and duty to defend* any "suit" seeking those damages.

Id. (emphasis added).

2. The overwhelming rule in the United States is that, for insurance coverage purposes, in the typical case an accident occurs not when the loss engendering act occurs but

other driver's injuries intensified in 1991 and 1992 but that does not change the result. We treat intensification of an injury as part of the initial injury.[3] Carrier *A* is the insuring entity whose policy will be called on to respond to the claim. In the vernacular that has developed in this area, we say that carrier *A*'s policy has been *triggered*. Unless *A* can invoke a policy defense, *A* will have to defend and indemnify the policyholder for all losses, up to policy limits, resulting from the 1990 accident.

Increasingly, however, the legal system is encountering situations where the fit between "claim" and "policy period" is not so neat. Mass exposure tort claims[4] involving progressive losses with long latency periods, such as asbestos,[5] diethylstilbestrol (DES),[6] environmental contamination.[7] and

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when the injury or harm *results* from that loss engendering act. *See, e.g.*, Highlands Ins. Co. v. Schrillo Co., 226 Cal. Rptr. 717, 720-21 (Ct. App. 1986). In the typical case the loss engendering act (*i.e.*, negligent operation of the motor vehicle) and resulting harm or injury (*i.e.*, collision or impact producing bodily injury or property damage) is practically instantaneous. Even when the time period between the act and resulting injury is long, difficulties are usually not encountered. For example, a defectively manufactured automobile may cause bodily injury or property damage years after manufacture; yet, the loss would still be identifiable and assigned to the policy period in which the loss occurred. It is when harm or injury is difficult to define because the injury is insidious, slow, and difficult to detect or diagnose that consensus breaks down over which carrier should respond to the claim.

3. This is known in other contexts as the "process of nature" rule. *See* National Life & Accident Ins. Co. v. Edwards, 174 Cal. Rptr. 31, 34 (Ct. App. 1981) (involving an accident and disability policy). Thus, if rabies developed from a dog bite or gangrene from a wound, the injury and its complications would be deemed to have occurred, for insurance coverage purposes, at the same time the bite or the wound was inflicted on the claimant. In such case, the carrier would be responsible, up to policy limits, for the full claim, including the aggravated injuries. *See infra* note 150 and accompanying text.

4. *See* Richard A. Nagareda, *Turning From Tort to Administration*, 94 MICH. L. REV. 899, 905-06 (1996) (noting that mass exposure torts consist of two necessary elements: they (1) "involve large numbers of persons who claim to suffer injuries that come in recurring patterns"; and (2) "entail a latency period . . . between exposure to the harmful product and the onset of physical impairment"). This category has received increased scholarly attention. *See generally* Symposium, *Mass Torts: Serving Up Just Desserts*, 80 CORNELL L. REV. 811 (1995); Francis E. McGovern, *An Analysis of Mass Torts for Judges*, 73 TEX. L. REV. 1821 (1995); Deborah R. Hensler & Mark A. Peterson, *Understanding Mass Personal Injury Litigation: A Socio-Legal Analysis*, 59 BROOK. L. REV. 961 (1993). This new category has even inspired a new casebook. *See* LINDA S. MULLENIX, MASS TORT LITIGATION (1996).

5. *See* Flintkote Co. v. American Mut. Liab. Ins., No. 808-594 (San Francisco Super. Ct., Oct. 14, 1992), *reported in* 6 MEALEY'S LITIGATION REPORTS—INSURANCE 48, at B-1 (Oct. 27, 1992). The court described the development of one form of asbestos-related disease (asbestosis) as follows:

> The fibrous tissue is initially deposited as hundreds of millions of microscopic spots which cannot be detected by x-rays until late in the disease process, when the scars combine to produce large opacities. There are no symptoms until about 20 percent of the lung is affected. Many years may pass between the exposure to asbestos fibers and the time scarring

product liability,[8] present situations where because of the passage of time there may be multiple policy periods and scores of carriers whose insurance policies overlay a portion of the latency period.[9] Determining which

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> becomes evident on x-ray. This apparently symptom-free span of time is known as the latency period.

Id. at B-20.

6. *See* Aetna Cas. & Sur. Co. v. Abbott Lab., Inc., 636 F. Supp. 546 (D. Conn. 1986). In *Abbott Laboratories*, the court described DES as:

> [A] synthetic hormone that was widely prescribed from the 1940s until 1971 for the prevention of miscarriages . . . . DES has been associated with a rare form of vaginal cancer called "clear cell carcinoma" and a benign vaginal condition called "adenosis" among women who were exposed to the drug *in utero*. It has also been suggested that exposure to DES may produce an increased incidence of breast and gynecological cancer among women who ingested the drug during pregnancy as well as an increased incidence of infertility and genital abnormalities among the sons and daughters of these women.

Id. at 547 n.1; *see also* Eli Lilly & Co. v. Home Ins. Co., 794 F.2d 710, 712-13 (D.C. Cir. 1986) (describing a connection reported in 1970 between ingestion of DES and development of cancer).

7. *See, e.g.*, Fairview Hosp. & Health Care Servs. v. St. Paul Fire & Marine Ins. Co., 535 N.W.2d 337, 338-39 (Minn. 1995). Volatile organic compounds (VOCs) disposed of in landfills between 1968 and 1972 were found in groundwater samples in 1982. In 1991, the policyholder was notified by the EPA that it was potentially responsible for clean-up costs at the landfill. *See also* Auto Owners Ins. Co. v. City of Clare, 521 N.W.2d 480, 482 (Mich. 1994) (describing leachate from landfill which contaminated ground water).

8. In *Endo Laboratories, Inc. v. Hartford Insurance Group*, 747 F.2d 1264 (9th Cir. 1984), the claims arose out of the prenatal anticoagulant Coumadin which caused damage to the fetus within the first trimester of the pregnancy; the injury was not, however, discoverable until birth. *Id.* at 1266. In *Sandoz, Inc. v. Employer's Liability Assurance Corp.*, 554 F. Supp. 257 (D.N.J. 1983), the claims arose out of the ingestion of (1) the drug "Mellaril" which resulted in the condition known as "tardive dyskinesia" and (2) the drug "Sansert" which resulted in the claimant becoming seriously ill and being diagnosed with a "granuloma of the left lower lobe of lung" and "fibrous plakue of diaphragm" (*e.g.*, fibrous growths in the lungs), which had to be surgically removed. *Id.* at 259-60. In both cases the drugs were ingested several years before the injuries were diagnosed. Endo Labs., Inc. v. Hartford Ins. Group, 747 F.2d at 1266; Sandoz, Inc. v. Employer's Liab. Assurance Corp., 554 F. Supp. at 259-60.

9. *See* Jerold Oshinsky et al., *Procedural and Practical Issues in Insurance Coverage Disputes Stemming from Mass Tort Claims*, at 83-84 (PLI Litig. & Admin. Practice Course Handbook Series No. H4-5211, 1995) (noting increasing complexity of mass tort coverage litigation, and giving the examples of *Waste Management, Inc., v. Admiral Insurance Co.*, 649 A.2d 379, 384 (N.J. Super. Ct. Law Div. 1994) (bringing suit against 150 carrier defendants) and *Champion International Group v. Aetna Casualty & Surety Co.*, No. 90-2-09616-5 (Wash. Super. Ct. 1991) (bringing suit involving 62 carrier defendants)). In *Dow Corning Corp. v. Hartford Accident & Insurance Co.*, 93-325788 (Michigan, Wayne County Circuit Court), the policyholder sought declaratory relief and damages in an action that involved nearly 100 separate carriers and more than 1000 different insurance policies that spanned approximately 20 years.

insurance policies are triggered by which claims and how and in what order covered losses will be allocated among the triggered policies has come to dominate liability insurance coverage litigation involving mass exposure torts in recent years.[10]

The practical consequences of adopting a particular trigger test should not be underestimated. Assume a products liability mass exposure tort, such as the breast implant controversy. Breast implants were marketed between 1964 and 1992. Many women who received breast implants subsequently sued the manufacturers for a variety of injuries, such as a contracture,[11] rupture,[12] and autoimmune diseases.[13] Let us assume a woman received breast implants in 1972 and in 1983 had the original implants replaced with new implants because she had begun to experience pain in her breast area in 1980. The pain was probably due to contracture. During the surgery the physician discovered one of the implants had ruptured. The physician cleaned the site, removed the old implants, and replaced them with new implants. In 1985 the woman sued the manufacturer who was continuously insured from 1964 through 1985 with a different carrier each year. Which carrier should respond to the claim?:

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10. Most commentary on the topic of payment has been in continuing legal education materials, where the focus has been on insurance coverage. *See* Sheila L. Birnbaum, *Trigger of Coverage in the Toxic Tort Context* (PLI Litig. & Admin. Practice Course Handbook Series No. H4-5173, 1993); John G. Buchanan, III, et al., *The Trigger of Coverage Under CGL Policies* (PLI Litig. & Admin. Practice Course Handbook Series No. H4-5173, 1993); Robert D. Fram, *End Game: Trigger of Coverage in the Third Decade of CGL Latent Injury Litigation* (PLI Litig. & Admin. Practice Course Handbook Series No. H4-5148, 1993); Douglas L. Hallett & Lawrence C. Berney, *Trigger of Coverage: A Posnerian Analysis* (PLI Litig. & Admin. Practice Course Handbook Series No. H4-5148, 1993); G. Marshall Moriarty, *Trigger of Coverage in Occurrence Policies* (PLI Com. L. & Practice Course Handbook Series No. A4-4143, 1986); James D. Otto, *Trigger-of-Coverage for Latent Injuries and Diseases: What Is It Going to Be?* (PLI Com. L. & Practice Course Handbook Series No. A4-4186, 1987). There have been a number of law student articles and a few articles written by law professors, but most of the writing on this topic has been by practicing lawyers and judges through published opinions.

11. Contracture refers to the development of fibrocystic tissue around the implant and the tendency in some cases for this tissue to contract and cause pain.

12. Rupture refers to the tendency of the implant to break. Many implants involved a soft silicone gel encased in a silicone elastomer shell. Trauma, thinness in the shell, contracture, etc., could cause the shell to break (rupture), permitting the gel to escape to the surrounding tissue.

13. Autoimmune diseases involve the breakdown of the human body's normal ability to distinguish between self and non-self.

1. The carrier at the time of implant;[14]
2. The carrier at the time of diagnosis;[15]
3. The carrier at the time when injury in fact occurred;[16]
4. The carrier at the time when injury is fixed as a matter of law;[17] or
5. The carrier at the time when the claim is made.[18]

Courts have developed three general approaches to determine when a policy has been triggered: (1) the exposure test; (2) the injury-in-fact test; and (3) the manifestation test. The exposure test aligns with the liability engendering acts, here implantation. The injury-in-fact test aligns with resulting injury, here contracture and perhaps rupture and the resulting release of silicone gel into the body. The manifestation test aligns with diagnosis or observance of symptoms and the resulting claim, here a diagnosis, the presence of symptoms of contracture, or the discovery of implant rupture.

Based on the coverage profile of the policyholder, both the carrier and the policyholder may argue for trigger tests that minimize or maximize available coverage. For example, policyholders with more coverage in the liability engendering years would prefer the exposure test, whereas policyholders with more coverage in the diagnosis, symptoms, or claims years would prefer the manifestation test. Carriers would have contrary strategic considerations. When policyholders have extensive coverage programs across

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14. *Cf.* Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 451 F. Supp. 1230 (E.D. Mich. 1978), *aff'd*, 633 F.2d 1212 (6th Cir. 1980) (holding that carriers providing coverage when claimant ingested asbestos must respond), *clarified*, 657 F.2d 814 (6th Cir. 1981). *See generally* Martin J. McMahon, Annotation, *Event Triggering Liability Insurance Coverage as Occurring Within Period of Time Covered by Liability Insurance Policy Where Injury or Damage Is Delayed—Modern Cases*, 14 A.L.R.5th 695 (1993).

15. *Cf.* Eagle-Picher Indus. v. Liberty Mut. Ins. Co., 682 F.2d 12, 25 (1st Cir. 1982) (finding that insurers providing coverage when asbestos-related disease manifested, *i.e.*, was discovered, must respond to claim). *See generally* McMahon, *supra* note 14, at 725-27.

16. *Cf.* American Home Prods. Corp. v. Liberty Mut. Ins. Co., 565 F. Supp. 1485 (S.D.N.Y. 1983) (finding that insurers providing coverage when certain pharmaceutical products, such as Ovral, Llovral, DES, Mysoline, Atromid-S, Premarin, and Anacin, caused injury *in fact* must respond to claims), *aff'd as modified*, 748 F.2d 760 (2d Cir. 1984). *See generally* McMahon, *supra* note 14, at 729-31 (providing a list of cases supporting the view that liability coverage is triggered when injury occurs).

17. *Cf.* Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981). "Regardless of whether exposure to asbestos causes an immediate and discrete injury, the fact that it is part of an injurious process is enough for it to constitute 'injury' under the policies." *Id.* at 1046. Earlier the court had found medical evidence on the pathogenesis of asbestos-related diseases to be irrelevant. *Id.* at 1038.

18. In 1986, the Insurance Service Office (ISO) offered a claims-made policy as an alternative to an occurrence policy. A claims-made policy provides coverage for claims made against the policyholder during the policy period, subject to the terms, conditions, and exclusions of the policy. *See infra* notes 25-46 and accompanying text (discussing differences between occurrence and claims-made coverages).

event, injury, and claim periods, they would prefer a continuous or multiple trigger which accesses more of the potentially available coverage. Carriers on the same facts may prefer a single trigger which confines coverage to one policy period. The possible application of loss sharing doctrines, however, may encourage some carriers, particularly the carrier whose policy is triggered under a single trigger approach, to argue for a continuous or multiple trigger when doing so would reduce their aggregate exposure.

This Article analyzes the various tests that courts have developed to determine when an insurance policy is triggered. Because the trigger issue cannot be evaluated in isolation, this Article also examines the larger context of legal issues within which the trigger decision is made. This approach will assist the reader in comprehending why mass exposure torts have had such an impact on established coverage doctrine, a doctrine that was originally articulated in the tradition of individualized claims. The primary conclusion of this Article is that courts in developing insurance trigger rules for mass exposure torts have placed too much emphasis on the desire to provide compensation for claimants[19] and given too little attention to the basic structure of the insurance contract in attempting to resolve the trigger issue.

II. TRIGGERING LIABILITY INSURANCE COVERAGE

The term "trigger" does not appear in policy language.[20] "Trigger of coverage" refers to the legal test used to determine which policy should be looked at to ascertain if that policy has coverage obligations regarding the claims asserted against the policyholder. As so conceptualized, the trigger concept is not designed to determine coverage; rather, it acts as a gatekeeper, matching particular claims with particular periods of time and hence particular insurance policies. The method by which the general liability insurance policy[21] is triggered, for example, "accident," "occurrence," or

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19. *See* JACK B. WEINSTEIN, INDIVIDUAL JUSTICE IN MASS TORT LITIGATION: THE EFFECT OF CLASS ACTIONS, CONSOLIDATIONS AND OTHER MULTIPARTY DEVICES 4 (1995) (stating that "[n]onlitigation settlements giving effective help to those who *think* they have been injured, without destroying those *believed* to be at fault, are the wave of the future") (emphasis added).

20. *See* Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 979 (N.J. 1994) ("The policies do not refer to a 'trigger'; 'the term 'trigger' is merely a label for the event or events that under the terms of the insurance policy determines whether a policy must respond to a claim in a given set of circumstances.'") (citations omitted).

21. Trigger issues also arise in first party property insurance contexts. Although the issues to some extent overlap, the focus here is on liability insurance policies. In *Montrose Chemical Corp. v. Admiral Insurance Co.*, 913 P.2d 878, 886-87 (Cal. 1995), the California Supreme Court identified reasons for distinguishing between first party and third party coverage insofar as identification of an appropriate trigger is concerned: (1) first party coverage is for loss or damage sustained directly by the policyholder; third party coverage is for liability of the policyholder to a third person; (2) first party coverage protects against loss caused by fortuitous, active, physical forces; in third party coverage contexts the right to coverage draws on traditional tort concepts of fault, proximate cause, and duty; (3) first party coverage is purchased in an amount sufficient to cover the value of the property insured; the

"claims-made," defines the type of policy that is being addressed.[22] Nevertheless, a legal rule identifying which insurance policies may be required to respond to particular claims will influence the eventual resolution of those claims.[23] For example, mass exposure tort cases have been marked by strenuous judicial efforts to settle rather than litigate the claims. In these cases, insurance is frequently perceived as a judicial carrot which a court may use to encourage settlements because to the extent insurance is available the burdens of settlement will be borne by the carriers not the policyholder.[24] Trigger rules may act to confine or spread that burden.

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amount of third party coverage is based on an educated guess by the policyholder as to his potential exposure; (4) third party coverages do not impose as a condition of coverage a requirement that the injury be discovered at any particular point in time; (5) first party coverages may require the policyholder to bring any action against the carrier within 12 months after "inception of the loss"; third party coverages do not include such a provision. *Id.* The court did not explain why these identified differences warranted a different "trigger" analysis for third party coverages from that provided in first party coverage cases.

22. Occasionally, liability insurance is written as "event" insurance. *See In re* Midlands Ins. Co., 623 N.Y.S.2d 689 (Sup. Ct. 1994).

> No reading of the AHAC policy language can lead to the conclusion that coverage is to be triggered by "bodily injury during the policy period" as in the numerous CGL policy cases cited by LAQ. The AHAC policy requires the "happening" of "an occurrence" during the policy period. The "thing that is to happen" during the policy period is, "an event . . . ." Thus, according to the policy's plain meaning, it is the event . . . which must occur during the policy period.

Id. at 693. *Cf.* Insurance Co. of N. Am. v. Sam Harris Const. Co., 583 P.2d 1335, 1337 (Cal. 1978) (holding that when liability policy covered either "occurrence" or "accidents" and defined neither, the court would interpret "occurrence" as including liability engendering events for which a reasonable policyholder would harbor an expectation of coverage). *See generally* David M. Brenner, *The Trigger of Coverage Under the London Marine Definition of Occurrence: Is It the Event, the Happening or the Injury?*, 8 MEALEY'S LITIGATION REPORTS—INSURANCE 12 (Jan. 18, 1994) (criticizing decisions that treat the trigger of coverage as the liability engendering event rather than the resulting injuries). "Event" insurance can raise trigger problems similar to those raised by "occurrence" policies because more than one event may contribute to a loss and those "events" may be spread out over multiple policy periods. What "trigger" should be used for "event" insurance in a mass exposure tort is, however, beyond the scope of this paper.

23. *See* WEINSTEIN, *supra* note 19, at 4-5.

24. For example, in the breast implant product liability litigation, Judge Pointer remarked on several occasions that he wished the settling manufacturers' carriers would participate in the settlement process. Judge Pointer voiced concerns that absent active participation by the carriers, the manufacturers would lack adequate financial resources to fund the settlement. The settlement ultimately was underfunded and collapsed, albeit for reasons that appear to be related to oversubscription by claimants rather than nonfunding by carriers. *See Judge Pointer Orders Second Opt-Out for Implant Plaintiffs*, 3 MEALEY'S LITIGATION REPORT—BREAST IMPLANTS 4 (Oct. 12, 1995) (permitting second plaintiff to opt out of a previously approved settlement due to upward ratching of amounts payable to current claimants and bankruptcy of the primary implant manufacturer Dow Corning); *Settlement Offer Rejected*

A. *Occurrence Versus Claims-Made Policies*

Prior to 1966, general liability insurance in the United States had an "accident" trigger. This trigger required that an accident occur within the carrier's policy period. Most courts deemed the accident to occur when the claimant suffered an actual loss as a consequence of the policyholder's action or inaction when there was a duty to act.[25] Most courts also required that the accident be a sudden event,[26] in other words slow, incremental, progressive losses would not be covered unless the policyholder purchased an endorsement that provided coverage if there was an exposure to injurious events during the policy period. In a few cases, courts broke the line and held that slow, incremental, progressive losses were "accidents" for coverage purposes.[27]

In 1966 the standard general liability insurance policy was revised and it became identified as an "occurrence" policy. The concept of "accident" was not abandoned but it was incorporated as a part of the definition of an "occurrence."[28] Thus, under the standardized language of the liability

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By Plaintiffs Negotiating Team, 3 MEALEY'S LITIGATION REPORTS—BREAST IMPLANTS 7 (Sept. 28, 1995) (noting that a revised settlement could not be reached between the parties).

25. *See* Diamond Shamrock Chems. v. Aetna Cas. & Sur. Co., 609 A.2d 440, 455-56 (N.J. Super. Ct. App. Div. 1992) (collecting decisions); *see also* J.P. Ludington, Annotation, *Liability Insurance: "Accident" or "Accidental" as Including Loss Resulting from Ordinary Negligence of Insured or His Agent*, 7 A.L.R.3d 1262 (1966).

26. *See, e.g.*, Casper v. American Guarantee & Liab. Ins. Co., 184 A.2d 247, 249 (Pa. 1962) (quoting Schnoll & Sons, Inc. v. Standard Accident Ins. Co., 154 A.2d 431, 432 (Pa. Super. Ct. 1959)):

> The word "accident" is not defined in the policy, and the term must therefore be interpreted in its usual, ordinary and popular sense. Webster has defined it as "an event that takes place without one's foresight or expectation; an undesigned, sudden, and unexpected event; chance; contingency." Many courts have quoted this definition and some have added to or embellished it, but in reality few have improved upon it.

27. For example, in *Beryllium Corp. v. American Mutual Liability Insurance Co.*, 223 F.2d 71, 73-76 (3d Cir. 1955), the court found that coverage existed for death caused by beryllium poisoning. Minute particles of beryllium attached to the clothing of the policyholder's employees and subsequently over time detached and entered the lungs of the claimants, which created a condition that was ultimately fatal to them. *Id.* at 73. The carrier denied coverage, arguing that the policy contemplated that the accidental means must be an isolated occurrence rather than a series of causes. *Id.* The court found that the policy language "caused by accident" was ambiguous in the context of a slow, progressive injury such as presented and construed the ambiguity against the carrier to find coverage. *Id.* at 76; *see* Singsaas v. Diederich, 238 N.W.2d 878, 880-81 (Minn. 1976) (collecting pre-1966 decisions involving progressive losses).

28. In 1973 the language was revised to provide:

> a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. . . .

insurance policy, coverage would be provided for "occurrences" resulting in bodily injury or property damage within the policy period. An "occurrence" was in turn defined as an "accident, including injurious exposure to conditions, neither expected nor intended from the standpoint of the insured."[29] In the general case the change was insignificant.[30] The change was significant, however, in the slow onset, progressive loss cases which would become more significant in the near future as mass exposure tort claims. The problem was that while the issue of coverage for progressive, multi-policy period losses was discussed by some of the drafters of the new occurrence language, no specific language was developed and incorporated into the new policy to deal expressly with the trigger question posed by mass exposure tort claims.

> b. This insurance applies to "bodily injury" and "property damage" only if:
>
> (1) The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory"; and
>
> (2) The "bodily injury" or "property damages" occurs during the policy period.

Insurance Services Office, Inc., Commercial General Liability Coverage Form CG 00 01 10 93, *reprinted in* 1 S. MILLER & P. LEFEBVRE, MILLER'S STANDARD INSURANCE POLICIES ANNOTATED 409 (1992). Occurrence is defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." *Id.* at 419. As to this portion of the 1973 revision, it is generally understood that the changes simply clarified rather than altered the scope of coverage provided under the 1966 forms. *See* George H. Tinker, *Comprehensive General Liability Insurance—Perspective and Overview*, 25 FED'N INS. COUNS. Q. 217, 224-25, 227, 231, 232-34, 254-60 (1975).

29. *See* John Tarpey, *The New Comprehensive Policy: Some of the Changes*, 33 INS. COUNS. J. 223, 223 (1966).

> One of the principal changes in the policy is the transition from an "accident" basis of coverage to an "occurrence" basis of coverage. Thus, in the comprehensive general liability policy the Insuring Clause reads:
>
> > The Company will pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies caused by an occurrence . . . .
> >
> > "Occurrence" is defined to mean:
> >
> > . . . an accident, including injurious exposure to conditions, which results during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the Insured.

Id.

30. Although much of the current emphasis has been directed toward the trigger issue as it relates to the concept of an "occurrence," the 1966 revision addressed a number of issues, each in its own way a significant development insofar as coverage was concerned. *See* Tarpey, *supra* note 29 (discussing changes accomplished by the 1966 revision); Willard J. Obrist, *New Comprehensive General Liability Insurance Policy*, DEFENSE RESEARCH INSTITUTE—MONOGRAPH (1966).

The failure of policy language specifically to define the appropriate trigger for slow onset, progressive injury claims has led to assertions that the "occurrence" definition is ambiguous, at least in the mass exposure tort context. Proponents of this position often rely on fragments of the drafting history which support their position. Opponents of the ambiguity position argue that the drafters did not intend to create a separate trigger test for progressive losses and they in turn rely on their own fragments of drafting history to support their position.[31] It is generally agreed that the 1966 change operated to delete the "suddenness" element from the "occurrence" requirement.[32] Beyond that there is disagreement—a disagreement that is

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31. The drafting history surrounding the development of the 1966 Occurrence policy has been extensively recounted. The trial judge in the *In re Asbestos Insurance Coverage Litigation*, *see infra* note 58, held extensive hearings that included testimony from many of the individuals who participated in the drafting of the 1966 Occurrence policy form. The judge ultimately concluded that the evidence of drafting history was not dispositive on the issue of policy meaning. *Id.* at 38. For a comprehensive survey of the competing positions and the drafting data, see Ronald R. Robinson, *The Best of Intentions: Drafting the 1966 Occurrence, and the 1973 Pollution Exclusion Policy Language* (PLI Com. L. & Practice Course Handbook Series No. A4-4450, 1994); *see also* THE DRAFTING HISTORY DEBATE: COMMENTARIES 1986-1994 (Mealey's Publications 1995) (containing reprints of papers published in *Mealey's Litigation Report—Insurance*, which support and oppose the use of drafting history as an interpretative aid). Courts have accepted and rejected the use of drafting history as an interpretative guide to resolving trigger questions under the 1966 Occurrence liability policy. *Compare* American Home Prod. v. Liberty Mut. Ins. Co., 565 F. Supp. 1485, 1500-03 (S.D.N.Y. 1983), *aff'd as modified*, 748 F.2d 760 (2d Cir. 1984) (relying on drafting history as an aid to interpreting standard form language in CGL policy) *and* Fireguard Sprinkler Sys., Inc. v. Scottsdale Ins. Co., 864 F.2d 648, 653 (9th Cir. 1988) (stating that drafting history is a helpful tool for ascertaining the meaning of language in CGL policies) *and* Just v. Land Reclamation, Ltd., 456 N.W.2d 570 (Wis. 1990) (same) *with* ACL Technologies, Inc. v. Northbrook Prop. & Cas. Ins. Co., 22 Cal. Rptr. 2d 206, 217 (Ct. App. 1993) (resorting to drafting history was inconsistent with the goal of interpreting contract the way a layperson would). *See generally* John Randolph Prince, III, *Where No Minds Meet: Insurance Policy Interpretation and the Use of Drafting History*, 18 VT. L. REV. 409 (1994). Drafting history has found a more receptive judicial audience when the issue involves the standard pollution exclusion in general liability policies. *See* Just v. Land Reclamation, Ltd., 456 N.W.2d at 573-75 (relying on drafting history to interpret the term "sudden" in 1973 pollution exclusion form); United States Fidelity & Guar. Co. v. Specialty Coatings Co., 535 N.E.2d 1071, 1077-78 (Ill. App. Ct. 1989); Kipin Indus., Inc. v. American Universal Ins. Co., 535 N.E.2d 334, 338 (Ohio Ct. App. 1988) (same).

32. This is accomplished by providing that an accident included "exposure to injurious conditions." *See* Obrist, *supra* note 30, at 6. Some commentators and courts read this language as separately and independently satisfying the "occurrence" requirement, thus creating an "exposure" trigger. *See, e.g.*, Shell Oil Co. v. Winterthur Swiss Ins. Co., 15 Cal. Rptr. 2d 815, 837 (Ct. App. 1993). In a twist of irony, many modern courts now find that the term "sudden" can mean "accidental" in the context whether numerous pollution discharges over a period of time were "sudden *and* accidental" within the meaning of the qualified pollution

central to the dispute over the appropriate trigger for mass exposure tort claims.

In the 1970s several lines of insurance, particularly the professional malpractice lines, began to offer a new form of coverage—the "claims-made" policy.[33] Under the claims-made policy, the critical event was the making of a claim[34] against the policyholder within the policy period.[35] This changeover in policy form did not by itself alter the scope of coverage, but it did redefine when coverage attached: the event that triggered coverage shifted from a focus on the claimant's actual realization of a loss resulting from policyholder delict to the claimant's presentation of a claim to the policyholder demanding payment for a loss.[36] Under an occurrence policy, the insured risk covered bodily injury or covered property damage *happening* within the policy period. Under a claims-made policy, the insured risk was a covered claim *being asserted* against the policyholder during the policy period. Whether the injury, damage, or claim is actually covered is a separate issue to be resolved by examining the terms of the insurance contract.

In the mid 1980s there was an effort to transform all general liability insurance coverage to claims-made, but it was not completely successful.[37]

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exclusion adopted in 1973. *See* Quaker State Minit-Lube, Inc. v. Fireman's Fund Ins. Co., 52 F.3d 1522, 1527-29 (10th Cir. 1995) (collecting decisions).

33. The change over took time and was initially met with some judicial resistance. *See, e.g.*, Gyler v. Mission Ins. Co., 514 P.2d 1219 (Cal. 1973) (insuring against "claims which may be made" during the policy was ambiguous as to whether it was intended to provide "occurrence" or "claims-made" coverage). That initial resistance has evaporated. *See* Zuckerman v. National Union Fire Ins. Co., 495 A.2d 395, 400 (N.J. 1985); *see also* BARRY OSTRAGER & THOMAS NEWMAN, HANDBOOK OF INSURANCE COVERAGE DISPUTES, § 4.02(b)[4] (7th ed. 1994).

34. The term "claim" is not defined in the ISO versions of professional malpractice insurance. Judicial decisions have coalesced around the principle that a "claim" involves a "demand." *See* Williamson & Vollmer Eng'g, Inc. v. Sequoia Ins. Co., 134 Cal. Rptr. 427, 431 (Ct. App. 1976) (holding that a "claim" is an express demand for money, services, or relief). Mere expressions of concern, unhappiness, disappointment and the like, even if likely to lead to a claim, do not satisfy the "claims-made" requirement. *See* Doctors' Co. v. Insurance Corp. of Am., 864 P.2d 1018, 1025 (Wyo. 1993); Abifadel v. Cigna Ins. Co., 9 Cal. Rptr. 2d 910, 920 (Ct. App. 1992).

35. *See, e.g.*, Hasbrouck v. St. Paul Fire & Marine Ins. Co., 511 N.W.2d 364, 368-69 (Iowa 1993).

36. *See* United States v. A.C. Strip, 868 F.2d 181, 184 (6th Cir. 1989) ("A claims made policy provides coverage for claims brought against the insured only during the life of the policy. An occurrence policy provides coverage for acts done during the policy period regardless of when the claim is brought.").

37. This effort is discussed in *In re Insurance Antitrust Litigation*, 723 F. Supp. 464, 467-70 (N.D. Cal. 1989), in which the carriers' efforts to use claims-made coverage for general liability insurance policies were challenged by various states' Attorneys General on antitrust grounds. The District Court granted summary judgment for the carriers, finding their conduct immune from antitrust scrutiny under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015

The spur for this change was the desire to be able to predict more easily and more accurately underwriting losses that a particular risk pool presents.[38] Under an accident or occurrence policy, a policy period may be triggered, but when mass exposure tort losses are involved the carrier is unable to gauge with reasonable accuracy, until the claims are presented, the actual loss for the policy period. Moreover, because of this latency factor, claims may be made long after the policy period ended. This is commonly referred to as "long tail" coverage.[39]

Policyholders may find that their ability to elect between occurrence or claims-made coverage is limited by the type of coverage each form provides. Once a policyholder adopts claims-made coverage it may be prohibitively expensive to change to occurrence coverage. The cost of conversion may be significant when the policyholder has a major insurance program with layers of excess coverage. The new occurrence policy will not pick up "incurred but not reported claims" which reflect injuries that predate the policy period.[40] The expired claims-made coverage will not cover claims that were not made (or reported) prior to the expiration of the policy.[41] Thus, a gap in

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(West 1976). *In re* Insurance Antitrust Litig., 723 F. Supp. at 491, *rev'd*, 938 F.2d 919 (9th Cir. 1991), *aff'd in part, rev'd in part sub nom.* Hartford Fire Ins. Co. v. California, 113 S. Ct. 2891 (1993). On remand, the case settled. *See Parties to Insurance Antitrust Case Outline Settlement in Principle*, 8 MEALEY'S LITIGATION REPORTS—INSURANCE 7 (Oct. 25, 1994). The industry's desire to implement claims-made coverage in the liability lines predated the 1986 revision. *See* Sol Kroll, *"Claims Made"—Industry's Alternative: "Pay As You Go" Products Liability Insurance*, 1976 INS. L.J. 63.

38. The underwriting differences between occurrence and claims-made policies are noted in *National Union Fire Insurance Co. v. Baker & McKenzie*, 997 F.2d 305, 306 (7th Cir. 1993). *See also* JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS § 10.6 (1994) (discussing reasons carriers attempted changeover to claims-made policies in the mid 1980s). *See generally* Carolyn Frame, Comment, *Claims-Made Liability Coverage: Closing the Gaps with Retroactive Coverage*, 60 TEMPLE L.Q. 165 (1987); Gerald Kroll, Note, *The "Claims-Made" Dilemma in Professional Liability Insurance*, 22 UCLA L. REV. 925, 925-31 (1975).

39. *See, e.g.*, Garmendi v. Mission Ins. Co., 19 Cal. Rptr. 2d 190, 195 (Ct. App. 1993); Zuckerman v. National Union Fire Ins. Co., 495 A.2d 395, 399 (N.J. 1985).

40. An interesting application of this principle was addressed in *A.C. Label Co. v. Transamerica Ins. Co.*, 56 Cal. Rptr. 2d 207 (Ct. App. 1996). In 1984, the A.C. Label Company purchased a parcel of real property. *Id.* at 208. In 1987, a cleanup and abatement action was brought in connection with that property against A.C. Label for groundwater contamination that allegedly began in 1967. *Id.* From May 1981 to May 1982, A.C. Label had been insured under a CGL policy issued by the Transamerica Insurance Company. *Id.* The court held that Transamerica did not owe coverage obligations to A.C. Label regarding the claim because a CGL occurrence policy covers only the liability of the policyholder during the policy period and, under the facts of the case, A.C. Label had no liability for environmental contamination *during the policy period. Id.* at 210.

41. *See* Lexington Ins. Co. v. St. Louis Univ., 88 F.3d 632, 634-35 (8th Cir. 1996) (holding that the policyholder's failure to report the claim before the policy expired defeated its contention that the claim was covered under its claims-made policy); United States v. A.C. Strip, 868 F.2d 181, 184 (6th Cir. 1989) (stating that the very essence of a claims-made policy

coverage exists that must be provided for either through the purchase of claims-made tail coverage, a nontraditional insurer, such as a captive where the policyholder owner has greater control over policy language,[42] or absorbed by the policyholder as an uninsured risk. Each alternative represents an additional cost to the purchase of the new occurrence policy.

Under a claims-made policy, the carrier's actual loss exposure is more closely tied to its current, incurred risk exposure. In other words, the carrier can identify its projected losses for a particular policy period by looking at the claims made during the policy period knowing that those claims largely represent the actual universe of its exposure. Under a claims-made policy, loss experience is more closely aligned with each succeeding policy period. As claims increase (or decrease) that trend may be projected into the next immediate policy period for which a premium may be calculated. Premiums, thus, can be more accurately calculated so as to cover actual loss exposure. In progressive loss cases, claims-made underwriting permits the carrier (and the policyholder) to trend actual loss experience in order to calculate expected losses with a greater degree of confidence because the underwriting is based on the better empirical base of immediate, actual claims experience. Each succeeding policy period builds on the experience of just closed policy periods. An accident or occurrence policy does not present the same luxury.

This is not to suggest that occurrence underwriting does not rely on claims experience for that is surely not the case. The problem is that "occurrence claim experience" is not as accurate a predictor of future underwriting experience as "claims-made experience" because the former but not the latter suffers from temporal distortion occasioned by delay between policy trigger (occurrence) and notice to the carrier that a claim has been made. A problem may fester for many years before the carrier may realize that the problem may affect underwriting assumptions that went into premium calculation. Under the occurrence model, the policies affected have already been written and the premiums collected. The risk now resides with the carrier. Under the claims made model, premium rates may be adjusted as new policies, which will respond to future claims, are issued.

The temporal distortion issue here is significant. Mass exposure tort claims made in the 1980s have been held to trigger policies issued in the 1940s, 1950s, 1960s, and 1970s.[43] Under an accident or occurrence policy

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is that the claim be brought against the policyholder during the policy period). The difference between the two cases is the result of the requirement of many claims-made policies that the claim also be *reported* to the carrier within the policy period.

42. *See* James A. Christopherson, *The Captive Medical Malpractice Insurance Company Alternative*, 5 ANNALS HEALTH L. 121, 121 (1996) (stating that "[t]he relationship between an insured and its captive is distinguished by the high degree of control the insured can exercise over its insurer. As the captive's owner, the insured can be directly involved in major decisions made by the captive regarding underwriting . . . claims management.").

43. *See* Boyce Thompson Inst. for Plant Research, Inc. v. Insurance Co. of N. Am., 751 F. Supp. 1137, 1138-39 (S.D.N.Y. 1990) (involving a policyholder who sought defense and payment in 1988 from its carrier on a risk from 1924-1969); Star Steel Supply Co. v. United States Fidelity & Guar. Co., 465 N.W.2d 17, 18-19 (Mich. Ct. App. 1990) (involving a

the risk of miscalculating the actual loss is much greater for mass exposure tort claims than under a claims-made policy because the policy periods remain open and, therefore, loss experience cannot be determined as immediately and as accurately.

Under a claims-made policy the carrier is better able to price next year's risk based on the quantification of this year's losses and the ability to match liability exposure with current and developing tort law.[44] An accident or occurrence writing carrier has already collected its premium for a loss which may not be asserted, much less fixed, until many years in the future. The claims-made carrier can fine-tune premiums to reflect current exposure and can exit markets when loss exposures become too great. Of course, each of these advantages for carriers may be perceived as disadvantages to policyholders who appear to prefer occurrence coverage over claims-made coverage.[45]

Some policyholders, because of their risk profile, can obtain coverage only on a claims-made basis. Generally, the more closely identified a risk has become with latency problems, such as delays between actual injury and presentation of the claim, the more likely it is that coverage will only be offered on a claims-made basis. For example, due to an exclusion for environmental damage added to the standard commercial liability policy in 1986, environmental liability insurance is available to my knowledge only on a claims-made basis. A similar situation exists to my knowledge in the case of policyholders who seek high level excess coverage for liability resulting from medical devices or pharmaceuticals. Nevertheless, this changeover from general liability carriers to claims-made, even on a limited basis, did not occur

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policyholder who sought coverage in 1986 from its carriers on a risk starting in 1920). Perhaps the most extreme example is *Northern States Power Co. v. Fidelity & Casualty Co. of New York*, 523 N.W.2d 657 (Minn. 1994), in which the environmental contamination occurred sometime between 1873 and 1933, yet no insurance claims were made until 1987. *Id.* at 659.

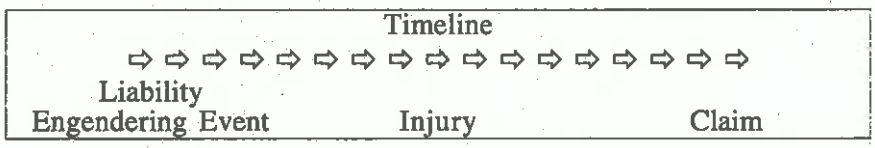
44. *See* Employers Reinsurance Corp. v. Sarris, 746 F. Supp. 560, 565 (E.D. Pa. 1990) (stating that the notice provision in a claims-made policy "allows the insurer to more accurately fix its reserves for future liabilities and compute premiums with greater certainty") (citing City of Harrisburg v. International Surplus Lines Ins. Co., 596 F. Supp. 954, 962 (M.D. Pa. 1984), *aff'd mem.*, 770 F.2d 1067 (3d Cir. 1985)); Chas. T. Main, Inc. v. Fireman's Fund Ins. Co., 551 N.E.2d 28, 30 (Mass. 1990) (finding that claims-made policies promote fairness in rate setting); Stine v. Continental Cas. Co., 349 N.W.2d 127, 131 (Mich. 1984) (stating that the claims-made policy allows a carrier "to underwrite the risk, compute the premiums, and establish reserves with greater accuracy").

45. *See, e.g.*, *In re* Insurance Antitrust Litig., 938 F.2d 919, 923 (9th Cir. 1991) (noting policyholder resistance to industry efforts to change over from the standard occurrence policy to a standard claims-made policy); *cf.* W.F. Young, *Is Insurance a Niche Business?: Reflections on Information as an Insurance Product*, 1 CONN. INS. L.J. 1, 29 (1995) (arguing that claims-made coverage is policyholder friendly; since claims-made coverage relies on more recent events to calculate premiums, it provides better risk information through premium rates to policyholders than does occurrence coverage in contexts where long tail liabilities are significant).

until 1986 and even today the change has been uneven.[46] Consequentially, trigger issues remain significant anytime a loss may implicate a pre-1986 occurrence policy even if the policyholder currently has a claims-made policy. It also is significant for post-1986 policies written on an occurrence basis.

B. *Trigger Tests*

The general rule for determining which liability insurance policy, written on an accident or occurrence basis, will respond to a claim of loss is to identify the policy period within which the claimant was actually injured—not when the act engendering injury occurred. It may be helpful to view the issue from the vantage point of a timeline. At one end of the timeline is the liability engendering event (that is, the loss initiating act by the policyholder); at the other end is the claim against the policyholder:



The vast majority of claims arise out of occurrences where event, injury, and claim are roughly contemporaneous. The timeline is not static, however, but elastic or accordian. In some cases the distance between points on the timeline may grow. This is frequently the case with mass exposure torts. Such cases present problems in claim assignment under a liability policy that, in most cases, is designed to be applied to claims involving close temporal proximity between the liability engendering event, the resulting injury, and the claim.[47]

Mass exposure torts represent cases outside the norm. In these cases it may be more difficult to identify the specific policy period within which the injury was sustained. For example, in the breast implant hypothetical raised in Part I, did the injury occur when implanted (initial exposure), when the claimant first felt pain due to contracture, when the implant ruptured, when the implants were removed, or some other point in time? It may be a difficult task to pinpoint when injury occurred.[48] Alternative trigger tests to injury in

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46. Because higher layer excess liability insurance coverage is generally available only on a claims-made basis, large corporations may be required, as a practical matter, to insure all their risks on a claims-made basis; otherwise, the integration of primary and excess coverages may be impossible to achieve.

47. *Cf.* Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 989 (N.J. 1994) (noting that standard liability insurance policy language "was never intended to cover apportionment when continuous injury occurs over multiple years").

48. *See* American Home Prods. Corp. v. Liberty Mut. Ins. Co., 565 F. Supp. 1485 (S.D.N.Y. 1983), *aff'd as modified*, 748 F.2d 760, 765 (2d Cir. 1984). The same difficulties are said to attend to property damage claims in mass exposure tort contexts. *See* Eljer Mfg., Inc. v. Liberty Mut. Ins. Co., 972 F.2d 805, 809 (7th Cir. 1992).

fact, such as exposure (liability engendering event) and manifestation (symptoms) are often perceived as reducing the costs of proving when injury occurred.[49] In addition, rather than using a single trigger of coverage, a jurisdiction may adopt a continuous or multiple trigger of coverage in the belief that such a trigger may ease problems of proof by eliminating the need to demonstrate that a single triggering event happened within a discrete, particular policy period. Under a continuous or multiple trigger, a larger time period, such as one that is an aggregate of policy periods, may become the reference point.

1. *Injury in Fact*

Under this test, a liability insurance policy is triggered if the claimant was actually injured during the policy period.[50] The fact that actual injury is not discovered until years after the policy period has expired does not defeat coverage,[51] although it may defeat the claim on the merits. That fact, however, is not relevant to the coverage issue because the carrier's obligations extend to groundless claims if they would be covered and if they were meritorious.[52] Thus, even though a claim may not be brought until many years after the injury occurred, the carrier who provided coverage during the policy period in which injury occurred will be called on to respond to the claim.

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49. *See, e.g.*, ACandS, Inc. v. Aetna Cas. & Sur. Co., 764 F.2d 968, 973 (3d Cir. 1985) ("Because of the unique character of the problem created by the policy language in the context of diseases with long latency periods . . . . [E]xposure-in-residence, and manifestation all constitute 'bodily injury' within the meaning of the policies.").

50. *See, e.g.*, Royal Globe Ins. Co. v. Great Am. Ins. Corp., 325 N.W.2d 556, 558 (Mich. Ct. App. 1982). Injury should, however, be distinguished from the legal concept of damages. For example, in *Waller v. Truck Ins. Exch.*, 900 P.2d 619 (Cal. 1995), the claimant sought emotional distress damages arising out of a series of alleged business torts. *Id.* at 623. The court characterized the claim as involving "derivative emotional distress damages" that flowed from uncovered economic loss rather than as covered bodily injury. *Id.* at 625. *See infra* note 134.

51. *See, e.g.*, Staefa Control-System Inc. v. St. Paul Fire & Marine Co., 847 F. Supp. 1460, 1473 (N.D. Cal. 1994), *amended by* 875 F. Supp. 656 (N.D. Cal. 1994).

52. *See, e.g.*, Flint v. Universal Mach. Co., 679 A.2d 929, 934 (Conn. 1996) (stating that duty to defend is determined by whether claimant *states* claim for an injury which is covered by the policy; whether the claim is meritorious or not is irrelevant to carrier's duty to defend); Sheets v. Brethern Mut. Ins. Co., 679 A.2d 540, 545 (Md. 1996) (same); Trustees of Princeton Univ. v. Aetna Cas. & Sur. Co., 680 A.2d 783, 786 (N.J. Super. Ct. App. Div. 1996) (noting that "[w]hether a claim is groundless, false, or fraudulent is irrelevant to the duty to defend. When a claim is made which, if valid, would trigger coverage, the duty to defend arises even if the claim itself ultimately proves to be unsuccessful or groundless.") (citations omitted); *see also infra* notes 129-130 and accompanying text.

The justification usually offered for this test is that it is most consistent with the plain meaning of the policy language.[53] The test is, however, neither self-defining nor without question as to its scope of application in the mass tort context. The quantum of injury necessary to trigger coverage in mass exposure torts has not been developed in the case law. The few decided cases have generally required some reasonably ascertainable and demonstrable physical damage or harm to the body or property; however, the injury does not have to be observable, or at its onset, to satisfy this trigger rule.[54] For bodily injury claims, injury in fact is often treated as a medical determination,[55] although the nature of the "injury" may influence the trigger date. For example, in the breast implant coverage cases, the injury has varied, insofar as the trigger date is concerned, depending on whether the claimant was alleging autoimmune diseases (date of implant or date of onset of disease trigger), breast implant rupture (date of rupture trigger), or breast implant contracture (date of experiencing pain trigger). Each of these dates has been deemed to constitute injury in fact sufficient to trigger coverage. It may also be claimed that the medical fact of injury for autoimmune diseases is not the date of implant but the date of body immune system compromise, a date usually long after the date of implant. Injury may be deemed to happen when the body first reacts to the implant after it has been placed in the body; alternatively, injury may be deemed to happen only when the body sustains an actual compromise of immune system integrity. The above illustrates that not only may the medical fact of injury be debated but that this inquiry is

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53. *See* American Home Prods. Corp. v. Liberty Mut. Ins. Co., 565 F. Supp. 1485, 1497 (S.D.N.Y. 1983), *aff'd as modified*, 748 F.2d 760, 765 (2d Cir. 1984). The Court of Appeals rejected the District Court's requirement that the actual injury be diagnosable and compensable within the policy period to trigger coverage. *But cf.* Independent Petrochemical Corp. v. Aetna Cas. & Sur. Co., 654 F. Supp. 1334, 1357-58 (D.D.C. 1986) (stating that "'occurrence' of personal injury means 'any point in time at which a finder of fact determines that the effects of exposure to a drug actually resulted in a diagnosable and compensable injury'") (citing American Home Prods. Corp. v. Liberty Mut. Ins. Co., 565 F. Supp. at 1489). Other courts adopting an injury in fact trigger include: Ray Indus., Inc. v. Liberty Mut. Ins. Co., 974 F.2d 754, 771 (6th Cir. 1992) (applying Michigan law); United States v. Conservation Chem. Co., 653 F. Supp. 152, 197 (W.D. Mo. 1986); Northern States Power Co. v. Fidelity & Cas. Co., 523 N.W.2d 657, 662 (Minn. 1994); St. Paul Fire & Marine Ins. Co. v. McCormick & Baxter Creosoting Co., 870 P.2d 260, 264-65, *modified on reconsideration on other grounds*, 875 P.2d 537, 559 (Or. Ct. App. 1994).

54. *See* American Home Prods. Corp. v. Liberty Mut. Ins. Co., 748 F.2d at 766 (holding that "a real but undiscovered injury, proved in retrospect to have existed at the relevant time, would establish coverage, irrespective of the time injury became [diagnosable]").

55. *See In re* Asbestos Ins. Coverage cases, *infra* note 58, at 23-31 (Phase III proceedings); *cf.* Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F.3d 1178, 1196 (2d Cir. 1995) (stating that this court requires that "injury in fact" be proven by medical evidence and fact finding, but noting that other jurisdictions may impose a less rigorous test); Hoechst Celanese Corp. v. Certain Underwriters at Lloyd's London, 673 A.2d 164, 169-70 (Del. 1996).

distinct from an analysis whether a causal relationship exists between the implant and the "injury."

2. *Exposure*

The exposure test holds that the date of occurrence, the trigger date, is the date of exposure to the injury producing agent.[56] The use of the test is justified by its adherents on two grounds. The pure exposure advocates contend that the language and the drafting history leading up to the 1966 occurrence policy support a pure exposure trigger.[57] A modified approach argues that in some mass exposure torts, exposure does constitute injury in fact. This finding is made either on the basis of case-specific medical evidence[58] or judicial notice.[59] Not all courts accept the "exposure equals injury" etiology for mass exposure torts.[60] In some cases carriers and

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56. Continental Ins. Co. v. Northeastern Pharms. & Chem. Co., 811 F.2d 1180, 1189 (8th Cir. 1987); Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 451 F. Supp. 1230, 1238 (E.D. Mich. 1978), *aff'd*, 633 F.2d 1212 (6th Cir. 1980).

57. Robinson, *supra* note 31, at 611 (discussing arguments of pure exposure advocates).

58. *In re* Asbestos Ins. Coverage Cases, Judicial Council Coordination Proceeding No. 1072 (Cal.), *reported in* MEALEY'S LITIGATION REPORTS—INSURANCE (SUPPLEMENT) (Feb. 27, 1990), *aff'd sub nom.* Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co., 26 Cal. Rptr. 2d 35 (Ct. App. 1993), *review granted sub nom. In re* Asbestos Ins. Coverage Cases, 866 P.2d 1311 (Cal. 1994), *vacated and remanded*, 904 P.2d 370 (Cal. 1995), *on remand*, 52 Cal. Rptr. 2d 690 (Ct. App. 1996) [hereinafter *In re* Asbestos Ins. Coverage Litig.]. Other courts adopting the exposure trigger include: E.B. & A.C. Whiting Co. v. Hartford Fire Ins. Co., 838 F. Supp. 863, 867 (D. Vt. 1993); TBG, Inc. v. Commercial Union Ins. Co., 806 F. Supp. 1444, 1452-53 (N.D. Cal. 1990); Clemco Indus. v. Commercial Union Ins. Co., 665 F. Supp. 816, 823 (N.D. Cal. 1987), *aff'd*, 848 F.2d 1242 (9th Cir. 1988); Cole v. Celotex Co., 588 So. 2d 376 (La. App. 1991), *aff'd*, 599 So. 2d 1058 (La. 1992).

The exposure equals injury approach has been applied outside the asbestos context. *See, e.g.*, Chantel Assocs. v. Mount Vernon Fire Ins. Co., 656 A.2d 779, 788 (Md. 1995) (lead-related injuries occurred immediately or soon after exposure to lead); *cf.* Cessna Aircraft Co. v. Hartford Accident & Indem. Co., 900 F. Supp. 1489, 1501 (D. Kan. 1995) (noting, but not deciding until development of full factual record, that in environmental contamination cases, exposure to contaminants and groundwater contamination could occur virtually simultaneously).

59. Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 982-83 (N.J. 1994).

60. *Compare* Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d at 1218 (stating that "[b]ecause each additional inhalation of asbestos fibers results in the build-up of additional scar tissue in the lungs, the district court deemed the 'bodily injury' to occur whenever asbestos fibers were inhaled") *with* Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co., 682 F.2d 12, 19 (1st Cir. 1982) (stating that "it is uncontested that even sub-clinical injury to the lung does not occur simultaneously with the inhalation of asbestos. Nor is . . . sub-clinical injury an inevitable by-product of exposure, since the body's natural mechanisms may remove the fibers before they became embedded in the lungs."). *See also* Commercial Union Ins. Co. v. Sepco Corp., 765 F.2d 1543, 1546 (11th Cir. 1985) (stating that "we believe that the exposure theory is more accurately analyzed as positing not that each

policyholders have stipulated that injury took place upon exposure.[61] In other cases exposure has involved some contamination of the exposure site.[62] In both of these situations, the line between exposure and injury may be difficult to define and more a product of legal impressionism than objective reality.

3. *Manifestation*

Under the manifestation trigger, claims are identified to the policy in effect when the injury became reasonably apparent or known to the claimant.[63] Advocates of the manifestation test raise two arguments in support of its use. First, they contend that actual injury occurs when the injury becomes apparent.[64] Second, they contend that the manifestation test promotes certainty.[65] A manifestation trigger is said to provide a clearer

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inhalation of asbestos fibers results in bodily injury, but rather that every asbestos-related injury results from inhalation of asbestos fibers")

61. Uniroyal, Inc. v. Home Ins. Co., 707 F. Supp. 1368, 1389 (E.D.N.Y. 1984) (involving parties that stipulated that persons exposed to Agent Orange, a highly toxic herbicide, were injured upon exposure).

62. Hancock Labs, Inc. v. Admiral Ins. Co., 777 F.2d 520, 524 (9th Cir. 1985) (involving a claimant that suffered "bodily injury" when he was exposed to contaminated heart valve; the valve had been contaminated with bacteria prior to implantation). There is a corollary here in the "property damage" case where the issue involves incorporation of a defective product into a larger product. Does "injury" happen at the time of incorporation of the defective product or at the time of the actual failure of the defective product? *Compare* Eljer Mfg., Inc. v. Travelers Indem. Co., 972 F.2d 805 (7th Cir. 1992) (adopting an installation date trigger) *with* Moen, Inc. v. Allstate Ins. Co., 93CH11662 (Ill. Cir. Ct. Oct. 23, 1995) *reported in Injury-In-Fact Triggers Policies in Plumbing Coverage Cases*, 10 MEALEY'S LITIGATION REPORTS—INSURANCE 10-11 (Nov. 7, 1995) (adopting a failure date (or "leak date") trigger). An Illinois appellate decision took the *Eljer* approach. *See* United States Gypsum Co. v. Admiral Ins. Co., 643 N.E.2d 1226, 1253 (Ill. App. Ct. 1994) (using date of incorporation trigger for asbestos property damage claims).

63. *See* New Hampshire Ball Bearings v. Aetna Cas. & Sur. Co., 848 F. Supp. 1082, 1092-93 (D.N.H. 1994), *rev'd on other grounds*, 43 F.3d 749 (1st Cir. 1995); Honeycomb Sys., Inc. v. Admiral Ins. Co., 567 F. Supp. 1400, 1405 (D. Me. 1983); Transamerica Ins. Co. v. Safeco Ins. Co., 472 N.W.2d 5, 7 (Mich. Ct. App. 1991). *But see* Eljer Mfg., Inc. v. Liberty Mut. Ins. Co., 972 F.2d 805, 814 (7th Cir. 1992) (involving property damage that occurred for purposes of triggering liability insurance policies when defective product was installed as component of larger product given overall failure rate of component). *See also* Harford County v. Harford Mut. Ins. Co., 610 A.2d 286, 293-94 (Md. 1992) (collecting decisions adopting manifestation trigger based on theory that injury occurs upon discovery of harm, but rejecting manifestation trigger nonetheless).

64. Chemstar, Inc. v. Liberty Mut. Ins. Co., 797 F. Supp. 1541, 1550-51 (C.D. Cal. 1992), *aff'd*, 41 F.3d 429 (9th Cir. 1994) (holding that in property damage case, injury occurred when the claimant realized economic loss as a result of the policyholder's conduct).

65. Chemstar, Inc. v. Liberty Mut. Ins. Co., 41 F.3d 429, 434-35 (9th Cir. 1994); Home Ins. Co. v. Landmark Ins. Co., 253 Cal. Rptr. 277, 282 (Ct. App. 1988). Although *Home Insurance Co.* involved first party property insurance coverage, its principles were

signal for coverage purposes than an injury in fact or exposure trigger in mass exposure torts because of ease of proof and a closer fit between time of discovery and time of presentment of the claim.[66] Critics of the manifestation trigger contend that the test effectively collapses occurrence coverage into claims-made coverage and allows carriers to exit markets, leaving policyholders uninsured for substantial exposures.[67] The critics contend that in most cases the time period between manifestation and claim-making is small; hence, the manifestation test collapses occurrence coverage and claims-made coverage. Since carriers could simply refuse to renew policies, the policyholder would be left uncovered for all post nonrenewal manifestations of injury by claimants.

While the manifestation trigger has been applied to bodily injury claims, those decisions are few, and what decisions exist have received limited application beyond the specific case. For example, in *Transamerica Insurance Co. v. Safeco Insurance Co.*,[68] the court adopted a manifestation trigger for claims of bodily injury resulting from allegedly harmful gases released from urea-formaldehyde foam insulation. Subsequent decisions have narrowly interpreted the decision, arguing that it is limited to claims involving latent diseases;[69] limited to claims involving the same chemical—urea formaldehyde;[70] or is limited to products liability progressive injury claims.[71] Most significantly, the primary decision applying the manifestation trigger in the context of a mass exposure tort bodily injury claim did so in a case where the only test that would provide any coverage was a manifestation trigger—the policyholder was uninsured if an "exposure" or "injury in

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extended to third party liability insurance coverage in *Fireman's Fund Insurance Co. v. Aetna Casualty & Surety Co.*, 273 Cal. Rptr. 431 (Ct. App. 1990). In light of the California Supreme Court's decision in *Montrose Chemical Corp. v. Admiral Insurance Co.*, 913 P.2d 878, 904 (Cal. 1995), in which the court adopted a continuous injury trigger for both bodily injury and property damage claims, neither *Chemstar* nor *Home Insurance Co.* reflect California law on the issue of "trigger."

66. *See* Douglas L. Hallett & Lawrence C. Berney, *Trigger of Coverage: A Posnerian Analysis*, 4 CAL. INS. L. REG. REP. (Apr. 1992), *reprinted in 10th Annual Insurance, Excess, and Reinsurance Coverage Disputes*, at 391 (PLI Litig. & Admin. Practice Course Handbook Series No. H4-5148, 1993).

67. Dow Chem. Co. v. Associated Indem. Corp., 724 F. Supp. 474, 485 (E.D. Mich. 1989); Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 901-04 (Cal. 1995). The *Montrose* court's rejection is particularly significant given its acceptance of a manifestation trigger for first party property damage coverage in *Prudential-LMI Commercial Insurance v. Superior Court*, 798 P.2d 1230 (Cal. 1990).

68. Transamerica Ins. Co. v. Safeco Ins. Co., 472 N.W.2d 5 (Mich. Ct. App. 1991).

69. *See* Inland Waters Pollution Control, Inc. v. National Union Fire Ins. Co., 997 F.2d 179, 184 (6th Cir. 1993).

70. Marathon Flint Oil v. American States Ins. Co., 810 F. Supp. 850, 852 (E.D. Mich. 1992).

71. Ray Indus. v. Liberty Mut. Ins. Co., 974 F.2d 754, 766 (6th Cir. 1992). *But see* Gelman Sciences, Inc. v. Fidelity & Cas. Co., 543 N.W.2d 38 (Mich. Ct. App. 1995) (following Transamerica Ins. Co. v. Safeco Ins. Co., 472 N.W.2d 5 (Mich. Ct. App. 1991)).

fact" trigger were used.[72] The manifestation test has fared slightly better in the "property damage" context.[73]

4. *Single Trigger*

In addition to the issue of the specific trigger test, there is the related and fundamental question whether the trigger test is a singular event or a process. We may analogize to the medium of photography. Do we emphasize the individual picture, the photograph or slide (single trigger), or do we emphasize the film as a process of moving frames, a motion picture (continuous trigger)? It is perhaps understandable that a framing bias may exist here. The tendency to see the medium in terms of individual photographs, or cells, as opposed to the entire process may influence how one appreciates the identification of the appropriate trigger of coverage in cases involving mass exposure torts.

The single trigger thesis is quite simple—only one policy period can be triggered by a loss. The specific trigger test may be exposure, injury in fact or manifestation, but whichever specific test is used, only a single policy period can be factually identified for each loss.

Proponents of the single trigger thesis contend that it is most consistent with the letter and spirit of the liability insurance policy, even in cases involving mass exposure torts.[74] Opponents of the single trigger thesis also rely on policy interpretation[75] but they also raise several discrete arguments which are addressed in the next section.

5. *Continuous or Multiple Triggers*

A continuous or multiple trigger theory provides that all policies in effect during the aggregate trigger period, for example, during the period of exposure or injury in fact, are activated and may be called on to respond to a loss.[76] A multiple trigger differs from a continuous trigger only in the fact that under a multiple trigger all the individual trigger tests, for example, exposure, injury in fact, and manifestation, are combined with the notion of continuity instead of singularity. Thus, under a multiple trigger theory each policy on the risk from date of initial exposure to manifestation would be

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72. *See* Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co., 523 F. Supp. 110 (D. Mass. 1981), *aff'd as modified*, 682 F.2d 12 (1st Cir. 1982). This fact has been judicially noted. Lac D'Amiante Du Quebec v. American Home Assurance Co., 613 F. Supp. 1549, 1557 (D.N.J. 1985).

73. *See* CPC Int'l, Inc. v. Northbrook Excess & Surplus Ins. Co., 668 A.2d 647 (R.I. 1996) (applying manifestation trigger test in environmental damage coverage matter).

74. Robinson, *supra* note 31, at 615.

75. *See* Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 888 (Cal. 1995).

76. By its very nature, manifestation is only a single trigger test. It is, however, sometimes combined with other trigger tests to form part of a multiple trigger.

triggered.[77] A simple continuous trigger theory would use only one definition of trigger. For example, using a continuous exposure trigger all policies in effect during the period of exposure would be triggered but no other policies would be triggered. Once exposure ceased, liability insurance policies incepted after that date would bear no coverage for the preinception risks.[78] Recently, many courts that have adopted a continuous trigger theory have done so in combination with an injury in fact definition of bodily injury that has defined bodily injury so broadly as to effectively duplicate the multiple trigger test.[79] Hereinafter, this article will use the term "continuous trigger" to include the multiple trigger concept.

Under a continuous trigger, the same claim may trigger more than one policy. Unless stacking principles are applied,[80] however, ultimately only one policy period will be selected to respond to the claim.[81] An analogy may illuminate what is occurring under this approach. It is customary to allow plaintiffs to plead multiple causes of action that address a single course of conduct by the defendant.[82] The causes of action may be inconsistent,[83] but the plaintiff is usually permitted to present all the theories of recovery. Ultimately, the plaintiff must elect one of the theories. Normally, this election need not occur until after the jury's verdicts have been rendered on the causes

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77. *See, e.g.*, Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034, 1045-47 (D.C. Cir. 1981); Eli Lilly & Co. v. Home Ins. Co., 482 N.E.2d 467, 471 (Ind. 1985).

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

79. *See infra* notes 106-13 and accompanying text; *see also* Zurich Ins. Co. v. Raymark Indus., Inc., 514 N.E.2d 150 (Ill. 1987) (stating that injury in fact occurred during periods of asbestos exposure and at time of diagnosis, but not in between). A similar approach has been adopted in property damage cases. *See, e.g.*, Sentinel Ins. Co. v. First Ins. Co. of Hawaii, 875 P.2d 894 (Haw. 1994) (stating that injury in fact occurred due to water seepage over multiple policy periods).

80. Stacking is a phenomenon most frequently encountered in uninsured motorist claims where the insured motorist seeks coverage under his own policy for injuries caused by an uninsured motorist. Where the motorist's policy insures more than one vehicle, some courts permit the injured motorist policyholder to stack each vehicle's uninsured motorist coverage so as to compensate the injured policyholder more completely for his loss. *See, e.g.*, Rusthoven v. Commercial Standard Ins. Co., 387 N.W.2d 642 (Minn. 1986). The Minnesota Supreme Court held that a commercial trucker's insurance policy which covered 67 leased vehicles would be stacked so that the policy provided $1.675 million (67 x $25,000 per vehicle uninsured motorist coverage) of total coverage. *Id.* at 645.

81. Only Louisiana courts have expressly accepted stacking in the context of long latency injuries or diseases. *See generally* Laurence A. Silverman & Phillip C. Essig, *Stacking of Policy Limits and Joint and Several Liability of Insurers in Cases Involving Long Term, Cumulative Injury or Damage* (Barry Ostrager & Thomas Newman eds.), at 56-60 (PLI Litig. & Admin. Practice Course Handbook Series No. H4-5062, 1989).

82. Melby v. Hawkins Pontiac, Inc., 537 P.2d 807, 811 (Wash. Ct. App. 1975) (holding that the election of remedies doctrine does not bar the plaintiff from seeking alternate remedies as long as this does not allow double recovery or seriously prejudice the defendant).

83. FED. R. CIV. P. 8(a).

of action presented.[84] The plaintiff can then elect the theory that maximizes the recovery. Similarly, when the continuous trigger test is adopted, the policyholder may be permitted to select which of several policy periods a particular claim will be assigned.[85] If this election is not restrained, the end result is that the policyholder may assign claims to policy periods in such a way as to maximize coverage.[86]

The most important argument of the advocate of the continuous trigger theory seems to be that of necessity. In mass exposure torts, attempts to identify and assign each claim to a particular policy period are often deemed by courts to be impractical:[87]

> We said that "mass-exposure toxic-tort cases involve public interests not present in conventional tort litigation." . . .
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> . . . [O]ur resolution of the issues is necessarily imperfect. Our concepts of legal causation were developed in an age of Newtonian physics, not of molecular biology. Were it possible to know when a toxic substance clicks on a switch that alters irrevocably the composition of the body and

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84. Williams v. Marshall, 235 P.2d 372, 379 (Cal. 1951).

85. J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502, 508 (Pa. 1993). This is sometimes referred to as the "joint and several" liability formula. *See* Hatco Corp. v. W.R. Grace & Co.—Conn., 801 F. Supp. 1334, 1345-46 (D.N.J. 1992); Monsanto Co. v. C.E. Health Compensation & Liab. Ins. Co., 652 A.2d 30, 35 n.6 (Del. 1994) (listing cases that follow the majority rule that under tort principles an insurer will be held jointly and severally liable rather than on a pro rata basis).

86. Such an approach has been explicitly approved as consistent with the policyholder's reasonable expectations of coverage. Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034, 1045-49 (D.C. Cir. 1981). It is unclear whether a policyholder's ability to maximize coverage by assigning particular losses (claims) to particular policy periods is subject to constraint. *Cf.* Kaiser Found. Hosp. v. North Star Reinsurance Corp., 153 Cal. Rptr. 678, 682 (Ct. App. 1979) (finding that policyholder and primary carrier acted in bad faith in allocating losses so as to maximize excess carrier's and minimize primary carrier's responsibilities for the loss). *But cf.* Commercial Union Assurance Cos. v. Safeway Stores, Inc., 610 P.2d 1038, 1041-42 (Cal. 1980) (holding that policyholder with self-insured retention owed no duty to excess carrier to accept reasonable settlement offer within self-insured retention; excess carrier was responsible for judgment in excess of retained limits). The parties' duties are highly correlated with the jurisdiction's acceptance of the insurer bad faith doctrine. *See* Aetna Cas. & Sur. Co. v. Dow Chem. Co., 883 F. Supp. 1101, 1111 (E.D. Mich. 1995) (finding no bad faith when carrier assigned claim involving continuous loss to only one of five triggered policies that permitted the carrier to assess a claims handling fee; no implied duty of good faith and fair dealing would be recognized which would reduce express contractual rights).

87. Northern States Power Co. v. Fidelity & Cas. Co., 523 N.W.2d 657, 662-63 (Minn. 1994) (adopting *continuous* trigger because of the "scientific complexity of the issues involved, the extended period of time over which damages may have occurred before discovery, and the number of parties potentially involved"); *see* United States Gypsum Co. v. Admiral Ins. Co., 643 N.E.2d 1226, 1255-57 (Ill. App. Ct. 1994) (applying the continuous trigger rationale).

> before which no change has "occurred," we might be more confident that occurrence-causing damages had taken place during a particular policy period. . . .
>
> Mass-exposure toxic-tort cases have simply exceeded the capacity of conventional models of judicial response. . . .
>
> . . . [C]ourts must adapt common-law doctrines "to the peculiar characteristics of toxic-tort litigation."[88]

Jurisdictions adopting the continuous trigger theory have also sought to substantiate their holding on the ground that it is consistent with the often stated public policy of maximizing coverage.[89] More recent decisions have questioned predicating a continuous trigger on the goal of maximizing coverage.[90]

Some courts have sought to buttress their position that a continuous trigger is appropriate by reference to the policy language itself.[91] Ironically, whether the language in the occurrence provision is deemed to be ambiguous[92] or unambiguous[93] courts have found it appropriate to use a

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88. Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 985 (N.J. 1985) (citations omitted); *cf.* Fairview Hosp. & Health Care Servs. v. St. Paul Fire & Marine Ins. Co., 535 N.W.2d 337, 341 (Minn. 1995) (holding that policyholder need only present evidence that a genuine issue of material fact exists as to whether an actual injury did occur within the policy period to survive a motion for summary judgment).

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

90. Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d at 981 (stating that "the presumption of maximizing coverage . . . appears an uneven principle in this setting. . . . A rule of law premised on nothing more than the result-oriented goal of maximizing coverage has been described as 'judicial legislation'") (citation omitted); Abex Corp. v. Maryland Cas. Co., 790 F.2d 119, 126 n.32 (D.C. Cir. 1986) (noting that goal of "maximizing coverage" is result oriented).

91. Keene Corp. v. Insurance Co. of N. Am., 667 F.2d at 1042. The court stated, "The first step in the analysis of the problem is to determine what events . . . trigger coverage under these policies. In the language of the policies, the question is when did 'injury' occur." *Id.* The court discussed the ambiguity of the policy language. *Id.* at 1043-44. *See also* ACandS, Inc. v. Aetna Cas. & Sur. Co., 764 F.2d 968, 972 (3d Cir. 1985) ("All parties agree, and it is evident from the policy language, that the trigger of coverage issue turns on the meaning of the phrase 'bodily injury.'"). The court deemed the phrase ambiguous. *Id.* Drafting history has also been relied on as supporting a continuous trigger. *See* Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 891-92 (Cal. 1995); *see also* Robinson, *supra* note 31, at 607.

92. For example, in *Keene Corp. v. Insurance Co. of North America*, the court noted that the use of a single trigger (exposure) test might leave the policyholder uninsured for some claims. Keene Corp. v. Insurance Co. of N. Am., 667 F.2d at 1044. Such a result was deemed inconsistent with the policyholder's reasonable expectations of coverage. Unless the policyholder could reasonably expect that every claim would be covered, this reasoning was circular—a point essentially conceded by the court in a later opinion. *See* Abex Corp. v. Maryland Cas. Co., 790 F.2d 119, 126 n.35 (D.C. Cir. 1986) (observing that *Keene Corp.* was result-oriented). *But cf.* Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co., 52 Cal. Rptr.

continuous trigger. Other courts have used a broad evidence approach under which a multiplicity of factors are considered.

To summarize, courts have identified and accepted four arguments for adopting a continuous trigger. First, a continuous trigger is consistent with the goal of maximizing coverage. Second, a continuous trigger is needed because of the inherent difficulties presented by mass exposure torts. Third, a continuous trigger is called for either by the plain meaning of the standard occurrence provision or the ambiguity of the standard occurrence provision. Fourth, a continuous trigger is called for by the plain meaning of the standard occurrence provision in the context of mass exposure torts.

C. *Some Observations on Trigger of Coverage Approaches*

In third party insurance coverage disputes involving mass exposure torts with long tail exposure, such as asbestos, DES, and environmental contamination, there is little doubt that the continuous trigger approach has enjoyed great success.[94] Yet, that success has come at a cost. First, we have witnessed the increasing complexity of insurance coverage litigation as courts struggle to address the new questions raised by adoption of the continuous trigger theory. Second, we are confronted with the challenge of how to cabin a context driven concept when the context does not itself provide any reasoned justification for the result, aside from the justification of coverage maximization.

The continuous trigger theory has its origins in *Keene Corp. v. Insurance Co. of North America*,[95] involving asbestos-related diseases. The court adopted a continuous trigger under which *all* carriers on the risk from initial exposure to manifestation were liable.[96] The court itself was somewhat opaque in its justification for the continuous trigger approach. The court did note that such a trigger would maximize coverage.[97] On the other hand, the court also evidenced concern that its trigger theory not expand the carriers' obligations beyond that which would be imposed if a single trigger were

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2d 690, 704-05 (Ct. App. 1996) (stating that court should not adopt construction or interpretation of an insurance policy that would have the practical effect of rendering insurance coverage illusory).

93. In *Montrose Chemical Corp. v. Admiral Insurance Co.*, 913 P.2d 878, 890 (Cal. 1995), the court held that the standard form policy's definition of an occurrence unambiguously provided for a continuous injury trigger.

94. *See, e.g.*, Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d at 896 (noting that "most courts that have analyzed the issue have found the continuous injury trigger of coverage applicable to the standard occurrence-based CGL policy"); *see also* Northern States Power Co. v. Fidelity & Cas. Co., 523 N.W.2d 657, 662-64 (Minn. 1994); Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 985 (N.J. 1994); McMahon, *supra* note 14, at 727-29.

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

96. *Id.* at 1044-46.

97. *Id.* at 1041; *but see supra* note 90 (criticizing use of a coverage maximization goal).

used.[98] The court sought to achieve a delicate balance between two competing and ultimately opposite goals. To achieve its goal that the carrier's obligations not be enhanced by the continuous trigger, the court stated that ultimately an allocation of the loss would be made among the carriers whose policies were triggered.[99] Notwithstanding the centrality of allocation of loss to the adoption of a continuous trigger, the allocation approach was adopted without a discussion of the costs of that approach, both administratively and substantively. Nor was any effort made to determine whether *in fact* allocation would cause the involved carriers to bear essentially the same exposure under a continuous trigger as would be the case with the use of a single trigger. Equivalency was assumed. Perhaps most importantly, the inconsistency between a coverage maximization goal and a no increase in exposure principle was not acknowledged by the court.

In this section of the paper, I examine the arguments for and against the use of an indemnity continuous trigger. In general, I find the arguments against the adoption of an indemnity continuous trigger to be more persuasive than the arguments in its favor. This is not to disparage the arguments made in favor of an indemnity continuous trigger for the question does not permit an easy resolution. Rather, the failing of the indemnity continuous trigger argument lies in its direct connection to the desire to maximize coverage. The argument in favor of an indemnity continuous trigger (1) fails to appreciate the significant differences between the carrier's contractual obligations to defend and to indemnify, (2) overstates the difficulties in fixing the date of loss for coverage purposes, and (3) ignores the complicated overlay between insuring against risk of loss and insuring against an existent loss. Finally, this section looks at some related problems an indemnity continuous trigger presents in the context of excess insurance.

1. *The Ambiguity Argument*

The claim that an indemnity continuous trigger is called for by the language of the insurance contract has been repeatedly litigated; nonetheless, the merits of the claim remain to be substantiated. As noted previously, the trigger concept itself is not found in the insurance policy; rather, the coverage and occurrence provisions of the policy are read as implying or supporting a continuous trigger.

When one is making or criticizing an argument based on policy language, it is appropriate to recognize the limitations of language. In some

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98. Keene Corp. v. Insurance Co. of N. Am., 667 F.2d at 1049. The scope of this concession is unclear. *See* Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d at 986 (finding it was unclear whether the *Keene* court was referring to carriers' responsibility for injuries or claims). This uncertainty is critical because responsibility for claims suggests a defense continuous trigger, while responsibility for injuries suggests an indemnity continuous trigger. *See infra* notes 116-34 and accompanying text.

99. Keene Corp. v. Insurance Co. of N. Am., 667 F.2d at 1050. Courts have adopted this argument as militating the effect of the adoption of a continuous trigger. *See* Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d at 902.

cases, words may fail even the best efforts to describe with exquisite precision how specific situations should be handled under the terms of the insurance contract. It is this fact that justifies use of the "reasonable person" point of view rather than a narrow, technical definitional approach. Reference to the reasonable person or the reasonable person's expectations is not a reference to a specific person, but a reference to a way of looking at problems. A reasonable person relates problems to the factual context in which the problem is situated.[100]

Many terms of the insurance contract require a context-oriented perspective to interpretation because language alone cannot encompass the myriad possibilities presented. Justice White once captured the dilemma particularly well when writing in the related area of statutory construction: "Words inevitably contain germs of uncertainty and . . . there may be disputes over the meaning of such terms . . . . But . . . 'there are limitations in the English language with respect to being both specific and manageably brief . . . .' " [101] Context provides a substitute for greater specificity, the cost of which may be incommensurable. Attempts to define a term more precisely may backfire because the dense and complex language which is a product of such attempts often results in a lack of clarity.

Recognizing that some terms of an insurance policy require context to be meaningful is not a major concession. For example, the term "accident"—which is central to the definition of occurrence—is frequently contextually driven.[102] Yet, if context is properly applied to *interpret* policy language, is it properly applied to *construe* it? By construe, I mean to apply a rule that does not operate on the contractual language itself but the legal effect of that language.[103] If trigger were a term of the contract, context might be necessary to interpret its meaning, but that is not the case. Trigger is a legal rule designed to determine when a policy must respond. It is no more appropriate to rely on reasonable expectations or context to determine the meaning of trigger than it is to use such concepts to interpret language statutorily mandated to be included in the insurance contract—which is to say that it is not proper.[104]

The argument of context has some appeal when applied to the indemnity continuous trigger question, but the argument is ultimately unavailing. It is pure fiction, for example, to suggest that in the case of mass

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100. *See* Miller v. Continental Ins. Co., 358 N.E.2d 258, 259 (N.Y. 1976).

101. Broaderick v. Oklahoma, 413 U.S. 601, 608 (1973) (quoting CSC v. Letter Carriers, 413 U.S. 548, 578-79 (1973)); *see* Suarez v. Life Ins. Co. of N. Am., 254 Cal. Rptr. 377, 383 (Ct. App. 1988) (noting that "the fact that language could be more explicit does not render it ambiguous").

102. *See* Michaels v. City of Buffalo, 628 N.Y.S.2d 253, 254 (N.Y. 1995).

103. *See* Edwin Patterson, *The Interpretation and Construction of Contracts*, 64 COLUM. L. REV. 833, 835 (1964); 3 ARTHUR CORBIN, CORBIN ON CONTRACTS § 534 (1960 & Supp. 1997).

104. Schreiber v. Pennsylvania Lumberman's Ins. Co., 444 A.2d 647, 649 (Pa. 1987); Interinsurance Exch. v. Marquez, 172 Cal. Rptr. 263, 264 (Ct. App. 1981). There are, of course, the inevitable cases to the contrary, but they definitely bespeak a minority viewpoint.

exposure torts a reasonable policyholder held a particular viewpoint at the time of contract formation regarding the trigger of coverage. The claimant's legal theories and diseases that drive the continuous trigger debate were not on the radar screen when the occurrence policies, which are currently being litigated over their coverage obligations, were written and sold. We cannot find in the language of the insurance contract answers the contract does not contemplate nor address. The appropriate trigger rule is purely a legal question. It cannot be answered in scholarly isolation, through adversarial argument, or by judicial *dixit*. It must be answered with regard for the realities of the parties' bargain, the role of insurance, and the capabilities of carriers to respond to the legal obligations imposed on them through judicial construction of the insurance contract. We must also acknowledge that judicial decisions may be impervious to objective criticism when they are based on political and cultural considerations that are not acknowledged by the court.[105]

The current approach to applying the continuous trigger can be seen most clearly in trial level determinations when appellate precedent must be applied to the actual controversy. Here the tendency has been not to rely simply on medical evidence, but to accept the most expansive medical viewpoints regarding the onset and progression of the ailment or disease that triggers coverage and to marry that concept to an expansive view of policy coverage. For example, in *In re Asbestos Insurance Coverage Litigation*,[106] the trial judge held that: "Pursuant to the Court's analysis of the policy language, extrinsic evidence of intent, and medical evidence, and in accordance with applicable legal principles, this Court finds that all of the policyholder's policies in effect from first exposure to asbestos . . . until date of death or date of claim . . . are triggered . . . ."[107] The conclusion concerning trigger in the most significant asbestos insurance coverage case litigated to date is noteworthy because there is nothing in the court's analysis

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105. Transferring health care costs to private entities, such as carriers not only helps spread those costs but also avoids transferring those costs to the government. Given the sizable liabilities companies that are subject to mass exposure tort claims face, it is not unlikely that the government may ultimately incur health care costs if the private sector is unable to assume them. For example, eleven of the major asbestos manufacturing companies filed for protection under Chapter 11 of the bankruptcy laws in the 1980s, citing, among other reasons, the increased cost associated with asbestos-related litigation and the inability to continue to operate with the spectre of liability hanging over their corporate heads. *See* AD HOC COMMITTEE ON ASBESTOS LITIGATION TO THE CHIEF JUSTICE OF THE UNITED STATES, SUMMARY REPORT OF THE JUDICIAL CONFERENCE 51 n.34 (Mar. 1991); *see also* Annette W. Jarvis & Kenneth L. Cannon, II, *Liability Insurance Settlements in Mass Tort Bankruptcy Cases*, 41 FED. B. NEWS & J. 199 (1994). The fact that a personal injury claim is discharged in bankruptcy does not heal the injury, it simply reduces the amount of private resources available to compensate the injured party and redirects that party to public sources for compensation. Whether these considerations subtly influence doctrinal development can only be conjectured; empirical proof is sparse and largely anecdotal.

106. *See In re* Asbestos Ins. Coverage Litig., *supra* note 58 (Phase III proceedings).

107. *Id.* at 42. *See infra* note 110.

of the policy language itself that specifically or expressly argues for a continuous trigger over a single trigger.[108] Ultimately the court rejected, for purposes of trigger analysis, reliance on the extrinsic evidence of drafting history and industry custom, finding, at best, it was consistent with what the court identified as the plain language of the policies.[109] It was in the medical evidence that the court identified factual support for its conclusion that the injury was progressive in nature.[110] However, the court did not explain why

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108. *Id.* at 21-22. Contrary to the approach in *In re Asbestos Insurance Coverage Litigation*, the court in *Montrose Chemical Corp. v. Admiral Insurance Co.*, relied on excerpts of the drafting history in concluding that the unambiguous language in the occurrence provision of the policy provided for a continuous injury trigger. Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 891-92 (Cal. 1995).

109. *See In re* Asbestos Insurance Coverage Litigation, *supra* note 58, at 32-41 (Phase III proceedings). Most particularly, the trial court noted that the drafting history evidence regarding the 1966 and 1973 CGL policy forms "does not mandate that a meaning other than the plain meaning" and that the course of conduct and custom evidence was inconsistent. *Id.* at 37, 39. The trial court's decision was based on extensive record testimony and evidence concerning the drafting history of the 1966 CGL policy, including many of the major participants. Ironically, the California Supreme Court in *Montrose Chemical Corp. v. Admiral Insurance Co.*, relied heavily on several papers written contemporaneously to the 1966 revision, but apparently without the same evidentiary record developed in the Asbestos Insurance Coverage proceedings, in determining that the drafters of the 1966 revision *intended* a continuous injury trigger. Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d at 891-92.

110. *In re* Asbestos Insurance Coverage Litigation, *supra* note 58, at 23-31 (Phase III proceedings). The medical evidence was that injury in fact occurred at the moment of initial exposure and was exacerbated by exposure in residence and subsequent external exposures to asbestos. The court believed that in the context of the medical evidence a continuous injury trigger was warranted.

Similarly, in *First State Insurance Co. v. Minnesota Mining & Manufacturing Co.*, No. 94-12780, slip. op. (2d Dist., Minn. July 11, 1996), a breast implant insurance coverage matter, the trial judge reviewed the medical testimony in a like manner in concluding that a continuous trigger (from the date of implantation to manifestation) was appropriate:

> The greater weight of the evidence, in the context of the undisputed fact of systemic disease symptoms and the assumed fact of legal causation and the necessary interference of the occurrence of an abnormality, supports the conclusion that the leaking silicone gel is the cause, the cellular damage is the injury, and the disease symptoms are the effects. Such cellular damage is determinable, constitutes the underlying bodily harm without which there would be no manifestation in the form of disease symptoms, and satisfies the "actual injury" legal standard for trigger.
>
> Finally, on the evidence and the assumptions noted above, the court concludes that a "continuous trigger" standard must be employed in this case. Thus, all policies are triggered if they were in effect at the time of implant or at the time of manifestation of symptoms or at any time between those events.

Id. at 9-10. Most significant, however, was the court's observation that it was guided by a "principle" that "the court cannot adopt any policy interpretation or construction that would have the practical effect of rendering insurance coverage illusory." *Id.* at 4. The court did not,

the fact that the asbestos-related disease was progressive and continuous in nature for medical purposes meant that the term injury in the insurance contract should be separately triggered in each policy period in which some part of a progressive, continuous injury was deemed to exist. Most injuries are progressive and continuous to the extent that the healing or repair process is not instantaneous; yet, courts subject only a small subset of injuries to continuous trigger analysis.

The courts appear to apply a continuous trigger for essentially instrumental reasons—since the injury underlying the claims is progressive, the policy language needs to be liberally construed to fit the occasion. Courts implicitly concede the point when they observe that interpretation of the policy language is context driven without explaining how context informs the analysis.[111]

There is nothing particularly novel about the context thesis; it has often been observed that all decisionmaking is essentially contextual.[112] It would be surprising if this insight were not applied to standardized contractual language that must address myriad fact situations in cases where the controlling decision as to the scope and application of *the* language to *a* situation is made *post hoc* rather than *ex ante*. Courts implicitly adopt this approach when they suggest that a continuous trigger may be limited to asbestos and hazardous

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however, specifically address how that principle applied in the case before it or how that "principle" differed from the concept of "coverage maximization." *See supra* note 90. Other decisions finding that cellular damage constitutes an injury in fact triggering coverage under an occurrence liability insurance policy include: Zurich Ins. Co. v. Raymark Indus., Inc., 514 N.E.2d 150, 156 (Ill. 1987) (involving asbestos-related disease); Chantel Assocs. v. Mount Vernon Fire Ins. Co., 656 A.2d 779, 785 (Md. 1995) (involving lead poisoning); *but cf.* Owens-Illinois, Inc. v. United States Ins. Co., 650 A.2d 974, 984 (N.J. 1994) (stating that in asbestos-related disease claims context, the "fact that a doctor would characterize cellular damage as a discrete injury does not necessarily imply that the damage is an 'injury' for the purpose of construing the policies").

111.

> The Court's duty is to attempt to apply the above plain and unambiguous language to the asbestos context in order to determine which policies are triggered. However, consideration of the medical evidence may convince the Court that the policy language is ambiguous as applied to the medical facts concerning the effects of asbestos inhalation.

See supra note 58, at 22; *see also* Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 984 (N.J. 1995). The idea that plain meaning is contextual has been accepted by other courts. *See, e.g.*, AIU Ins. Co. v. Superior Court, 799 P.2d 1253, 1267-75 (Cal. 1990) (meaning of damages in CGL policy must be determined based on reasonable expectations of policyholder).

112. *See, e.g.*, H.L.A. HART, THE CONCEPT OF LAW 125 (1961) (noting that attempts to control future conduct, as by legislation or contract, are necessarily limited by the parties "relative ignorance of fact" and "relative indeterminacy of aim"); *cf.* E. ALLAN FARNSWORTH, CONTRACTS § 7.10 (2d ed. 1990) (noting that "it is questionable whether a word has a meaning at all when divorced from the circumstances in which it is used").

waste contamination contexts.[113] In effect, the insurance policy is "adjusted" to fit the case. Reasoning from that postulate, courts appear to have concluded that a continuous trigger is an appropriate method for dealing with the unique questions raised by mass exposure torts.[114] While this approach has been widely adopted, it simply begs the question: What factors or aspects of the insurance contract or the insurance relationship warrant adoption of an indemnity continuous trigger for mass exposure tort claims? To acknowledge that decisionmaking regarding policy interpretation and construction is contextual is not to suggest or concede that it is unbounded.[115] We still must identify the factors and policies that make a continuous trigger more appropriate than a single trigger in a particular context. It is to these factors and policies that we now turn.

2. *Defense Versus Indemnity*

One aspect of the continuous trigger debate that is salient to the propriety of adopting a continuous trigger is often overlooked. The leading cases espousing a continuous trigger involve the duty to defend,[116] not the duty to indemnify. As countless courts have observed, the duty to defend is broader than the duty to indemnify, and the defense obligation may exist when in fact no duty to indemnify will arise.[117] The case for adopting a

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113. *See, e.g.*, Dow Chem. Corp. v. Associated Indem. Co., 724 F. Supp. 474, 483 (E.D. Mich. 1989).

114. This uniqueness argument has been raised by Judge Weinstein who has made no secret of his belief that mass exposure torts require modification of the legal process and rules that are applied in "traditional" litigation. *See, e.g.*, Jack B. Weinstein, *Ethical Dilemmas in Mass Tort Litigation*, 88 NW. U. L. REV. 469 (1994).

115. HERBERT A. SIMON, ADMINISTRATIVE BEHAVIOR 241 (3d ed. 1976) (noting that decision making is generally an exercise in bounded rationality where predetermined goals and objectives guide but do not dictate particular results).

116. *See, e.g.*, Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034, 1039 (D.C. Cir. 1981) (noting that the procedural posture of the case was that the defendant carriers had rejected Keene's tender of the cases for defense and indemnification). Although indemnification is mentioned at several points in the opinion, it does not appear that payments for closed claims were sought or litigated. *Id.* at 1050 (focusing on defense and defense costs). *See also* Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878 (Cal. 1995). There are cases which have applied a continuous indemnity trigger, but they have done so without acknowledging, much less discussing, the significant differences between the duty to defend and the duty to indemnify.

117. *See, e.g.*, Detroit Edison Co. v. Michigan Mut. Ins. Co., 301 N.W.2d 832, 835 (Mich. Ct. App. 1980) (stating that the carrier must defend the policyholder so long as the allegations "even arguably come within the policy coverage"); Gray v. Zurich Ins. Co., 419 P.2d 168, 177 (Cal. 1966) (stating that the carrier must defend when there is a *potentiality* that the carrier will have to indemnify the policyholder). The converse is also true—the duty to indemnify may exist when the evidence at trial demonstrates that the claim is covered even though the allegations did not show a covered claim. *See* Delta Sand & Gravel Co. v. General Ins. Co., 826 P.2d 82, 85 (Or. Ct. App. 1992).

defense continuous trigger is different from that for adopting an *indemnity* continuous trigger.

Unlike the determination of whether the duty to indemnify attaches, which involves a retrospective analysis of a record of established facts,[118] the determination of whether the duty to defend attaches involves a prospective analysis which must be done largely in the absence of a record of established facts. The carrier must make this determination at the time the policyholder informs the carrier that a lawsuit has been commenced.[119] At the time of lawsuit commencement, the carrier is in the least informed position relative to what the actual facts regarding coverage will eventually be found to be.[120]

A consequence of decisionmaking under a veil of uncertainty is that the risk of error is significant. Courts could attempt to weigh the respective costs of an erroneous decision and favor the party who would be harmed most by error. In other words, the costs of an erroneous decision for the policyholder (erroneous denial) would be compared with the costs of an erroneous decision for the carrier (erroneous acceptance). The approach is substantially similar to that used by courts to determine whether temporary equitable relief should be granted.[121] This approach would, however, require judicial involvement in

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118. *See infra* notes 133-34 and accompanying text.

119. Professor Abraham explored why a carrier would breach the duty to defend under the assumption that the liability costs for nonperformance in doubtful cases are greater than performance costs in doubtful cases. KENNETH S. ABRAHAM, DISTRIBUTING RISK 195-96 (1986). Professor Abraham noted that breach was most often caused by uncertainty:

> Nevertheless, the duty to defend sometimes is breached. As in the case of settlement of suits against the insured, however, the reason generally is not subjective bad faith, but contractually unregulated discretion. The problem is that policies provide for a duty to defend whenever a judgment against the insured in the suit in question would be payable under the policy. But if at the outset of a suit against the insured the ultimate coverage responsibility of the insurer under the policy is uncertain, then it is also unclear whether the duty to defend has been triggered. The language of the standard liability policy provides almost no guidance.

Id. at 196 (footnote omitted).

120. A consequence of this information deficit is that the carrier is required to make its coverage decision based on facts known when the tender is made. Courts may bar the carrier from using posttender discovery to justify previous coverage denials. *See, e.g.*, Haskel, Inc. v. Superior Court, 39 Cal. Rptr. 2d 520, 527-28 (Ct. App. 1995) (holding that a carrier may not seek to delay adjudication of its defense obligation until it develops sufficient evidence to justify retroactively its refusal to provide a defense on tender of the claim). The court did note that once a carrier was able to demonstrate that it had no defense obligation as a result of posttender investigation and discovery, it could obtain declaratory relief from its defense obligation. *Id.* at 528.

121. DAN B. DOBBS, LAW OF REMEDIES: DAMAGES—EQUITY—RESTITUTION § 2.11(2) (2d Student ed. 1993) (noting that the risk of an erroneous decision at the time temporary equitable relief, in the form of a temporary restraining order or preliminary injunction, is requested is a substantial factor in the decision to grant or deny temporary equitable relief).

a vast number of private decisions. Courts have opted to establish rules which operate to encourage, perhaps "coerce" is a more appropriate term, carriers to accept tenders in all doubtful cases and to absorb the cost of erroneous acceptances as a cost of doing business.[122]

When confronted with claims arising out of mass exposure torts neither the policyholder nor the policyholder's carriers may be able to identify at the outset of the litigation which claim(s) align with which specific policy period(s). It is not uncommon for a policyholder to make policy changes, including changing carriers, policy limits, and scope of coverage. The policyholder may have been uninsured for a significant period of time. Matching claims to policy periods enables a carrier to determine if the risk belongs to the carrier, another carrier, or the policyholder. If the risk belongs to the carrier, the policy limits and coverage applicable to that risk can be determined.[123]

> It is most unlikely that courts intend to ignore the potential harm an erroneous injunction could cause to the defendant. In fact, courts have long considered the possibility that error at the preliminary stage could cause irreparable harm to *either* party and have long tried to take that risk of error into account in deciding whether an injunction should go before trial.
>
> So the gist of the standards is probably easy to understand in common sense terms even if the expression is imperfect: the judge should grant or deny preliminary relief with the possibility in mind that an error might cause irreparable loss to either party. Consequently the judge should attempt to estimate the magnitude of that loss on each side and also the risk of error.

Id. (footnote omitted).

122. *See* Montrose Chem. Corp. v. Superior Court, 861 P.2d 1153, 1157 (Cal. 1993) (noting that courts have been solicitous of policyholders' expectation that carriers will assume the defense of a policyholder immediately on tender of the defense). *See generally* James M. Fischer, *Broadening the Insurer's Duty to Defend: How* Gray v. Zurich Insurance Co. *Transformed Liability Insurance into Litigation Insurance*, 25 U.C. DAVIS L. REV. 141 (1991) (concluding that the judicial motivation behind expansion of the carrier's duty to defend was to encourage carriers to provide settlement dollars in doubtful coverage cases).

123. Identification of a claim to a specific policy period is also necessary from the policyholder's perspective. Most courts treat tender of the claim to the carrier as a condition to the triggering of the duty to defend. *See* SCSC Corp. v. Allied Mut. Ins. Co., 533 N.W.2d 603, 614 (Minn. 1995), *amended by* 536 N.W.2d 305 (Minn. 1995) (finding that formal tender of defense of claim to carrier is condition precedent to recover costs of defense); *see also* La Farge Corp. v. Hartford Cas. Ins. Co., 61 F.3d 389, 399-400 (5th Cir. 1995); Eastman v. United States, 257 F. Supp. 315, 319 (S.D. Ind. 1966); Celina Mut. Ins. Co. v. Citizens Ins. Co., 349 N.W.2d 547, 551 (Mich. Ct. App. 1984). Mere notice of the claim to the carrier absent a tender is generally deemed insufficient to trigger the duty to defend. *See* Sampson v. Cape Indus., Ltd., 593 N.E.2d 1158, 1161 (Ill. App. Ct. 1992). *But see* Employers Cas. Co. v. Mireles, 520 S.W.2d 516 (Tex. Civ. App. 1975) (holding that notice to carrier was sufficient); Towne Realty, Inc. v. Zurich Ins. Co., 548 N.W.2d 64, 67 (Wis. 1996) (holding that tender occurs once policyholder gives notice of claim to carrier; any uncertainty as to policyholder's motives must be resolved by the carrier). Constructive tender may also be recognized. *See*

Delay is inherent in any process, which would require some fact finding, negotiation, or adjudication prior to assignment of a claim to a specific policy period and hence a specific carrier so that a tender could be made. To avoid that delay, and assuming for the sake of simplification that the sole issue is one of when bodily injury or property damage occurred, courts may adopt a defense continuous trigger which obligates carriers, which have a duty to defend their policyholders, to defend first and litigate defense obligations second.[124] This approach is consistent with standard CGL language in which primary carriers make a specific, affirmative promise to defend, not a promise to reimburse the policyholder or a promise simply to pay the costs of defense. Primary carriers promise a specific type of performance, not the payment of money to procure performance by another.

A defense continuous trigger is also consistent with the reasoning that has led many courts to adopt the "potentiality" test as a duty to defend test.[125] It is, finally, consistent with the principle that the duty to defend

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White Mountain Constr. Co. v. Transamerica Ins. Co., 631 A.2d 907, 910 (N.H. 1993) (finding that notice by policyholder to carrier of claim constituted implicit tender when notice was coupled with policyholder's statement of its belief that carrier had duty to defend). The tender should provide sufficient notice to the carrier so that it can reasonably determine if the tendered claim raises a duty to defend. The burden may be different depending upon whether the carrier's duty is deemed to sound in contract or in tort. *See* California Shoppers, Inc. v. Royal Globe Ins. Co., 221 Cal. Rptr. 171, 189, 201-03 (Ct. App. 1985) (holding that carrier breached contractual duty to defend by failing to investigate or follow up inadequate tender, but carrier's breach did not constitute tortious bad faith).

124. Carriers which accept tenders may find that they will be the beneficiaries of more favorable expense allocation rules than carriers which refuse tenders. *See, e.g.*, Buss v. Superior Court, 50 Cal. Rptr. 2d 447, 457-58 (Ct. App. 1996), *review granted*, 917 P.2d 1165 (Cal. 1996) (holding that carrier which accepts tender of claim containing both potentially covered and uncovered claims may allocate defense costs between potentially covered and uncovered claims; moreover, while carrier has the burden of proof, test is not "undeniable evidence of allocability of specific expenses" but preponderance of evidence because stricter "undeniable evidence" test is reserved for cases when carrier breaches promise of defense); *see also* Imcera Group, Inc. v. Liberty Mut. Ins. Co., 50 Cal. Rptr. 2d 583, 607 (Ct. App. 1996), *review granted*, 917 P.2d 1164 (Cal. 1996) (permitting carrier which accepts tender to allocate portion of defense costs into uninsured years when defense continuous trigger is used), *review granted*, 54 Cal. Rptr. 2d 41 (Cal. 1996).

125. *See, e.g.*, Montrose Chem. Corp. v. Admiral Ins. Co., 861 P.2d at 1161:

> In other words, the insured need only show that the underlying claim *may* fall within policy coverage; the insurer must prove it *cannot*. Facts merely tending to show that the claim is not covered, or may not be covered, but are insufficient to eliminate the possibility that resultant damages (or the nature of the action) will fall within the scope of coverage, therefore add no weight to the scales.

See also Hecla Mining Co. v. New Hampshire Ins. Co., 811 P.2d 1083, 1089 (Colo. 1991). *See generally* 7C JOHN APPLEMAN, INSURANCE LAW & PRACTICE § 4683.01 (Berdal ed., 1979 and 1996 Supp.).

relates to the possibility of coverage not the actuality of liability.[126] In mass exposure torts, there is the potentiality of coverage of the claim within more than one policy period. It is reasonable and consistent with the goal of encouraging the prompt providing of a defense when a claim is potentially covered, even if the potential is remote,[127] to use a defense continuous trigger and defer coverage disputes until indemnification issues become prominent.[128]

The arguments which favor the adoption of a defense continuous trigger counsel against adoption of an indemnity continuous trigger. Unlike the duty to defend which can be triggered by the possibility of coverage, even if the claim itself is false or groundless,[129] the duty to indemnify is triggered by the actuality of coverage. Simply put, no coverage, no indemnity.[130]

Unlike the question of providing a defense, whether a carrier must provide an indemnity is determined from an adjudication involving the policyholder.[131] Because of the prevalence of "no action" clauses in liability insurance contracts, which bar direct actions against carriers by claimants or policyholders for indemnification, a general precondition to accessing indemnification without the consent of the carrier is conclusive adjudication of the policyholder's liability.[132] The adjudication in turn rests on a record. It is this fact which has led courts to note the conflict of interest of the carrier whose control of the defense enables it to control the very thing (the record) which will determine whether it has any obligation to indemnify the

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126. *Id.* § 4682.

127. *See* Montrose Chem. Corp. v. Superior Court, 861 P.2d at 1157 (holding that a duty to defend exists when a possibility exists that the claim may be covered by the policy).

128. *See* Burroughs Wellcome Co. v. Commercial Union Ins. Co., 632 F. Supp. 1213, 1220 (S.D.N.Y. 1986) (holding that the possibility that exposure to the DES might result in injury to claimants within the policy period triggered the carrier's duty to defend). When more than one carrier's defense obligation is triggered and *one* of the carriers assumes the defense, the *other* carriers need not provide additional or back-up defenses. *See, e.g.*, Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034, 1050-51 (D.C. Cir. 1981). Preliminary coverage decisions related to the duty to defend may also require that certain legal assumptions be made that will not be made for purposes of final coverage determinations associated with indemnification. *See, e.g.*, *supra* note 110 (assuming in context of breast implant insurance coverage dispute that claimants' injuries were *caused* by the policyholder's product).

129. *See, e.g.*, Catholic Diocese v. Raymer, 825 P.2d 1144, 1147 (Kan. App.) (quoting Patrons Mut. Ins. Ass'n v. Harmon, 232 P.2d 741, 744 (Kan. 1987)) (carrier must defend even when potentiality of coverage is remote), *aff'd*, 840 P.2d 456 (Kan. 1992); *see also supra* note 52.

130. *See, e.g.*, Pennsylvania Mfrs. Ass'n Ins. Co. v. Lumberman's Mut. Cas. Co., 648 F.2d 914, 918 (3d Cir. 1981) (holding that a duty to defend and duty to indemnify are not coterminous and that circumstances may exist where carrier must defend, but damages award may be payable by another, including the policyholder); McLeod v. Tecorp Int'l, Ltd., 865 P.2d 1283, 1288 (Or. 1993); *see also* ROBERT JERRY, UNDERSTANDING INSURANCE LAW § 111[b], at 562-63 (1987).

131. *See* JERRY, *supra* note 130, § 84, at 415 (1987).

132. *See id.* § 84[b], at 418.

policyholder.[133] The record is evidence not only of the claim but also of those facts which will show whether the claim is covered—what type of injury underlies the claim.[134] Most importantly for purposes of the trigger determination, an evidentiary record provides the concreteness as to when the loss occurred that is missing when the defense obligation is being considered.

Two counterarguments may be offered in support of the use of an indemnity continuous trigger in mass exposure torts. First, even an evidentiary record may leave the issue of timing—when did the loss occur—murky. Second, most lawsuits settle and the trigger rule must address litigation realities.

a. *Quality of the record.* It may be conceded that not every adjudication of an underlying claim will necessarily amplify the record and facilitate coverage determinations. The coverage issue may not be foremost in the claimant's mind, although the availability of insurance to satisfy a judgment is probably considered in most cases. All other things being equal, claimants probably prefer that a judgment be insurable; nevertheless, before that issue is resolved, the claimant must secure the judgment. It may be expected that absent efforts to set up a carrier for a bad faith action, the claimant's primary focus will be on establishing the policyholder's liability and only secondarily on assuring that the resulting judgment is within coverage. I do not want to be understood as minimizing the claimant's coverage concerns.[135] However, the more solvent the defendant and the more likely the defendant may be able to respond to a damages award without resort to insurance, the less emphasis the claimant will place on presenting a case that preserves the defendant's coverage. Mass exposure tort claims are generally prosecuted against defendants with extensive financial resources even if liability insurance is put aside. In these contexts, the presence or absence of insurance is not as significant as in cases when the defendant's primary litigation asset is the insurance policy. Nevertheless, given the significant sums sought by claimants, the desire to access available insurance cannot be denied. In the situations where mass tort claims are prosecuted in a class action or consolidated format, the importance of insurance increases and

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133. *See* OSTRAGER & NEWMAN, *supra* note 33, § 2.03[a].

134. For example, while the policy language "bodily injury" provides broad coverage, pure emotional distress is usually treated as outside coverage. *See, e.g.*, National Cas. Co. v. Great Southwest Fire Ins. Co., 833 P.2d 741, 746 (Colo. 1992) (en banc). A majority of courts hold that the term "bodily injury" in standard liability policy does not encompass pure emotional distress. *Cf.* Garvis v. Employers Mut. Cas. Co., 497 N.W.2d 254, 257 (Minn. 1993) (holding that pure emotional distress does not constitute bodily injury, but emotional distress with resulting physical manifestation of injury does constitute a bodily injury). A claim for bodily injury could trigger the duty to defend. A claim for bodily injury which was eventually determined to encompass only pure emotional distress would not trigger indemnity coverage.

135. *See* Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Counsel*, 45 DUKE L.J. 255, 258 (1995) (noting that the presence or absence of liability insurance explains a great deal of what happens in litigation).

it is in these situations that we see traditional adversarial relationships break down and new ones form.[136]

It may be accepted that the interests of the parties in the underlying liability litigation will not necessarily be focused on creating a record that will facilitate a fair and equitable coverage determination. Indeed, the strategic interests of the parties to the settlement may be just to the contrary.[137] On the other hand, it should not be supposed that the litigation will be conducted in a fashion to create a misshapen record for coverage purposes. Insofar as the policyholder and carrier are concerned, the carrier is generally restricted in its control of the defense that it not prejudice the policyholder, although the term prejudice must be somewhat qualified.[138] Whether the policyholder is similarly restricted is less clear; cases addressing this issue, in the absence of carrier breach, are not common.[139] Nonetheless, the contractual and implied

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136. *See* John C. Coffee, Jr., *Class Wars: The Dilemma of the Mass Tort Class Action*, 95 COLUM. L. REV. 1343 (1995). Recently, in *Flanagan v. Ahearn*, 90 F.3d 963 (5th Cir. 1996), Judge Jerry Smith dissented from the majority's approval of a mass tort settlement class action that operated to bar opt outs. Judge Smith noted that the practical effect of the settlement was to enrich the policyholder and claimants' counsel at the expense of the absent members of the class. *Id.* at 994 (dissenting opinion).

137. *See* Lynn M. Lopucki, *Legal Culture, Legal Strategy, and the Law in Lawyers' Heads*, 90 NW. U. L. REV. 1498, 1533-41 (1996) (describing how lawyers may advance their clients' goals by using strategies that align with their adversaries' assumptions as to how the process is supposed to work but which achieve what Lopucki characterizes as "system unintended consequences").

138. *See generally* William T. Barker, *When Does the Insurer Lose the Right to Control the Defense?*, 58 DEF. COUNS. J. 469 (1991) (discussing what situations create a conflict of interest such as to deprive the carrier of its contractual right to control the defense).

139. When the carrier breaches, the general rule is to permit the policyholder to assume control of the defense. Any resulting settlement, absent fraud or collusion, is generally deemed binding on the breaching carrier. *See* Isaacson v. California Ins. Guar. Ass'n, 750 P.2d 297, 308 (Cal. 1988). *See generally* RESTATEMENT (SECOND) OF JUDGMENTS § 57 (1980) (noting that indemnitor is bound by judgment establishing indemnitee's liability if indemnitor bypassed opportunity to take control of the defense). There is authority to the contrary holding that a carrier which breaches its duty to defend is not estopped from contesting coverage under the duty to indemnify. *See* Sentinel Ins. Co. v. First Ins. Co. of Haw., 875 P.2d 894, 909-14 (Haw. 1994); Polaroid Corp. v. Travelers Indem. Co., 610 N.E.2d 912, 919-22 (Mass. 1993). *See generally* 7C APPLEMAN, *supra* note 125, § 4690.

A few cases have obligated carriers to cover settlements negotiated by the policyholders without the input of the carriers and in the absence of a finding that the carrier breached a duty owed to the policyholder under the insurance contract. Each of the cases is, however, unusual in its factual setting and it is unclear to what extent the decisions should be extended or whether, on their facts, they were correctly decided. In *Uniroyal Inc. v. Home Insurance Co.*, 707 F. Supp. 1368 (E.D.N.Y. 1988), the court rejected the carrier's contention that it was entitled to a no coverage decision because the policyholder failed to establish that actual injury took place within the relevant policy periods. *Id.* at 1378. The policyholder had settled product liability claims through a class action settlement approved by the court. *Id.* at 1378-79. The court held: (1) the policy contemplated the compromise of claims; (2) the carrier's

duties of both the carrier and policyholder would suggest that absent breach each party should refrain from conduct that is harmful to the interests of the other party, except to the extent either party has contractually authorized the other party to act notwithstanding some adverse impact on the first party's interests.[140] The means of accomplishing this idea of mutually restraining the carrier and the policyholder from harming the other to help itself, remains a question that attracts the attention of the legal community.[141]

It should be expected that even a partial, incomplete record will reduce uncertainty and thus assist in the determination of the trigger issue, that is, when bodily injury or property damage occurred.[142] Of course, even a developed record may not provide the answer to the trigger issue. How often

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position would complicate the policyholder's life; and (3) the carrier's position would undermine the judicial policy favoring settlements; therefore (4) a reasonable settlement entered into by the policyholder should bind the carrier. *Id.* These points are inadequate to support the position taken. *See infra* notes 156-57 and accompanying text.

In *UNR Industries, Inc. v. Continental Casualty Co.*, 942 F.2d 1101 (7th Cir. 1991), the policyholder's bankruptcy reorganization, which included the compromise of outstanding claims against the policyholder, was deemed a judgment or settlement which triggered an excess policy which defined loss in terms of a judgment or settlement. *Id.* at 1104-05. The bankruptcy court's valuation of claims against the policyholder was binding on the excess carrier despite the no action clause in the policy. *Id.* The carrier had notice of the bankruptcy organization and the opportunity to participate. *Id.* The court further found that the carrier was not unreasonably deprived of the benefits of the no action clause, which the court defined as protecting the carrier from collusive or overly generous settlements at the expense of the carrier, because:

> [T]he reorganization could not have taken place with the consent of just UNR (insured) and the asbestos victims. UNR's other creditors also had to approve, and they had a strong reason to fight for as low a valuation of the asbestos claims as possible. The lower the valuation, the greater the portion of UNR's assets these other creditors could reach. This antagonism of interests removes any significant danger that the $254 million valuation of the asbestos victims' claims might contain any artificial inflation at CNA's expense.

Id. at 1106.

140. For example, control of the defense permits the carrier to settle a claim even though, because of deductible reimbursement obligations, the policyholder will bear all or a substantial portion of the loss. *See* Jon Epstein, Annotation, *Liability of Insurer to Insured for Settling Third Party Claim Within Policy Limits Resulting in Detriment to Insured*, 18 A.L.R. 5th 474, 487-88 (1994) (noting that majority of jurisdictions do not permit the policyholder to escape the obligation to reimburse the carrier for deductibles after the carrier has settled a claim against the policyholder).

141. *See generally* Symposium, *The Law of Bad Faith in Contract and Insurance*, 72 TEX. L. REV. 1203 (1994).

142. *Cf.* Hudson Ins. Co. v. City of Chicago Heights, 48 F.3d 234, 237-38 (7th Cir. 1995) (finding that although jury verdict was returned but never entered because of subsequent settlement, the record demonstrated that policyholder intentionally discriminated and expected resulting injury thereby precluding coverage).

that would happen cannot be predicted. Yet, the fact that the existence of an evidentiary record will not unequivocally answer the trigger question in each case is no reason to reject an approach that will help answer the question in a great many cases. As Voltaire once noted, "the best is the enemy of the good."[143] We should not sacrifice a mechanism that will work, and work well in a good many cases, simply because we cannot guarantee it will work in every case. In some instances, the coverage issue may require further adjudication;[144] in some cases, the problem may resist fact finding and require ad hoc solutions.[145] But the fact that in some cases we may need to go beyond the record developed and prepared in the underlying case should not cause us to ignore the reality that the record may provide answers to the question of which insurance policy is responsible to indemnify for a particular loss.

Proponents of an indemnity continuous trigger will argue that in many cases the evidentiary record will demonstrate that individual claims implicate multiple policy periods. For example, asbestos bodily injury claimants may show that they were exposed to asbestos in successive policy periods or the medical evidence may support their claim that their injuries were aggravated or enhanced by asbestos in residence in their bodies. Should such an evidentiary record, when combined with policy language that requires the carrier to pay "all sums [or those sums] which the policyholder becomes legally obligated to pay as damages because of 'bodily injury' . . . to which this insurance applies,"[146] support the use of a continuous trigger? These claimants may also argue that their progressive loss cases are distinguishable from the process of nature claims which a single insult, such as a dog bite or blow, progresses to a more serious injury, such as rabies or a concussion, respectively. The modern progressive loss cases may involve cumulative injuries from multiple, distinct events rather than the linear progression from a single insult which exemplifies the process of nature claim.

The multiple policy period injury argument has appeal but ultimately proves too much, confuses distinct concepts, and creates unnecessary burdens. The argument proves too much because it unduly emphasizes differences

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143. VOLTAIRE, LA BÉGUÈDE (1772).

144. The needed specificity may be found in subsequent coverage litigation. *Cf.* SCSC Corp. v. Allied Mut. Ins. Co., 533 N.W.2d 603, 615 (Minn. 1995) (finding no prejudice resulted from the giving of jury instructions which requested the jury to find a single date of injury when jury found that injury was not divisible and thus entire loss was necessarily allocated to policy period in which jury found actual injury occurred).

145. *See, e.g.*, Uniroyal, Inc. v. Home Ins. Co., 707 F. Supp. 1368, 1392 (E.D.N.Y. 1988) (determining that bodily injury due to exposure to defoliant Agent Orange occurred one week after initial exposure).

146. This is standard language in CGL policies—the brackets refer to a terminology change adopted in the mid-1980s. Carriers often argue that the relevant language is not the "all sums" phrase but the language "to which this insurance applies" which is defined in the policy as: "This insurance applies to 'bodily injury' . . . which occurs during the policy period." Carriers also contend that if a continuous trigger is used, the loss must be divided up and allocated to each policy period triggered. This is known as "pro rata" allocation.

between loss and aggravation of loss. Aggravation of loss is part of the single loss unless the past, present, and future losses can be deemed divisible and capable of separate identification by a function other than time. We may draw an analogy from the Law of Remedies. A plaintiff is normally entitled to recover future damages relating to a present injury.[147] The converse is also true: The failure to seek recovery of future damages usually operates as a bar to their recovery in a separate action.[148] The distinction is usually expressed in terms of the relatedness of the injury to the loss-engendering event.[149] Included within the initial loss or injury are aggravation and intensification of the loss or injury, even though the latter consequences might far outstrip the initial manifestations, for example, the bruise that turns out to be a concussion that results in death, or the sore back that turns out to involve a crushed vertebrae.[150]

The argument that multiple exposures or multiple injurious insults amount to divisible occurrences over different policies represents simply affixing a different label or separate characterization to what is essentially a single occurrence.[151] The issue is essentially one of causation—did the loss

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147. *See* David Minneman, Annotation, *Future Disease or Condition, or Anxiety Relating Thereto, as Element of Recovery*, 50 A.L.R. 4th 18 (1986).

148. *See* RESTATEMENT (SECOND) OF JUDGMENTS § 18 cmt. b, illus. 1 & 2 (1982) (discussing merger); *id.* § 24 (involving splitting causes of action).

149. *Id.* §§ 24-25. *See generally* JAMES FLEMMING, JR. ET AL., CIVIL PROCEDURE § 11.8 (4th ed. 1992) (discussing scope of claim preclusion arising out of prior adjudication); *cf.* Martinez-Ferrer v. Richardson-Merrell, Inc., 164 Cal. Rptr. 591 (Ct. App. 1980). In *Martinez-Ferrer*, the plaintiff's 1976 claim for damages (cataracts) allegedly caused by taking MER/29 in 1960 was not time barred even though in 1960 he had sustained injuries (dermatitis) that his physician told him were likely caused by MER/29, and some swelling of the retina (macula edema) which the plaintiff's ophthalmologist "assumed" might be caused by MER/29. *Id.* at 592-93, 597. The court found that because the plaintiff's cataract was sufficiently distinct from his earlier injuries, his action did not accrue until he discovered or should have discovered it. *Id.* at 594. *See also* Fearson v. Johns-Manville Sales Corp., 525 F. Supp. 671, 673-74 (D.D.C. 1981) (finding that distinct injuries may give rise to separate causes of action with different accrual dates). This dual or multiple injury concept is well known in limitations law. *See, e.g.*, Braune v. Abbott Lab., 895 F. Supp. 530, 555-56 (E.D.N.Y. 1995) ("Under the [two-injury] rule, diseases that share a common cause may nonetheless be held separate and distinct where their biological manifestations are different and where the presence of one is not necessarily a predicate for the other's development."); *see also* Wilber v. Owens-Corning Fiberglass Corp., 476 N.W.2d 74, 78 (Iowa 1991) (holding that manifestation of asbestosis does not trigger the running of the statute of limitations on all "separate, distinct, and later-manifested diseases" which may have stemmed from the same exposure).

In cases where incremental injuries are recognized, such as temporary versus permanent nuisances, the distinction is recognized as instrumental and not grounded in the nature of the injury. *See* DAN B. DOBBS, LAW OF REMEDIES § 5.11(3) (West 1993).

150. *See generally* CHARLES T. MCCORMICK, HANDBOOK ON THE LAW OF DAMAGES § 76 (1935).

151. When the question is framed in terms of the number of occurrences within a defined policy period because an insurance policy has "per occurrence" limits, the dominant view is to

emanate or was it "hurried up" by the loss engendering event—at least this is how the question is generally conceived when substantive liability is concerned.[152] An occurrence liability policy is triggered by an accident, not the measure of the consequences of an accident. That the loss is progressive is not to say it is multiple or divisible. If every event associated with a loss is characterized as an occurrence, the concept of policy periods would be rendered meaningless.

The additional insults qualification appears to rest on the premise that if a separate liability engendering event or cause aggravates or contributes to an existing loss or loss in progress, the policy in effect when the additional insult occurs is triggered and may be called upon by the policyholder. If this qualification is accepted by the courts, it should be applied consistently. It is essentially a continuous exposure trigger. Once the exposure ceases, further aggravation or development of the loss or injury cannot be attributed to separate, distinct events within subsequent policy periods. Consequently, acceptance of the additional insults qualification requires acceptance of a continuous exposure trigger over a continuous injury trigger.[153]

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use a proximate cause approach. *See* CSX Transp., Inc. v. Continental Ins. Co., 680 A.2d 1082, 1091 (Md. 1996). For example, in United Services Automobile Ass'n v. Baggett, 258 Cal. Rptr. 52 (Ct. App. 1989), the court held that there was a single occurrence when the policyholder negligently struck the decedent's vehicle immediately before a third vehicle struck both vehicles, killing the decedent who was standing next to her vehicle. *Id.* at 58. If liability is based on the policyholder's general policy or practice, the tendency is to treat all claims based on that policy as involving one occurrence. *See, e.g.*, Chemstar Corp. v. Liberty Mut. Ins. Co., 41 F.3d 429, 433 (9th Cir. 1994) (holding that faulty plaster pitting in 28 separate homes constituted a single occurrence under manufacturer's liability insurance policy where essential cause of the losses was the manufacturer's failure to warn which consisted of its failure to mark properly bags in which its product was shipped to ultimate users); Mead Reinsurance v. Granite State Ins. Co., 873 F.2d 1185, 1188 (9th Cir. 1988) (holding that when insured's liability *must* be based on custom or policy, such as municipal liability under 42 U.S.C. § 1983, there was necessarily only one occurrence); Transport Ins. Co. v. Lee Way Motor Freight, Inc., 487 F. Supp. 1325, 1326 (N.D. Tex. 1980) (holding that there was one occurrence when all discrimination claims were based on policyholder's pattern and practice of discrimination). A few courts have reached contrary results by emphasizing any temporal disparity between the loss inflicting events. For example, in *American Indemnity Co. v. McQuaig*, 435 So. 2d 414 (Fla. Dist. Ct. App. 1983), the policyholder fired three shotgun blasts at two deputy sheriffs within a period of less than two minutes. *Id.* at 415. The court viewed the insured's activities to be sufficiently interrupted and discontinuous to amount to two occurrences. *Id.* at 416.

152. *See, e.g.*, Steinhauser v. Hertz Corp., 421 F.2d 1169, 1172-73 (2d Cir. 1970) (discussing a defendant's liability for all damages "proximately caused," or precipitated, by defendant's breach of duty).

153. Concededly, the courts have not acknowledged this distinction in mass tort contexts. *See* Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F.3d 1178, 1195-96 (2d Cir. 1995) (holding that successive injuries would justify a continuous injury trigger). If injury is indivisible, it should, however, be assigned to that policy period in which the evidence demonstrates that the injury first became real and appreciable, otherwise, any

Liability carriers provide coverage in temporal increments. Once a policy is triggered, it is responsible for the loss. There is a correlation that must be recognized: when a loss occurs within a policy period but that loss is aggravated or enhanced by events outside the policy period, the whole loss should be attributed to the carrier whose policy covers the period when the loss was first sustained.[154] Indeed, it is rather inexplicable that a system of loss allocation that has been recognized as workable and fair in the field of Remedies has been devalued without explanation, much less justification, when an insurance policy is called on to respond to the damages awarded under the Law of Remedies. Rather than a mismatch of remedy and accompanying insurance coverage, one would expect a match, or at least a reasoned explanation for the nonmatch.

It is simply wordsmanship, devoid of substance, to parse an event and its consequences, even an ongoing event, to find distinctions that transform an indivisible injury for remedial purposes into divisible components for insurance coverage purposes. This is particularly true when the effort serves no purpose other than to maximize or minimize coverage. Rules of construction applied to insurance policies should operate neutrally unless they are designed to deter or encourage desired conduct. For example, the biased rule of *contra proferentum* (construction against the drafter) can be justified as a default rule that encourages the drafter to use plain and unambiguous language in the contract. Such a practice, on its face, favors neither the policyholder nor the carrier. Of course, when the doctrine is applied, the policyholder invariably prevails. But this is done because it creates the necessary incentives for the drafter-carrier to implement the neutral goal—plain and unambiguous policy language. In the indemnity context, a continuous trigger rule serves no identified purpose other than to maximize coverage. Such a rule can hardly be called neutral, nor can it be validated by any external policy of deterrence.

b. *Settlement.* It may be argued that tying the indemnity coverage trigger to facts adduced at trial ignores the reality that most disputes settle short of a final adjudication necessary to create the factual record needed to apply the single trigger approach.[155] Claimants will be disinclined to settle

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injury with long-term consequences necessarily raises a continuous trigger argument for the policyholder. If the injury is divisible, a different result may be in order. In *United States Liability Insurance Co. v. Selman*, 70 F.3d 684 (1st Cir. 1995), the court held that each ingestion of lead paint by a child constituted a separate injury, triggering distinct policy periods. *Id.* at 689. The finding was based on medical testimony. *Id.* at 688-89. The medical evidence was that each major ingestion of lead paint probably caused brain damage and that increases in toxicity levels after each major ingestion were measurable. *Id.* Since each major ingestion apparently resulted in a distinct, separately measurable injury, the court found that more than one policy period could be triggered. *Id.* at 690.

154. *See, e.g.*, Home Ins. Co. v. Landmark Ins. Co., 253 Cal. Rptr. 277, 281 (Ct. App. 1988) (holding that a carrier on risk when property damage first manifests itself is liable for the entire loss).

155. Fewer than five percent of cases filed in federal court end in trial. ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS, ANNUAL REPORT OF THE DIRECTOR 186, 217 (1991)

unless a source of the settlement is identified and secured. Why accept a discount on the claim if satisfaction of the claim will require further litigation between the carriers and the policyholder over which policy periods to assign the loss? It will be difficult to persuade claimants to accept the discount on the claim unless closure can be obtained and payment guaranteed.

These concerns may be avoided if the carriers and the policyholder can agree on an interim funding mechanism with appropriate provisions for reimbursements depending on the ultimate resolution of the coverage issue. Such an arrangement, however, may be: (1) financially unfeasible because the policyholder is insolvent, (2) beyond the parties' ability to craft through the negotiation process,[156] or (3) deterred by the law of insurer bad faith.[157]

An indemnity single trigger may present a conflict of interests problem between carriers and policyholder(s) that an indemnity continuous trigger avoids. In the single trigger context, the conflict arises out of the differing interests the carriers and the policyholder may have regarding which policy period to assign the claim and the ability to influence, if not dictate, that decision by the control of the defense.[158] By vesting control of the defense in

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(stating that of 211,713 civil cases terminated between July 1, 1990 and June 30, 1991, only 11,024 involved trials). State court clearance rates are similar. For a discriminating and critical look at settlement rates, see Marc Galanter & Mia Cahill, *"Most Cases Settle": Judicial Promotion and Regulation of Settlements*, 46 STAN. L. REV. 1339 (1994).

156. Negotiation involves an inherent tension over the division of something, and this tension may be exacerbated by the negotiation tactics chosen by the parties, the needs of the parties at the moment, and each parties' perception of the needs of the others in the negotiation. *See* DAVID LAX & JAMES SEBENIUS, THE MANAGER AS NEGOTIATOR 30-35 (1986) (noting that the fundamental tension of negotiation may frustrate the ability of parties to achieve mutually beneficial agreements).

157. The carrier's duty to seek and evaluate settlement offers is independent of the policyholder's financial resources. In cases where coverage is at issue, the extent to which the carrier should or may involve the policyholder in the settlement process is unclear. For example, California courts have found carriers acted in bad faith when, in cases of disputed coverage, they failed to give policyholders an opportunity to contribute to the settlement. *See* Miller v. Elite Ins. Co., 161 Cal. Rptr. 322, 332 (Ct. App. 1980); *see also* Brown v. Guarantee Ins. Co., 319 P.2d 69, 75 (Cal. Ct. App. 1957) (listing whether the carrier attempted to convince the insured to make a settlement contribution as one of several factors to be considered in deciding if the carrier exercised bad faith in refusing to settle); *cf.* Palmer v. Financial Indem. Co., 30 Cal. Rptr. 204, 213 (Ct. App. 1963) (stating that carrier has no right to seek contribution from umbrella excess for settlement within the policy limits). At the very least court approval of the carrier's tactics may be necessary to avoid a successful bad faith claim. *Cf.* Maryland Cas. Co. v. Imperial Contracting Co., 260 Cal. Rptr. 797, 803-04 (Ct. App. 1989) (finding court approval of carrier's settlement as reasonable, and permitting a carrier action against policyholder for reimbursement of settlement expense when carrier defended under reservation of rights and it was subsequently determined that claim was not covered).

158. Normally the carrier controls the defense, including the right to select defense counsel. *See* Spindle v. Chubb/Pacific Indem. Group, 152 Cal. Rptr. 776, 781 (Ct. App. 1979) (holding that the carrier controls the defense including the selection of defense counsel to

the policyholder, the court avoids the potential that the carrier would conduct the defense in a fashion that would benefit the carrier over the policyholder and bind the policyholder to that position.[159] A policyholder who has control of the defense has, of course, a similar conflict which is the converse of that presented to the carrier; however, relatively little law has been written on this subject.[160]

A continuous trigger moots these concerns. A continuous trigger, with policyholder control over claim assignment to policy periods, removes the trigger issue from the carriers versus policyholder contentions list and places it on the carrier versus carrier contentions list. A continuous trigger approach, when coupled with joint and several liability, up to policy limits for *each* triggered policy, obligates carriers to fund settlement now and litigate their individual responsibility for the total loss, as between the carriers, later. Standing alone, this approach improves the possibility of settlement between the claimants and the policyholder. A continuous trigger also reduces conflicts of interest between the carriers and the policyholder that arise out of the carriers' control of the defense. A continuous trigger largely takes the policyholder out of the which-policy-period-is-triggered dispute. Assuming the settlement is within triggered aggregate limits, the policyholder becomes largely indifferent, except to the extent deductibles and retentions are impacted, as to how the loss is allocated among the carriers. Allocation then becomes the concern of only the contributing carriers. Consequently, control of the defense will not prejudice the policyholder, at least on this issue; hence, no conflict of interest exists between the carriers and the policyholder that necessitates depriving the carriers of their contractual right to control the defense.

These are not insubstantial arguments in favor of adoption of a continuous trigger over a single trigger for indemnification purposes.

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represent the policyholder in the underlying action); Merritt v. Reserve Ins. Co., 110 Cal. Rptr. 511, 527 (Ct. App. 1973) (holding that carrier must employ competent counsel for policyholder's defense). When a conflict of interest exists between the carrier and the policyholder, however, the right to control the defense may shift to the policyholder. *See* Tomelin v. Canadian Indem. Co., 394 P.2d 571, 577 (Cal. 1964). Jurisdictions vary as to the types of carrier-policyholder conflicts that will cause the carrier to lose its right to control the defense. *See generally* JERRY, *supra* note 130, § 114[d], at 613 (describing recurring forms of carrier-policyholder conflicts).

159. *See, e.g.*, McGee v. Superior Court, 221 Cal. Rptr. 421, 423-24 (Ct. App. 1985) (stating that mere reservation of rights did not create a conflict vesting in the policyholder the right to select defense counsel; the conflict must relate to the policyholder's conduct, which, as developed in the underlying action, will affect the determination of coverage).

160. *Cf.* Kaiser Found. Hosps. v. North Star Reinsurance Corp., 153 Cal. Rptr. 678, 682-83 (Ct. App. 1979) (holding that an excess carrier was not bound by claim assignments to particular policy periods agreed to between policyholder and primary carrier when assignments operated to expand excess carrier's obligations and limit primary carrier's obligations); *see also* First State Underwriters Agency v. Travelers Ins. Co., 803 F.2d 1308, 1314 (3d Cir. 1986) (holding that the excess carrier may challenge dates of loss assigned by policyholder and primary carrier).

Nevertheless, I do not believe that the arguments are substantial enough to carry the day. First, the principle that settlements should be encouraged cannot be treated as a legal *deus ex machina* that resolves all conflicts without the need for further reflection or consideration. The issue is not whether settlements should be encouraged but what values are advanced or retarded by settlement.[161] A legal policy that encourages settlement by depriving a carrier of a legitimate argument that the carrier bears no responsibility for the loss because it occurred outside the policy period and relegates the carrier to a battle among contributing carriers for contribution or indemnification sounds suspiciously like the legal policy of the Queen of Hearts, "Sentence first—verdict afterwards."[162] The realization that requiring a party to immediately advance funds and subsequently litigate whether the claimant is entitled to the funds has, in other contexts, called for the application of the strictest protections before the advance is required.[163]

Second, the use of a continuous trigger approach does not avoid determinations regarding which claims belong in which policy period—the determinations are simply deferred. Ultimately, an allocation must be made. A single trigger approach using the exposure test, the injury in fact test, or manifestation test may still be used to allocate the loss among the contributing carriers on a claim-by-claim basis. Alternatively, a formula may be used to allocate the loss.[164] Either approach, however, begs the question—why a

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161. While courts affirm the goal of settlement, primarily for functional purposes of docket control, they recognize that settlements as an end do not justify achievement by any means necessary. *See* Dawson v. United States, 68 F.3d 886, 897 (5th Cir. 1995) (finding that while settlements may be encouraged, they may not be forced, directly or indirectly, on parties who prefer not to settle). For a less than enthusiastic view of settlement, see Owen Fiss, Comment, *Against Settlement*, 93 YALE L.J. 1073, 1075 (1984) ("Like plea bargaining, settlement is a capitulation to the conditions of mass society and should be neither encouraged nor praised.").

162. LEWIS CARROLL, ALICE'S ADVENTURES IN WONDERLAND *reprinted in* THE COMPLETE WORKS OF LEWIS CARROLL 117 (Barnes & Noble Books 1994) (1865). Lord Chief Justice Coke recognized the evil of such an approach many centuries ago: "The philosophical poet [Virgil] doth notably describe the damnable and damned proceedings of the judges of hell . . . . First he punisheth, and then he heareth: . . . but good judges and justices abhor these courses." EDWARDO COKE, INSTITUTES OF THE LAW OF ENGLAND, Part 2, at 54-55 (1793), *reprinted in* HISTORICAL WRITINGS IN LAW AND JURISPRUDENCE (R.H. Helmholtz & Bernard D. Reams, Jr., eds., William S. Hein & Co. 1986).

163. *See, e.g.*, DOBBS, *supra* note 121, § 5.17(2) (noting that provisional remedies, such as attachment, garnishment, and freeze orders have been severely circumscribed by constitutional requirements implemented because of the deprivation of property resulting from enforcement of the remedy). The problem has also been noted in the related context of mass exposure tort class action certification. *See In re* Rhone-Poulenc Rorer Inc., 51 F.3d 1293, 1299-300 (7th Cir. 1995) (holding that class action certification should be withheld when it would unfairly subject manufacturers to extraordinary risk of a single adverse verdict that would force manufacturers to settle or file for bankruptcy).

164. *See* OSTRAGER & NEWMAN, *supra* note 33, §§ 9.04, 10.04 (discussing formulaic allocation).

"before settlement" allocation is unfair or unworkable but an "after settlement" allocation is fair and workable. Peace between the carrier and the policyholder is purchased by instigating warfare between the carriers.

Third, and most importantly, the indemnity continuous trigger approach does not resolve the conflict of interest problem, it simply turns it on its head and then assumes the conflict no longer exists. The conflict of interest argument is based on the observation that the ability to control the defense, allocate the loss, and bind the noncontrolling party, tempts the controlling party to prefer its interest over those of the noncontrolling party in a situation where there should be no preference.[165] The temptation exists whether the carrier or the policyholder controls the defense. Policyholder-carrier conflicts of interest are dual. The overlapping liability-coverage issue, which creates an incentive for the carrier to direct the case in a way that negates or minimizes coverage, creates an equal but opposite incentive on the part of policyholders to direct the case in a way that maximizes coverage. Control over the litigation simply positions the interested party to manipulate the proceedings to obtain what it wants. This problem can be avoided by allowing the party not in control of the defense to contest the results of the underlying litigation in a subsequent action to access the insurance coverage. This approach, for litigation efficiency reasons, tends not to be favored.[166]

The issue is not averted by raising the observation that the carrier owes duties of care to the policyholder. Insofar as relevant here, the carrier's obligation not to harm the policyholder arises out of its control of the defense; it does not exist independent of control simply because the carrier is an insurer.[167] Thus, if a policyholder assumes control of the defense,

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165. Although courts and commentators sometimes suggest that the carrier must prefer the interests of the policyholder in the control of the defense, the tests as applied are neutral, not biased. *See* KEETON & WIDISS, *supra* note 1, § 7.8, at 884-85 ("In deciding whether to settle a claim against an insured, a liability insurer should evaluate whether to accept a proposed settlement in the same way as would be used by an ordinarily prudent defendant who will be fully liable for any judgment that may be subsequently rendered.") (footnote omitted).

166. There are not many cases dealing with the issue of preclusion against the party not in control of the defense. The issue is presented here as an action against the carrier for the policy benefits when the carrier has not breached its duty to defend, the policyholder has settled the underlying claim, and the policyholder has not breached a cooperation requirement of the insurance contract by doing so. The tendency of the courts is to enforce the settlements against the carrier, *see supra* note 139, although the cases are too few and factually unique to suggest they establish a rule or principle of law.

167. Hence, the occasional reference to the carrier being a fiduciary to the policyholder is misplaced. A carrier may be treated like a fiduciary—be held to have quasi-fiduciary status, because of its control of the defense. Szumigala v. Nationwide Mut. Ins. Co., 853 F.2d 274, 280 n.7 (5th Cir. 1988). A carrier is not a fiduciary simply because it is a carrier. *Id.* No court has held that a carrier is a fiduciary per se; those courts that have prescribed an obligation most commonly refer to the duty as fiduciary in nature. *See id.* (noting that although "there is no fiduciary relationship between an insurance company and its insured under a first-party insurance contract," such a relationship exists in the third-party failure to settle context); *see also* Hassard, Bonnington, Roger & Huber v. Home Ins. Co., 740 F. Supp. 789, 792 (S.D. Cal.

particularly in cases in which the carrier has lost control due to a conflict of interest, there is no merit to the argument that the policyholder can conduct itself in a way that the carrier cannot when there is an expectation that the carrier should be bound by the resolution of the claim. Control begets responsibility to act fairly and reasonably no matter who is exercising control. This is particularly true when, as here, we would seek to bind the party not in control to a result achieved by the party in control of the litigation. We can, as noted earlier, moot the problem by not treating the carrier as bound by determinations made while the policyholder is in control of the defense where, if the tables were turned, we would not bind the policyholder due to a conflict of interest.[168] If the carrier is not bound, however, the value of the settlement from the claimant's and policyholder's perspective is diluted.

The argument that the continuous trigger approach encourages settlement simply fails to demonstrate that the values the argument advances are not outweighed by the costs imposed. A continuous trigger approach creates consequences that must be evaluated with the same careful attention as would be given to the consequences associated with the use of a single trigger approach. Only by evaluating and weighing all the consequences associated with each approach can a decision be made as to which approach is preferable and whether that preference is sufficiently strong to warrant construing the policy language as articulating either a continuous or single trigger. Instrumental arguments invariably beg the question of what drives the policy to be implemented and achieved. Maximization or minimization of coverage results because the legal rule says that a continuous or single trigger should be used. The goal—maximization or minimization—is both a goal and a consequence of the legal rule. It is, moreover, an after-the-fact

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1990) ("[T]he relationship between a policyholder and a carrier has many of the elements of a fiduciary relationship, but is not an actual fiduciary relationship."); Love v. Fire Ins. Exch., 271 Cal. Rptr. 246, 251-52 (Ct. App. 1990) (stating that the carrier's obligations "have been characterized as *akin* to fiduciary-type responsibilities"). In effect, the carrier is a fiduciary in the same sense as a constructive trustee—which is to say that the carrier is not actually a fiduciary. The fiduciary reference is instrumental, metaphorical, and fictional. *See* William T. Barker et al., *Is an Insurer a Fiduciary to Its Insureds?*, 25 TORT & INS. L.J. 1, 1-2 (1989) (arguing that although some courts recently have "come to use the term 'fiduciary' to characterize the relationship of [a carrier] to [its policyholder]," a carrier generally is not and should not be considered a fiduciary to its policyholder); *see also* William T. Barker & Donna J. Vobornik, *The Scope of the Emerging Duty of First-Party Insurers to Inform Their Insureds of Rights Under the Policy*, 25 TORT & INS. L.J. 749, 749-58 (1990) (discussing the carrier's duty to inform its policyholder, particularly when the policyholder relies on the carrier to inform it of its rights or when the carrier is aware of the policyholder's ignorance of its rights).

168. The carrier will not be collaterally estopped when control of the defense was assumed by the policyholder because of a conflict of interest between the carrier and the policyholder. *See* JERRY, *supra* note 130, § 114[c][2], at 605. Nor is the carrier responsible for the advice given to the policyholder by independent counsel selected by the policyholder but paid by the carrier because a conflict of interest has deprived the carrier of the power to control the defense. *See* Republic W. Ins. Co. v. Spierer, Woodward, Willens, Denis & Furstman, 68 F.3d 347, 350-51 (9th Cir. 1995).

characterization to say that coverage was maximized or minimized. The question is maximized or minimized relative to what. In this case, the "what" is the available amount of coverage. But it is specious to speak of maximizing or minimizing the very subject to be determined by the inquiry. More importantly, the what should be determined *before* the decision is made to maximize or minimize it. Only in this way are we in a position to assess and evaluate the consequences of the decision.[169]

3. *Length of the Trigger Period*

The decision to adopt a continuous trigger rarely considers the interrelationship between the nature of coverage and the trigger period. Courts often describe the trigger period as if it is self-evident. For example, in *E.I. du Pont de Nemours & Co. v. Admiral Insurance Co.*,[170] the court stated that "[t]he continuous trigger will activate all policies that were on the risk *during the injurious process*."[171] Yet the injurious process rarely receives definition. As noted in the previous section, the injurious process may vary depending on the nature of the product, the nature of the claim, and the nature of the injury. Injury may mean one thing in the context of environmental contamination, something else in the context of construction defect cases, and yet something altogether different in the context of ingested substances. Of course, injury to property is different from injury to person, but the decisions seem to suggest that the idea of injury is context driven and malleable. For example, consider several recent California decisions on the issue of a continuous trigger.[172] In *Montrose Chemical Corp. v. Admiral*

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169. One could argue that adoption of a continuous trigger is necessary to prevent carriers, particularly excess carriers, from reaping windfall profits from previously written occurrence policies. Whether windfall profits were realized is beyond the scope of this paper, but it is a doubtful proposition at best. *See, e.g.*, Continental Cas. Co. v. Pittsburgh Corning Corp., 917 F.2d 297, 298 (7th Cir. 1990) (Posner, J.) (stating that "[a]lthough Continental's limits of liability are very large—more than $200 million—the insurance premiums were very low: a few thousand dollars"). Judge Posner's statement seems a bit low. Premiums for excess layers run more to the order of $500 to $1000 per $1 million of coverage, which would increase the quote a hundredfold. Dave Lenckus & Deborah Shalowitz Cowans, *Surplus Market Sees Slight Improvement*, BUS. INS., Jul. 1, 1996, at 18-19. ("Risk managers are paying as little as $500 to $750 per $1 million of coverage on high excess liability layers . . . [b]ut, that still is at least double the amount that risk managers were paying during the soft market of the early 1980s . . . ."). Even allowing for the inflation and uncertainty over rates in the period relevant to Judge Posner's decision, the numbers appear unrealistic. Nevertheless, if a disgorgement of profits approach is taken, the appropriate remedy is restitution of benefits realized by the carriers, which would direct the remedy toward the premium dollars received by the carriers as the appropriate measure of redress.

170. E.I. du Pont de Nemours & Co. v. Admiral Ins. Co., No. CIV.A.89C-AV-99, 1995 WL 654020 (Del. Super. Ct. Oct. 17, 1995).

171. *Id.* at 10 (emphasis added).

172. *See, e.g.*, Astro Pak Corp. v. Fireman's Fund Ins. Co., 665 A.2d 1113, 1117 (N.J. Super. Ct. App. Div. 1995) (extending the trigger period beyond the date of manifestation in order to pick up postmanifestation occurrence policies, noting that the "progression of . . .

Insurance Co.,[173] the court held that a continuous injury trigger would be applied in an environmental contamination matter.[174] The court, however, did not specify what constituted injury for purposes of the coverage trigger.[175] The only reference the court made to defining injury was in a footnote where it observed that "[u]nder the injury-in-fact approach, coverage is triggered by 'a real undiscovered injury, *proved in retrospect* to have existed at the relevant time . . . irrespective of the time the injury became [diagnosable]."[176]

This concept may be difficult to apply even in the case in which it was articulated. For example, how does the test apply to groundwater contamination when the groundwater is diffuse, as is common in California, rather than collected in underground aquifers, lakes, or streams? When the determination whether injury has occurred must be made in contexts where we lack customary boundaries, generalized tests designed with the customary case in mind may prove to be of little assistance.

In *Montrose Chemical*, the court further complicated the issue by suggesting that the asbestos injury cases may conceptualize injury differently from environmental contamination cases. In the asbestos injury case, the lower court "had relied on medical evidence to make factual findings on the physiological processes that actually occur upon inhalation of asbestos fibers and continue until death in determining to apply a continuous injury trigger in that case."[177] The court noted:

> Although the *Armstrong* court's trigger of coverage discussion appears largely consistent with our analysis of the applicable principles of third party CGL coverage in the present case, because we do not here face *the unique facts of asbestos-related bodily injury claims*, we deem it appropriate that trigger of coverage questions specifically involving asbestos claims be left for decision, in the first instance, on an appropriate record in a case in which they are squarely presented.[178]

The *Montrose Chemical* court's decision left it unclear whether the injury trigger was defined differently in different contexts, proved differently in different contexts, or influenced the environment in which decision making is

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[environmental] contaminants into the surrounding land and water continued well after [the manifestation] date").

173. Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878 (Cal. 1995).

174. *Id.* at 906.

175. *Id.* at 906-07.

176. *Id.* at 895 n.16 (citing American Home Prods. Corp. v. Liberty Mut. Ins. Co., 748 F.2d 760, 766 (2d Cir. 1984)) (emphasis added).

177. *Id.* (relying on Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co., 26 Cal. Rptr. 2d 35, 52 (Ct. App. 1993)).

178. *Id.* (emphasis added). A similar approach was evidenced in *Stonewall Insurance Co. v. Asbestos Claims Management Corp.*, 73 F.3d 1178, 1197 (2d Cir. 1995), which noted that "in view of the different etiologies of asbestosis and cancer, it is possible to hold, as the District Court did, that these two diseases trigger policies differently."

made differently in different contexts. Any of these approaches could influence the length of the continuous trigger which is defined by the injury and injurious process itself.[179]

The California Supreme Court's vacating and remanding of two decisions involving progressive property damage adds uncertainty over the scope and extent of the continuous injury trigger. One case involved a loss from a landslide allegedly caused by third party negligence;[180] the other decision involved construction defects that also presented a progressive, latent property damage claim.[181] It is unclear whether the concept of injury that is emerging from the continuous trigger cases is a single, coherent legal concept or whether it is a series of related yet distinct concepts.[182] The courts have not identified the concerns that are causing them to procrastinate on the proper characterization of the injury element of the continuous injury trigger. This indecision suggests some remaining and well-entrenched concern over the scope and consequences of the developing continuous trigger doctrine.

A changeover in policy forms from occurrence to claims-made occurred in 1986. This further complicates the application of continuous trigger doctrine because of uncertainty over the length of the injurious process. For example, if a woman received a breast implant in 1981, the implant manufacturer probably would have all layers occurrence coverage from 1981 through and including 1985, and all layers claims-made coverage thereafter. Assume that the woman filed suit in 1990 claiming autoimmune disease and other implant related complaints.[183] If the jurisdiction has adopted a date of implant onward continuous trigger,[184] and the medical evidence shows the injury (autoimmune disease) began at the implant date and continued indefinitely even past removal (explantation) of the medical

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179. The California Supreme Court subsequently vacated and remanded the *Armstrong* appellate decision for reconsideration in light of *Montrose Chemical Corp. v. Admiral Insurance Co. See California High Court Remands Ruling in Asbestos Coverage Cases*, 10 MEALEY'S LITIGATION REPORTS—INSURANCE 12 (Nov. 7, 1995). On remand, the appellate court reached the same result as in its earlier opinion. *See* Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co., 52 Cal. Rptr. 2d 690 (Ct. App. 1996).

180. Stonewall Ins. Co. v. City of Palos Verdes Estates, 9 Cal. Rptr. 2d 663 (Ct. App. 1992), *vacated and remanded*, 904 P.2d 370 (Cal. 1995).

181. Ohio Cas. Ins. Co. v. Hartford Accident & Indem. Co., 40 Cal. Rptr. 2d 27 (Ct. App.), *vacated and remanded*, 902 P.2d 1298 (Cal. 1995); *see also* Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F.3d 1178, 1195-96 (2d Cir. 1995) (exhibiting some flexibility in applying the injury in fact trigger test to progressive diseases).

182. Many jurisdictions have adopted different trigger tests in different contexts. For example, courts use an exposure trigger for asbestos-related injury, but an injury in fact test for personal injury arising from product defect. These variations are illustrated in a state by state survey prepared by Marc S. Maister, *Trigger of Coverage: A Contract Approach*, BRIEF, Spring 1996, at 14, 45-54.

183. *See supra* notes 11-13 (describing implant related ailments claimed by women who have received breast implants).

184. In other words, every occurrence policy period from 1981, the date of implant, to 1990, the date the claim is made, is potentially triggered.

devices, should the injurious process, as opposed to the issue of injury in fact, be viewed as an insurance coverage issue or as a medical fact issue?

As an insurance coverage issue, it may be argued that a continuous trigger is applied only to occurrence policies because of their language defining the insured against risk—bodily injury within the policy period. By definition and common understanding, claims-made coverage is claim specific because the insured against event is the making of a claim. A claim is either made or it is not; no court has recognized the concept of a continuous claim trigger for purposes of claims-made coverage.[185] This is not to say that it is impossible to have overlapping coverage under more than one claims-made policy. The presence of extended reporting period provisions may permit a single claim to touch several policies. Nonetheless, for the reasons noted earlier, claims-made policies do not present the same environment for triggering multiple policies in mass exposure tort cases that occurrence policies do. The very nature of claims-made coverage, the fact that what is insured against, a claim, which is an open, visible, and knowable event, reduces the likelihood that multiple policies will be affected. On the other hand, the very nature of occurrence coverage, the fact that what is insured against, an occurrence, which is, in mass exposure tort contexts, usually dormant over long periods of time, concealed, and difficult to identify, increases the likelihood that multiple policies will be affected.

As a medical fact, the injurious process relating to the breast implant hypothetical exists independently of coverage. Implant related injury either exists or it does not exist. If it exists, it has a definable time frame. The question then becomes whether the medical fact of injury exists along side or separate from the coverage concept of injury. If injury is only a coverage concept, the injurious process has a defined lifespan of 1981-1985 (five years) for coverage trigger purposes. If injury is, however, a medical fact, the injurious process, given the assumptions in the hypothetical, has, at the minimum, a defined, potential lifespan from 1981-1990 (ten years) for coverage purposes.

The difference between the two approaches becomes extremely significant when allocation issues are addressed, a topic beyond the scope of this paper. For the purposes here, it is sufficient to note that extending the trigger may benefit either the policyholder or the carrier depending on the allocation principle used. We have assumed so far that the policyholder would prefer a longer trigger because it operates to sweep up more policies. There is a downside, however, for policyholders if the trigger period extends beyond the occurrence years into the claims-made years. The same concerns apply to periods of self-insurance or noninsurance when they overlap the

185. Courts have on occasion found policies to be ambiguous as to whether they provided claims-made or occurrence coverages. *See, e.g.*, Gyler v. Mission Ins. Co., 514 P.2d 1219 (Cal. 1973) (finding policy language ambiguous and construing language in favor of policyholder, the court held there was coverage for a legal malpractice claim under an expired claims-made policy for malpractice occurring during the policy period).

injurious process period.[186] If a carrier is only required to contribute its pro rata share, which represents the amount of injury allocated to each policy period, extending the injurious process, and hence the trigger, will tend to reduce each carrier's required contribution.[187] Claims-made coverage is policy period specific in the sense that a claim is made activating the policy, or no claim is made and the policy is therefore unavailable for that claim. This is the direct opposite of occurrence policies under continuous trigger rules. Using a pro rata approach and extending the injurious process into the claims-made period may result in a reduction of the occurrence carriers' obligations without a corresponding increase in the obligations of claims-made carriers. A claim cannot be spread among a series of claims-made carriers the way an injury can be spread among occurrence carriers. Thus, only the 1990 claims-made carrier in whose policy period the claim is made, will respond, if at all, to the hypothetical claim. Occurrence carriers (1981-1985) may have their pro rata allocations determined as if there were ten carriers on the risk, each carrier representing a different policy year and assuming proportional spreading over the ten year period of injurious process. The occurrence carriers would thus in the aggregate pay fifty percent of the loss and the remaining portion would be borne by the 1990 claims-made carrier, the policyholder, or both. There are other ways of addressing this issue, but the critical point here is that the period of the continuous trigger has manifest consequences that can affect the policyholder either positively or negatively.

4. *Loss Intensification Versus Known Loss*

Mass exposure torts frequently require courts to address the applicability of the known loss rule. This rule is also known as the loss in progress doctrine. There are some subtle distinctions between the two iterations of the concept. In the known loss iteration, the loss is complete; in the loss in progress iteration, the loss is inevitable. For example, if the policyholder seeks to insure against fire loss after the property has been lost due to fire, we speak in terms of known loss; if the policyholder seeks coverage for his home in the path of a wild fire, we speak of loss in progress. Aside from the issue of the statistical certainty of the loss, which may be a factor in some cases, the courts handle the two iterations the same. Sometimes this concept is also referred to as the known risks doctrine. This usage can create confusion. There is nothing improper about insuring against most known risks—coverage decisions by both the policyholder and the carrier are

186. *See* OSTRAGER & NEWMAN, *supra* note 33, § 11.04 (discussing allocation of covered losses among carriers with overlapping coverage).

187. A number of jurisdictions have adopted this approach. The leading case in this area is *Owens-Illinois, Inc. v. United Insurance Co.*, 650 A.2d 974, 993 (N.J. 1994) (using a continuous trigger but each carrier is liable *to the policyholder* only for the portion of the total loss allocable to the triggered policy period). A competing theory is the joint and several liability theory under which each carrier whose policy is triggered is liable *to the policyholder* up to its policy limits. *See* Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981).

made on the basis of risk analysis. The real concern is over purchasing insurance where there is no risk because a specific loss has already happened or is practically certain to happen. It is a basic principle that insurance may be obtained only against contingent or unknown losses.[188] Analysis of loss in progress requires a deeper understanding of how the insurability of a risk is influenced by knowledge that the risk has ripened into a loss and the extent to which there is any meaningful contingency associated with the transformation of risk into loss. These concerns are heightened when a continuous trigger is applied because the breadth of policy exposure created by a continuous trigger approach will often overlap periods where the facts indicate that the policyholder has some level of awareness of the actuality of a loss.

a. *Known loss.* For the purpose of determining the applicability and scope of the known loss doctrine the relevant questions are what does the policyholder have to know and when does he have to know it? If the requisite knowledge is possessed at the appropriate point in time, then the loss is known and cannot be insured against. When the quantum of the policyholder's awareness or knowledge is the key, courts have divided over whether a subjective (knew) or objective (should have known) test is to be used.[189] Whether a court will adopt a subjective or objective approach is perhaps influenced by the discoverability of loss. The objective approach is more frequently found in combination with the manifestation trigger.[190] When the

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188. *See* KEETON & WIDISS, *supra* note 1, § 5.3(a). This element of contingency can be expanded into a separate inquiry whether the loss was intended or expected. That analysis is beyond the scope of this paper; however, the intended or expected analysis is taken from the standpoint of the policyholder, whereas the focus here, insofar as contingency is concerned, is on the inherent progress of events leading to the realization of a loss. In *United States Liability Insurance Co. v. Selman*, 70 F.3d 684 (1st Cir. 1995), the court identified two versions of the known loss doctrine. First, the court identified the neither expected nor intended doctrine as a contractual form of the known loss doctrine. *Id.* at 690. It identified the "knew of substantial probability" test as the common law version of the doctrine. *Id.* (citing SCA Servs., Inc. v. Transportation Ins. Co., 646 N.E.2d 394, 397-98 (Mass. 1995)); *see also* Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F.3d 1178 (2d Cir. 1995). The *Stonewall* court distinguished between the expected or intended exclusion and the known loss defense as follows:

> The "expected or intended" claim requires consideration of whether, at the time of the acts causing the injury, the insured expected or intended the injury, an inquiry that generally asks merely whether the injury was accidental. The "known loss" defense requires consideration of whether, at the time the insured bought the policy (or the policy incepted), the loss was known. The contentions may overlap, but they are distinct . . . .

Id. at 1215 (citations omitted).

189. *See generally* M. Elizabeth Medaglia, et al., *The Status of Certain Nonfortuity Defenses in Casualty Insurance Coverage*, 30 TORT & INS. L.J. 943 (1995); Fredi L. Pearlmutter, *Known Loss: Too Much Knowledge May Be a Dangerous Thing*, 10 MEALEY'S LITIGATION REPORTS—INSURANCE 15 (December 1, 1995).

190. *See* Gantman v. Union Pac. Ins. Co., 284 Cal. Rptr. 188, 193-94 (Ct. App. 1991). The court rejected the homeowner's claims against their carriers in connection with defective

loss is more difficult to detect, a court might more appropriately use a subjective approach since the evident rationale for the known loss rule is to protect against a form of adverse selection as applied to liability insurance.[191] In many cases, however, the distinction suggested above has not been observed by courts.[192]

When the subjective approach is used, the inquiry becomes fact specific and context sensitive. In general, courts have not required that the policyholder have actual knowledge that the loss occurred before inception of the policy.[193] It is probably sufficient that the policyholder knew to a substantial certainty or high likelihood that the loss had occurred.[194] The

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roofing noting that the losses had become manifest because they were observable to a reasonable person in 1979 which was well before the inception of the policy period in 1982.

191. *See* SCA Servs., Inc. v. Transportation Ins. Co., 646 N.E.2d 394, 397 (Mass. 1995) ("Courts have found that the insurable risk is eliminated in the instance where an insured knows, when it purchases a policy, that there is a substantial probability that it will suffer or has already suffered a loss. . . . Courts have applied this known loss principle in environmental contamination cases.").

192. *See* Inland Waters Pollution Control, Inc. v. National Union Fire Ins. Co., 997 F.2d 172 (6th Cir. 1993) (holding that the loss in progress doctrine applies only if policyholder was aware of immediate threat of loss, but thereafter stating that the doctrine would apply if loss would have been apparent to the policyholder).

193. *See supra* note 191. *But cf.* Chu v. Canadian Indem. Co., 274 Cal. Rptr. 20, 27-31 (Ct. App. 1990) (discussing the known loss rule in terms of actual knowledge but not expressly ruling out substantially certain standard as satisfying proof).

194. *See* OSTRAGER & NEWMAN, *supra* note 33, § 8.02[c]. If the policyholder is a legal entity such as a corporation or a partnership, the issue is complicated by the additional question of whose knowledge counts? *See generally* United States v. T.I.M.E.-D.C., Inc., 381 F. Supp. 730 (W.D. Va. 1974):

> A corporation can only act through its employees and, consequently, the acts of its employees, within the scope of their employment, constitute the acts of the corporation. Likewise, knowledge acquired by employees within the scope of their employment is imputed to the corporation. In consequence, a corporation cannot plead innocence by asserting that the information obtained by several employees was not acquired by any one individual who then would have comprehended its full import. Rather, the corporation is considered to have acquired the collective knowledge of its employees and is held responsible for their failure to act accordingly.

Id. at 738.

United States v. T.I.M.E.-D.C. was a criminal prosecution but its principles have been applied in the known loss context. *See* Upjohn Co. v. New Hampshire Ins. Co., 476 N.W.2d 392, 400-01 (Mich. 1991) (finding that the loss was expected where the company had sufficient information available through its various employees to appreciate the consequences of its actions); *cf.* White v. City of New York, 615 N.E.2d 216 (N.Y. 1993) (finding that the knowledge of a police officer was imputed to municipal policyholder for purposes of determining whether policyholder was aware of the circumstances requiring it to timely notify its carrier of claim). *But cf.* Kinzer v. Fidelity & Deposit Co., 652 N.E.2d 20, 29 (Ill. App. Ct. 1995) (finding that only knowledge of key employees was imputed to municipal corporation);

difficulty here lies in the manner in which the test is framed and the overlap between a knowledge-based test and the related expected-intended test.[195] The known loss formulation is whether the policyholder knew or had *reason to know* that there was a substantial probability that he will suffer or has already suffered a loss.[196] As noted previously, it is unclear whether the reason to know language refers to an objective test (should have known) or refers to a less than actual but still subjective test of knowledge (aware that loss was substantially likely or substantially certain). This ambiguity may explain the inconsistency noted previously in the *Inland Waters* decision.[197]

b. *Contingency.* The known loss rule also includes the element of contingency or risk. The principle here is one inherent throughout insurance law—the requirement that the loss be fortuitous. Fortuity is generally considered an inherent aspect of insurance; thus, it is not controlled by the absence of specific policy language expressing a fortuitousness requirement.[198] Insurance protects against the risk, not the certainty of loss.[199] As phrased in that fashion, however, the concept is too general. For example, we purchase life insurance even though we know of the certainty of death. The risk we insure against, however, is not the inevitability of death, but death's timing. Will we die this year, or next, or in ten years? A manufacturer can protect itself against liability claims even though it knows that its manufacturing process is not flawless and that some defective products will be produced, sold, and cause injury. The risk insured against is that a particular product will cause injury. The insurability of the risk may be

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but see Dayton Indep. Sch. Dist. v. National Gypsum, 682 F. Supp. 1403, 1408 n.14 (E.D. Tex. 1988) (noting that statements by policyholder's personnel regarding awareness of possible health problems does not demonstrate that policyholder intended to cause injury).

195. *See supra* note 188. Use of the substantial certainty language is common when the question is asked whether the policyholder expected that his conduct would result in a loss. *See* Shell Oil Co. v. Winterthur Swiss Ins. Co., 15 Cal. Rptr. 2d 815, 835 (Ct. App. 1993) (holding that the term "expect" conveys a practical certainty, not an absolute one; therefore, any interpretation that requires the foreknowledge to be detailed and positively certain would change the plain meaning of the word).

196. Outboard Marine Corp. v. Liberty Mut. Ins. Co., 607 N.E.2d 1204, 1210 (Ill. 1992).

197. *See* Inland Waters Pollution Control, Inc. v. National Union Fire Ins. Co., 997 F.2d 172 (6th Cir. 1993). The policyholder's claimed state of knowledge cannot be unreasonable.

198. *See, e.g.*, University of Cincinnati v. Arkwright Mut. Ins. Co., 51 F.3d 1277, 1280 (6th Cir. 1995) (finding that "an all risk policy, like any other insurance policy, insures only against fortuitous losses"); Two Pesos, Inc. v. Gulf Ins. Co., 901 S.W.2d 495, 501 (Tex. Ct. App. 1995) ("Generally, fortuity is an inherent requirement of all risk insurance policies.").

199. SCA Servs., Inc. v. Transportation Ins. Co., 646 N.E.2d 394, 397 (Mass. 1995) ("The basic purpose of insurance is to protect against fortuitous events . . . . Parties wager against the occurrence or nonoccurrence of a specified event; the carrier insures against a risk, not a certainty.").

viewed differently if the manufacturer knowingly places a particular defective product in the marketplace.[200]

As used here, the concept of contingency assumes that loss is not inevitable or the product of a calculated gamble—"heads I win, tails the carrier pays." We do not want to encourage a manufacturer or a provider to cut corners now and pass the expense of corner cutting to the liability carrier. For example, legal doctrine should not encourage a building contractor to use substandard materials or workmanship because the inevitable consumer complaints will be tendered to the liability carrier rather than rectified by the builder. In first party insurance contexts, the concept is captured through the use of such terms as wear and tear or inherent vice which had their origins in judicial efforts to give meaning to the concept of fortuity.[201] The crossover to liability insurance policies is neither exact nor complete. There is, however, a sense that insurance is inappropriate where the loss is essentially a cost of doing business—a concept that likewise has made its way to policy exclusions,[202] but not, however, at the cost of losing for us an insight into what insurance should and should not cover.

c. *Known loss doctrine and indemnity continuous trigger.* An indemnity continuous trigger coexists rather uneasily with the known loss doctrine. For example, assume a policyholder generated wastes that were deposited at a landfill between 1965 and 1980.[203] In 1980, the landfill closed, and in 1985 the federal and state government sued the policyholder and other generators of wastes deposited at the landfill under CERCLA[204] seeking reimbursement for clean-up costs incurred in connection with the remediation of the waste contamination at the landfill site. Carrier *X* provided CGL coverage for the period 1984 to 1985. The lawsuit alleges, and the fact is not disputed, that waste contaminated the landfill site from 1965 to 1985 when remediation was instituted and completed. Is Carrier *X* obligated to provide indemnification for a loss that was on going and essentially complete when the policy incepted?

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200. *See* KEETON & WIDISS, *supra* note 1, § 5.4.

201. *See* Andrew C. Hecker, Jr. & M. Jane Goode, *Wear and Tear, Inherent Vice, Deterioration, Etc.: The Multifaceted All-Risk Exclusions*, 21 TORT & INS. L.J. 634, 635 (1985-86). The basic concept is that insurance does not protect against loss due to wear and tear or usage. The inevitable and natural deterioration of goods is a risk that is borne by the consumer, not the insurance carrier, absent specific forms of protections such as warranties. *Id.*

202. These are referred to as business risk exclusions. *See* Weedo v. Stone-E-Brick, Inc., 405 A.2d 788, 790-94 (N.J. 1979). This is not to suggest that an individual cannot shift the costs of business risks, such as qualitative performance defects, to another. The appropriate method of transfer is, however, a guarantee or an indemnity agreement, not a general liability insurance policy.

203. The hypothetical is patterned on the facts of *Montrose Chemical Corp. v. Admiral Insurance Co.*, 913 P.2d 878 (Cal. 1995).

204. Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. §§ 9601-9675 (1994).

Courts are divided regarding the application of the known loss doctrine in mass exposure tort cases. In *SCA Services v. Transportation Insurance Co.*,[205] the Massachusetts Supreme Judicial Court held that there could be no coverage for a loss when at the time the policy incepts the policyholder knows that there is a substantial probability that it will suffer or has already suffered a loss.[206] In *SCA Services*, the policyholder operated a landfill that had been declared a nuisance in 1978.[207] In 1980, the insurance policy incepted, and in 1982 suit was brought.[208] The court held that SCA Services knew that the landfill was a nuisance when it purchased the policy and was therefore interfering with the use of surrounding property, satisfying the substantial probability standard.[209] This approach can also be extended to future damages which are the foreseeable consequence of known damage-causing current acts.[210]

In *Montrose Chemical Corp. v. Admiral Insurance Co.*,[211] the court held that as long as the likelihood of liability and the extent of that liability was uncertain, the loss was insurable.[212] The fact that the policyholder was aware of the problem prior to the inception of the policy—in *Montrose* through receipt by the policyholder of a Potentially Responsible Party (PRP) letter—was not controlling:

> The PRP notice is just what its name suggests—notice that the EPA considered Montrose a "potentially" responsible party. While it may be true that an action to recover cleanup costs was inevitable as of that date. Montrose's *liability* in that action was not a certainty. There was still a contingency, and the fact that Montrose knew it was more probable than not that it would be sued (successfully or otherwise) is not enough to defeat the potential of coverage (and, consequently, the duty to defend).
>
> Moreover, since Admiral's policies did not purport to cover damage or injury that occurred prior to the time those policies went into effect, and only covered those bodily injuries and damages (or continuing bodily injuries and damages resulting from "continuous or repeated exposure to conditions") that *might occur in the future during the policy periods*, the

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205. SCA Servs. v. Transportation Ins. Co., 646 N.E.2d 394 (Mass. 1995).

206. *Id.* at 397.

207. *Id.* at 396.

208. *Id.*

209. *Id.* at 398. Courts are split whether knowledge of a lawsuit prior to the purchase of insurance triggers the known loss doctrine. *See* Pearlmutter, *supra* note 189, at 17-18.

210. *See* City of Okanogan v. Cities Ins. Ass'n, 865 P.2d 576 (Wash. Ct. App. 1994). The court distinguished *Gruol Construction Co. v. Insurance Co.*, 524 P.2d 427 (Wash. Ct. App. 1974) on the basis that *Gruol Construction Co.* involved undiscovered negligence causing a loss, whereas in *City of Okanogan*, the lawsuit put the policyholder on notice that its conduct was causing injury. *Id.* at 579-80.

211. Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878 (Cal. 1995).

212. *Id.* at 905-06 (noting that so long as there is "uncertainty about the imposition of liability and no legal obligation to pay yet established," there is "an insurable risk").

> existence and extent of such prospective injuries were clearly unknown and contingent, from Montrose's standpoint, at the time Montrose first purchased its policies from Admiral.[213]

The real problem in this area is that both the coverage (*Montrose*) and no coverage (*SCA Services*) positions have merit. Many progressive losses emanating from mass exposure torts are inevitable and potentially knowable. Cracks in the wall may disclose natural aging, defective construction, or earth movement. Offensive odors may suggest a contamination problem. Absenteeism may precede worker injury. To suggest, however, that the knowledge of some harm deprives the policyholder of the opportunity to insure against loss assigns to the policyholder degrees of omniscience beyond the pale of mere mortals. On the other hand, to impose a subjective test (knew) rather than an objective test (should have known), encourages the policyholder to either be ignorant or believe it was ignorant of the specific and actual perils and risks which the policyholder now wants the carrier to assume. Since a little knowledge may be a dangerous thing—resulting in the loss of coverage because further investigation would have disclosed the loss or the near certainty of loss—ignorance is bliss. A principle that rewards ostrich-like behavior on the ground that the goal is to maximize coverage ignores the benefits of loss prevention that would accrue if policyholders were encouraged to abate loss engendering activities[214] because the specific risk is

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213. *Id.* at 904-05. The court did not address whether the policyholder's failure to communicate its knowledge about it loss engendering activities could raise a policy defense of misrepresentation. Many jurisdictions impose an affirmative obligation on policyholders to disclose facts a reasonable person would consider to be material to the risk. *See, e.g.*, CAL. INS. CODE § 332 (West 1993). *See generally* OSTRAGER & NEWMAN, *supra* note 33, § 3.01[b]. On the other hand, many decisions limit that duty to questions asked the policyholder in the insurance or renewal application. The danger is that the carrier will be whipsawed if the two doctrines are looked at in isolation: the loss is insurable because there is some minimal contingency, but the policyholder has no duty to disclose its superior knowledge of the risk presented because the carrier failed to ask.

Courts have split on the issue whether receipt of a PRP letter prior to the purchase of insurance triggers the known loss doctrine. *See* Pearlmutter, *supra* note 189, at 18-19.

214. In commercial contexts, courts appear to be more willing to find that the policyholder appreciated the actuality and scope of the loss than in matters involving consumers. *Compare* Two Pesos, Inc. v. Gulf Ins. Co., 901 S.W.2d 495, 502 (Tex. Ct. App. 1995):

> Taco Cabana's motion did not allege an offense occurring during Gulf's policy period, and that coverage for Two Pesos' continued trade dress infringement is precluded because the claim constitutes a known loss or loss in progress. Here . . . the risk of liability was no longer unknown because injuries resulted when Two Pesos first copied Taco Cabana's trade dress. The risk of injury from continued infringement was readily apparent, or should have been. Moreover, affording coverage to Two Pesos would violate public policy by allowing protection for a known loss and permitting an insured to benefit from its wrongdoing.

not insurable, at least absent a more complete disclosure to the carrier.[215] Loss prevention is surely as important a goal as loss compensation.

A loss will often seem more inevitable after the fact than before the fact. This is known as hindsight bias.[216] It may be difficult to persuade triers of fact that what they now know with the benefit of hindsight did occur is what they would have anticipated would occur. On the other hand, to deem that an event remains contingent for insurance law purposes until such times as the event becomes irreversibly certain imposes a sense of finality to human activities that is alien to what we know, or think we know, about natural processes. Under the *Montrose* court's definition of contingent, a carrier's policy that became effective the day before the trier of fact rendered a decision in the CERCLA case could be triggered because the loss (clean-up costs) was "still in contingency" as of that date:

> Third party liability insurance policies, in contrast, afford coverage for "sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage." In the liability insurance context, insurance cannot be obtained for a known liability.
>
> Where, as here, there is uncertainty about the *imposition of liability* and no "legal obligation to pay" yet established, there is an insurable risk for which coverage may be sought under a third party policy.[217]

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with United States Liab. Ins. Co. v. Selman, 882 F. Supp. 1163, 1164 (D. Mass. 1995), *aff'd*, 70 F.3d 684 (1st Cir. 1995):

> Carol Ann's injury had been diagnosed by May 4, 1985, and Selman may have known that the effects of this injury would extend into the new policy period. There is no evidence, however, that Selman knew that Carol Ann would continue to ingest lead paint in the new policy period. Thus, while it was certain that Carol Ann would continue to suffer the effects of her previous ingestions, it was by no means clear that her condition would worsen after May 4, 1985. To the extent that Carol Ann's injuries arose out of ingestions after that date, Selman was not insuring against a "known loss."

From the facts of the case, it was not clear whether the insured landlord was a sophisticated or unsophisticated purchaser of insurance.

215. *See* Outboard Marine Corp. v. Liberty Mut. Ins. Co., 607 N.E.2d 1204, 1210 (Ill. 1992) (stating that when the policyholder knows of a probable loss, that loss is uninsurable unless the parties specifically intended to cover that loss).

216. *See* Kim A. Kamin & Jeffrey J. Rachlinski, *Ex Post ≠ Ex Ante: Determining Liability in Hindsight*, 19 LAW & HUM. BEH. 89, 90 (1995) ("When trying to reconstruct what a foresightful state of mind would have perceived, people remain anchored in the hindsightful perspective. This leaves the reported outcome looking much more likely than it would look to the reasonable person without the benefit of hindsight . . . .").

217. Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 905-06 (Cal. 1995). The court's position ignores its earlier comment that litigation was inevitable. Hence, the court permitted the policyholder to transfer a known loss, the cost of the defense of the inevitable action, simply because the full extent of the loss was not known at policy

Under the *Montrose Chemical Corp.* approach, the known loss rule is largely read out of third party coverages unless and until the policyholder suffers an adverse adjudication which quantifies its exposure, and then the rule applies only to that particular resolution. It is unclear, however, how rigorously this test will be applied. Does the court intend the test to apply to anticipated claims, existing claims, or existing claims whose scope is presently open? It is unlikely that this broad test would be applied to a specific product liability claim for an identified claimant that was known before the policy period incepted.[218] On the other hand, the test is applied when an environmental contamination claim is made before the policy's inception. It is dangerous to speculate why a difference in the nature of the injury could give rise to different applications of the known loss rule, but two arguments are available. First, the progress of environmental claims is more complex, the outcomes more uncertain, and the legal setting more unsettled than in the individual product liability case. Second, environmental contamination cases, while often presented as a single claim for remediation, are in fact an aggregate of individual claims. The form in which the action is presented should not determine the application of the known loss doctrine. In this regard, a products liability class action may bear a strong resemblance to the environmental contamination claim and thus resist application of the known loss rule because some uncertainty exists as to the size of the class, the nature of the class members' claims, and the scope of liability presented.

This may be an area in which we cannot capture by a rule what we perceive to be desirable outcomes.[219] We should not lose sight, however, that this situation—with the uncertainty and resulting costs—is the product of the adoption of an indemnity continuous trigger approach. A single trigger approach would assign the entire loss to a particular time period even though

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inception. This is simply a remarkable decision, quite at odds with the general approach to the problem. This notion of contingency was extended even further in *UTI Corp. v. Fireman's Fund Insurance Co.*, 896 F. Supp. 362 (D.N.J. 1995). The court held that, as to excess insurance, not only did the carrier have to establish the certainty that legal liability existed prior to the policy's inception, the carrier also had to quantify the amount of legal liability. *Id.* at 377 (carrier must show that the policyholder knew that legal liability would invade excess limits). Similarly, in *Stonewall Insurance Co. v. Asbestos Claims Management Corp.*, 73 F.3d 1178 (2d Cir. 1995), the court held that the policyholder's knowledge that its products risked asbestosis and cancer diseases and that it had received a large number of claims did not compel application of the known loss defense. According to the court there remained sufficient uncertainty "as to the prospective number of injuries, the number of claims, the likelihood of successful claims, and the amount of ultimate losses it would be called upon to pay" to permit the policyholder "to replace the uncertainty of its exposure with the precision of insurance premiums and leave it to the insurer's underwriters to determine the appropriate premiums." *Id.* at 1215.

218. *See* Bartholomew v. Appalachian Ins. Co., 655 F.2d 27 (1st Cir. 1981) (holding that when defective car wash equipment caused damage to the vehicles using the car wash, the policyholders' knowledge of the defect in the equipment precluded coverage).

219. *See* Outboard Marine Corp. v. Liberty Mut. Ins. Co., 607 N.E.2d 1204, 1210 (Ill. 1992) (stating that application of the known loss rule is best made on a case-by-case basis).

the loss may evolve and intensify over a discrete period of time. Treating the loss itself as if it occurs day-by-day increases the likelihood that a continuous trigger and the loss-in-progress doctrine will come into conflict in mass exposure tort cases. To give preference to one of the two competing goals (compensation and indemnity against risk) over the other (loss reducing activities), without reasoned articulation as to why compensation is preferable over loss prevention, is unsatisfactory and reflects an unwillingness to address the inevitable consequences of adopting an indemnity continuous trigger.

5. *Primary Versus Excess Coverage Triggers*

Almost all the decisional law addressing the issue of trigger has involved primary insurance policies, and more particularly the duty to defend.[220] Because of the size of the claims, mass exposure tort cases frequently raise issues regarding the liability of excess carriers.[221] Primary and excess coverages are designed to work as a package; nonetheless, the form of coverage provided is different. Principles developed to address problems encountered with primary coverage may not be transferable to excess coverage. It is to this issue, we now turn.

a. *Excess policies.* True excess insurance policies provide coverage that is additional to that provided by underlying insurance.[222] Excess coverage

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220. *See, e.g.*, Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981); Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878 (Cal. 1995). A few cases have addressed the indemnity continuous trigger issue. *See* Owens-Illinois, Inc. v. Aetna Cas. & Sur. Co., 597 F. Supp. 1515 (D.D.C. 1984) (applying multiple trigger to excess policies).

221. *See, e.g.*, Georgine v. Amchem Prods., Inc., 157 F.R.D. 246 (E.D. Pa. 1994) (approving an estimated $3.2 billion settlement of an asbestos class action to be paid by defendants and their carriers), *rev'd*, 83 F.3d 610 (3d Cir.), *cert granted*, 117 S. Ct. 379 (1996); Lindsey v. Dow Corning Corp., No. CV.92-P-10000-S, 1994 WL 578353 (N.D. Ala. Sept. 1, 1994) (approving an estimated $4.2 billion settlement of a class action against certain manufacturers and suppliers of silicone breast implants). Dow Corning filed for bankruptcy after the *Lindsey* settlement unraveled. Litigation between Dow Corning and its liability insurance carriers commenced in Michigan. Dow Corning has entered into settlements with a number of its carriers. The terms and conditions of the settlements vary. Some carriers have received releases; others have agreed to provide coverage in place. Although the value of the settlements is difficult to determine because of the variations and contingencies, it has been estimated to be approximately $1 billion. In addition, Dow Corning received a verdict for defense costs incurred to date of approximately $225 million. *Final Judgment Entered In Dow Corning Implant Coverage Litigation*, 10 MEALEY'S LITIGATION REPORTS—INSURANCE 14 (July 16, 1996).

222. *See* American Home Assurance Co. v. Republic Ins. Co., 984 F.2d 76, 77 (2d Cir. 1993). "The word 'primary' is used also in the field of excess insurance to distinguish coverage which attaches immediately upon the happening of an occurrence, from excess coverage, which attaches only after a predetermined amount of 'primary' coverage has been exhausted." *Id.* (citations omitted); *see also* National Union Fire Ins. Co. v. Lawyers' Mut. Ins. Co., 885 F. Supp. 202, 205 (S.D. Cal. 1995).

can most easily be comprehended by envisioning insurance coverage as layered.[223] Thus, excess insurance may be excess to first layer primary coverage or it may be excess to second or higher layers of excess coverage, in other words, excess to underlying excess coverages.[224]

Excess coverage will specify the amount of the underlying coverage and that the excess coverage provided will not be applicable unless that specified underlying layer has been exhausted.[225] Unlike primary policies which are usually quite detailed, higher layer excess insurance policies are often quite spartan. One page subscription agreements are not uncommon,[226] although some carriers prefer more developed policies. Excess policies normally "follow form" to an underlying coverage.[227] A common insurance coverage program for a corporate policyholder will normally include a primary policy, a lead excess policy, and higher layer excess policies. In order to maintain consistency between the layers, the placing brokers and underwriters will provide that the respective layers of coverage must follow form to a common policy. Normally the lead excess policy will follow form to the primary

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True excess insurance should be distinguished from coverage which becomes excess due to operation of the other insurance clause of the policy. *See* OSTRAGER & NEWMAN, *supra* note 33, § 11.01-.03 (7th ed. 1994); KEETON & WIDISS, *supra* note 1, § 3.11(a), (e), (g). Whether a policy is a primary policy, a true excess policy, or a primary policy that has become excess due to the operation of the other insurance clause may be difficult to determine without fact finding. *See, e.g.*, Rhone-Poulenc, Inc. v. International Ins. Co., 71 F.3d 1299, 1305-06 (7th Cir. 1995) (holding that a triable issue of fact existed precluding summary judgment on whether Environmental Impairment Liability (EIL) insurance was primary or true excess with respect to the CGL policy).

223. *See* Michael M. Marick, *Excess Insurance: An Overview of General Principles and Current Issues*, 24 TORT & INS. L.J. 715, 717 (1989).

224. Some confusion is generated because excess coverage is frequently sold as a package, a part of which provides for expanded primary coverage. This package of true excess and expanded primary coverages is frequently referred to as umbrella coverage. The term umbrella is also used, however, for pure excess coverage. *See* 16 GEORGE A. COUCH, COUCH ON INSURANCE § 62.48, at 484 (2d ed. 1983); 8C APPLEMAN, *supra* note 125, § 5071.65. When expanded primary coverage and excess coverage is sold as a package, the umbrella carrier may have duties with respect to *some* claims equivalent to those of a primary carrier. *See* Aetna Cas. & Sur. Co. v. Centennial Ins. Co., 838 F.2d 346, 349-50 (9th Cir. 1988) (requiring the umbrella carrier to "drop down" and provide defense where its policy had broader coverage than underlying policies); Cranford Ins. Co. v. Allwest Ins. Co., 645 F. Supp. 1440, 1445-46 (N.D. Cal. 1986) (finding that the umbrella carrier had to provide defense where the claim was excluded under the underlying policy but not under the umbrella policy). For purposes of this paper, excess coverage means true and only excess coverage or only the excess coverage portion of an umbrella policy as defined here.

225. OSTRAGER & NEWMAN, *supra* note 33, § 13.02.

226. A subscription agreement or policy is subscribed to by two or more carriers with each carrier subscribing to a portion of the total risk and with each carrier's liability limited to the portion of the risk to which it subscribed.

227. *See* Part II.C.5.b (discussing the "following form" clause in excess insurance policy).

policy and higher layer excess policies will follow form to the lead excess policy.

This integration between layers is essential because access to overlaying layers is dependent on the exhaustion of the immediately underlying layer. Any differences in the scope or nature of coverage between layers creates a ripple which may distort overlaying layers.[228]

Unlike primary policies, excess policies usually do not contain an express promise to defend the policyholder.[229] These policies do, however, often vest the right to assume the defense in the excess carrier. Unlike primary policies, excess policies do not use the all sums language discussed earlier;[230] rather, excess policies usually provide for payment under an ultimate net loss formula[231] which obligates the excess carrier to pay a loss in excess of either: (1) the amount recoverable under the underlying insurance as set out in the schedule of underlying insurance; or (2) a retained limit for uncovered occurrences in respect to each occurrence not covered by the

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228. Again the assumption is that of a true excess program. As noted previously, an umbrella policy, as defined here, may provide gap coverage which fills out an underlying primary level policy. In these cases the umbrella policy provides two forms of coverage—excess coverage to the primary and primary coverage insofar as specified in the policy.

229. *See, e.g.*, Signal Cos. v. Harbor Ins. Co., 612 P.2d 889, 894 (Cal. 1980) (holding that an excess carrier has no duty to participate in the defense of an action against the policyholder until underlying limits are exhausted, absent policy language to the contrary). The excess carrier may, however, be required to contribute after the fact to a portion of the defense costs incurred. *See* OSTRAGER & NEWMAN, *supra* note 33, § 6.03. After the underlying policy is exhausted, the excess carrier's loss obligation is defined by the ultimate net loss formula rather than by the express promise to defend characteristic of primary policies.

An excess carrier may, however, be obligated to assume the defense of the policyholder once an underlying layer of indemnity coverage has been exhausted, *see, e.g.*, Elas v. State Farm Mut. Auto. Ins. Co., 352 N.E.2d 60, 62-63 (Ill. App. Ct. 1976), when the excess policy contains an express promise to defend, *see, e.g.*, Hocker v. New Hampshire Ins. Co., 922 F.2d 1476, 1481-82 (10th Cir. 1991), or when the excess policy is excess to a self-insured retention, *see, e.g.*, Cooper Labs., Inc. v. International Surplus Lines Ins. Co., 802 F.2d 667, 675 (3d Cir. 1986). Courts have held that the excess carrier's duty to defend may be triggered by a *claim* which *invades* the excess limits when the excess policy obligates the carrier to defend the policyholder. *See, e.g.*, Celina Mut. Ins. Co. v. Citizens Ins. Co., 349 N.W.2d 547, 550-51 (Mich. Ct. App. 1984).

230. *See supra* note 146 and accompanying text.

231. *See* OSTRAGER & NEWMAN, *supra* note 33, § 11.02[d], at 474.

Excess insurance policies are generally written to provide indemnification for "ultimate net loss" defined as:

> the sums paid in settlement of losses for which the Insured is liable *after making deductions for* all recoveries, salvages and other insurances (other than recoveries under the policy/ies of the Primary Insurers), *whether recoverable or not* and shall exclude all expenses and "costs."

Id.

scheduled underlying insurance.[232] The arguments policyholders and courts have relied on in adopting the continuous trigger approach in primary coverage contexts are not directly transferable and should not be applied to trigger excess coverage. The proper trigger for excess policies is the exhaustion of underlying coverage(s).[233] This raises, however, the question whether exhaustion should be horizontal, that is, *all* policies at the same layer of coverage must be exhausted before the next layer of coverage is triggered, or whether exhaustion should be vertical—only *the* underlying scheduled policy must be exhausted.[234] Vertical exhaustion raises, however, the additional question of whether it is vertical all the way up or only vertical to the next policy layer—exhaustion of one underlying policy would only trigger *all* excess policies at the next layer of coverage.[235]

b. *Following form.* It may be argued that the policyholder's reasonable expectations of vertical integration between the primary and excess coverage, coupled with the following form language, binds the excess policies to the primary policies' coverage trigger. This would include the power of the policyholder to assign claims among carriers whose policies have been triggered. Thus, once a particular underlying policy was exhausted, the overlaying excess policy would be accessed. This approach, while limiting the continuous trigger approach to primary policies and maintaining the traditional exhaustion requirement as the sole trigger for excess policies, permits the policyholder to assign claims to primary policies in any manner that maximizes coverages through access to excess layers. That argument, however, has several difficulties. First, the reasonable expectations doctrine

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232. This latter situation involves excess insurance over a self-insured retention (SIR). *See* William T. Barker, *Combining Insurance and Self Insurance: Issues for Handling Claims*, 61 DEF. COUNS. J. 352 (1994) (discussing the complications that arise when a self-insured policyholder is substituted for a primary carrier); OSTRAGER & NEWMAN, *supra* note 33, § 13.13 (discussing the relationship between excess coverage and SIRs).

233. *See, e.g.*, Aetna Cas. & Sur. Co. v. Chicago Ins. Co., 994 F.2d 1254, 1257-58 (7th Cir. 1993); *see also* St. Paul Fire & Marine Ins. Co. v. Gilmore, 812 P.2d 977, 980 (Ariz. 1991) (finding that with excess insurance, scheduled underlying coverage "operate[s] as a kind of deductible, and 'an insured pays a reduced premium to the excess carrier expressly because that carrier will be obligated to pay a claim only after a certain amount has been paid' by the insured's primary insurer") (quoting Maricopa County v. Federal Ins. Co., 757 P.2d 112, 114 (Ariz. Ct. App. 1988)); Loy v. Bunderson, 320 N.W.2d 175, 179 (Wis. 1982) (noting that true excess coverage reflects in its rates the fact that underlying coverages will absorb most of the losses experienced by the policyholder).

234. Whether a layer has in fact been exhausted often raises difficult issues involving the following facts: (1) the proper assignment of claims to particular policy periods; (2) the appropriateness of sums paid to claimants as settlements when the policyholder or an underlying carrier has control of the defense; and, (3) the reasonableness of litigation expenses incurred by a policyholder who has rightfully assumed control of the defense. These issues are beyond the scope of this article.

235. The scope of the exhaustion requirement as a condition to accessing excess policies is beyond the scope of this article. *See generally* OSTRAGER & NEWMAN, *supra* note 33, § 13.02, .04.

may not enjoy the same level of judicial acceptance as it did in the past.[236] Second, the general sophistication of the parties to excess insurance transactions rarely raise the consumer-oriented perspective that typifies the reasonable expectation doctrine in practice.[237] While the doctrine is invoked in mass tort coverage cases, the decisional calculus seems less wedded to the policyholder's expectations than in the more consumer-oriented life, automobile, and homeowner coverage contexts and more grounded in explicit public policy and pragmatic approaches.

Reasonable expectations in the form of practical and policy-based considerations have been relied on to determine the trigger issue in mass tort coverage cases even when the policy language is unambiguous in certain settings where the court believes that context considerations outweigh textual considerations,[238] but the contextual setting for the introduction of the policyholder's reasonable expectations has involved the duty to defend. The argument that the policyholder has a reasonable expectation that the excess policy's indemnity obligation should be activated by a continuous trigger, as applied to the primary policies by the policyholder, is difficult to sustain because the context in which the defense promise is assessed differs from the context in which the indemnity promise is assessed. Having emphasized for decades the differences between the two promises,[239] courts can hardly justify a U-turn in order to collapse the two promises into a single obligation for purpose of trigger. Defense and indemnity triggers raise separate and distinct considerations.[240] Excess policies are traditionally written on a reimbursement basis. This requires that the policyholder or the carrier in control of the defense conclude the underlying litigation by settlement or judgment and that the settlement or judgment invades the excess. At that point in time, a claim for indemnity under the excess policy has accrued. In this respect, the duty of the excess carrier to indemnify the policyholder differs little from that of the primary. The claim must be resolved before indemnity is due.[241]

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236. *See* STEMPEL, *supra* note 38, § 11.4.4; *see also* Peter N. Swisher, *Judicial Interpretations of Insurance Contracts Disputes: Toward a Realistic Middle Ground Approach*, 57 OHIO ST. L.J. 543 (1996) (discussing the receptivity of American jurisdictions to the insurance law reasonable expectations doctrine).

237. *See* STEMPEL, *supra* note 38, § 11.3 (noting justifications for and criticisms of the doctrine).

238. *See, e.g.*, Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 901-04 (Cal. 1995).

239. The idea that the standard liability insurance policy contains two promises, the promise to defend and the promise to indemnify, has been the foundation upon which the scope of the carrier's duty to defend has been forged. *See, e.g.*, C.H. Heist Caribe Corp. v. American Home Assurance Co., 640 F.2d 479, 481 (3d Cir. 1981); CNA Cas. v. Seaboard Sur. Co., 222 Cal. Rptr. 276, 278-79 (Ct. App. 1986). *See generally* OSTRAGER & NEWMAN, *supra* note 33, § 5.02.

240. *See supra* notes 116-34 and accompanying text.

241. Depending on policy language, litigation expense claims may accrue against excess carriers as the expenses are incurred or paid by the policyholder. *See* Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F.3d 1178, 1218-19 (2d Cir. 1995) (noting that

Any argument that the follow form language somehow compels consistency in the trigger of coverage between primary and excess also fails. Following form is not the same as "following the fortunes"—a term often seen in reinsurance.[242] The following the fortunes clause binds the reinsurer to the good faith payment of the insured loss by the ceding insurer.[243] Following form language requires adherence to the actual language of the underlying policy where the excess policy is silent but does not require adherence to a judicial interpretation of the underlying policy or the underlying carrier's conduct.[244] Following the fortunes language creates the equivalent of privity between reinsurer and cedent;[245] however, no such privity

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whether an excess carrier must reimburse a policyholder for the costs of defense is determined by the contract language of the excess policy). This situation requires that the underlying coverages have been exhausted by appropriate indemnity payments, and thus, the excess layer has been accessed, unless the underlying policy is a consumptive or eroding limits policy, where defense costs are counted against policy limits, in which case defense costs may exhaust the limits. Deductibles are normally not counted against limits but are reimbursed to carriers by policyholders. *See* Lafarge Corp. v. Hartford Cas. Ins. Co., 61 F.3d 389, 401 (5th Cir. 1995).

242. *See* North River Ins. Co. v. Cigna Reinsurance Co., 52 F.3d 1194, 1199 (3d Cir. 1995) ("'Follow the fortunes' clauses prevent reinsurers from second guessing good-faith settlements and obtaining de novo review of judgments of the reinsured's liability to its insured."). *But cf. infra* note 243.

243. *See* OSTRAGER & NEWMAN, *supra* note 33, § 16.01. Recent decisions have suggested that reinsurers may have more leeway in challenging claim adjustment practices of ceding carriers than was previously supposed. *See* Sarah Goddard, *Members and U.K. Courts Give 'Momentum' to Lloyd's R&R Plan*, BUS. INS., Aug. 5, 1996, at 39 (noting that the recent House of Lords decision in *Hill & Others v. Mercantile & General Reinsurance Co.* portends more challenges by reinsurers to settlements concluded by ceding carriers); *see also* National Am. Ins. Co. v. Certain Underwriters at Lloyds' London, 93 F.3d 529, 535 (9th Cir. 1996) (holding that triable issue of fact exists as to whether facultative reinsurance industry had prior custom and practice to follow the settlements absent express language in the policy). *See generally* Debra Baker, *The Effect of Evidence of Industry Custom and Practice and the Parties' Course of Dealing on the Application of "Follow the Fortunes" in Reinsurance Contracts*, 31 TORT & INS. L.J. 947 (1996).

244. *See In re* Midland Ins. Co., 623 N.Y.S.2d 689 (Sup. Ct. 1994); *cf.* Aetna Cas. & Sur. Co. v. Home Ins. Co., 882 F. Supp. 1328, 1337 (S.D.N.Y. 1995):

> Where a following form clause is found in the reinsurance contract, concurrency between the policy of reinsurance and the reinsured policy is presumed, such that a policy of reinsurance will be construed as offering the same terms, conditions and scope of coverage as exist in the reinsured policy, i.e., in the absence of explicit language in the policy of reinsurance to the contrary.

245. Recognition of privity between the parties to the reinsurance contract, insofar as the ceding carrier's handling of the underlying claim is concerned, is sound. Reinsurance is simply insurance for insurance. When the reinsurance contract recognizes that the ceding carrier will control the defense and both cedent and reinsurer have a shared, common interest in the handling of the claim, judicial efficiency is advanced by binding the reinsurer to the

exists between the excess and primary carriers.[246] The fact that a primary policy has been deemed triggered either by stipulation or adjudication is therefore not necessarily binding on the nonparticipating excess carrier who may determine the trigger issue for its own account.

The excess carrier's obligations must be determined by reference to the excess policy. The excess policy will provide that it follows form only to the extent the excess policy does not address the issue.[247] Regarding the issue of trigger, the following form language will usually be of assistance only when the excess policy has not defined an occurrence. When occurrence is not defined, the following form language binds the carrier to the definition of occurrence contained in the primary policy. If, however, the excess policy contains a definition of occurrence, the excess carrier's provision usually controls. The express language of the excess carrier's policy will preempt the primary policy language that is reviewed when the trigger determination is made.

Following form policy language is not a substitute for privity; it merely incorporates the primary policy language into the excess policy to an extent not inconsistent with the actual terms of the excess policy. Consequently, a determination that the primary policy's language creates or gives rise to a continuous trigger does not necessarily require that a continuous trigger be applied to true excess policies with following form provisions.[248]

The use of an indemnity continuous trigger thus raises profound allocation of loss issues that must be resolved. How those issues are resolved will affect how much coverage the policyholder has and how the loss will be allocated among the various carriers whose policies have been triggered. The resolution of these issues has begun to dwarf litigation involving the

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adjudication or compromise reached by the cedent. More importantly, this relationship is contemplated by the parties to the reinsurance contract.

246. *See* OSTRAGER & NEWMAN, *supra* note 33, §§ 13.05-.08 (noting that outside New York, the excess carrier who believes the primary carrier has breached its contractual duties must sue using the doctrine of equitable subrogation—there is an absence of privity for a direct action to lie).

247. *See id.* § 13.01. Excess coverage programs may be shared by multiple carriers, each of whom will accept a portion of the total risk assumed by the carrier and become severally liable as to that portion. These programs are often marketed through subscription agreements. Some subscription agreements provide that the terms of the subscription agreement control over any contrary language contained in any policy the carrier may attach to the subscription agreement. I am unaware of any appellate decisions addressing this potential conflict between policy forms. The issue did arise on somewhat unusual facts in *Fulton v. Lloyds & Inst. of London Underwriting Cos.*, 903 P.2d 1062 (Alaska 1995).

248. Some courts have bound the excess carrier under a theory of estoppel to decisions made in litigation involving the policyholder or the underlying carrier when the excess carrier had notice that its limits may be accessed and declined to exercise its right to assume control of the defense. Whether an excess carrier is or should be bound by a settlement entered into by the policyholder or the other carriers even though the excess carrier disagrees with the settlement is beyond the scope of this Article. *See generally* OSTRAGER & NEWMAN, *supra* note 33, § 13.10 (noting split in authorities).

appropriate trigger. Yet, the cause and effect relationship cannot be ignored. Adoption of an indemnity continuous trigger necessarily raises allocation issues. The decision whether to adopt an indemnity continuous trigger should be informed by an awareness of how the allocation issue will be addressed. The large dollar values at stake preclude the type of piecemeal approach to problems that is the common law tradition. Yet, the integrated nature of the problem has largely gone unnoticed by courts. This is beginning to change.[249] Unfortunately, this insight has not encouraged courts to reexamine the premises and assumptions that have led to the general adoption of a continuous trigger of coverage for mass exposure torts.

III. CONCLUSION

The mass exposure tort cases for which a continuous trigger approach to insurance coverage is urged invariably involve substantial claims.[250] While the focus of most decisions has been over the defense obligations of primary carriers, the real battle is often over indemnity coverage because this is where the dollars are that can provide immediate resources to help resolve the dispute. The settlement will be hampered unless both claimants and policyholders have some degree of comfort that the settlement is adequate to conclude the matter, will not prove to be financially worse than continued litigation, and will not require additional litigation. These questions involve the determination of the amount of insurance that actually can be devoted to satisfying the claims. The more insurance funds available, the greater the likelihood that an adequate (from the claimant's viewpoint) settlement can be achieved at the minimum (from the policyholder's viewpoint) disruption to the continued business activities of the policyholder. In mass exposure tort cases, it is increasingly the case that those dollars to fund the settlement will be looked for in the liability insurance programs purchased by the policyholder.

The desire to access liability insurance to find monies to fund a settlement only presents one-half of the equation; it must still be determined to what extent, if at all, the liability carriers have obligated themselves to cover the claims presented. Before the liability carriers are willing to contribute all

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249. *See, e.g.*, Northern States Power v. Fidelity & Cas. Co., 523 N.W.2d 657, 662 (Minn. 1994) (noting that "the choice of trigger theory is related to the method a court will choose to allocate damages between insurers").

250. Liability for asbestos related damages has been estimated at $50 billion. PAUL W. MACAVOY, THE FINANCING OF LIABILITY PAYMENTS FOR ASBESTOS-RELATED DISEASE 52-57 (1992). The costs associated with environmental cleanup have been estimated as ranging from $60 billion to $1065 billion. Dan R. Anderson, *Insurance Coverage Litigation and the Financial Impact of Superfund-Mandated Hazardous Waste Liabilities on the Insurance Industry*, 13 J. INS. REG. 53, 77 (1995). Recently, a federal judge held that a $4.25 billion settlement of a portion of breast implant claims was inadequate. *See* NAT'L L.J., Sept. 18, 1995, at A7. The breast implant litigation is discussed in Heidi Li Feldman, *Science and Uncertainty in Mass Exposure Litigation*, 74 TEX. L. REV. 1, 18-23 (1995). The cost of abating lead poisoning has been estimated at $150 billion. *See* Joanne Wojcik, *Insurers Battling Increasing Claims from Lead Paint*, BUS. INS., July 12, 1993, at 1.

or a portion of their policy limits to settle a claim, the liability carriers need to have some assurance that their policies provide coverage or that settlement is in their interests as opposed to continued litigation.

The debate between single and continuous trigger was initially waged at the margin (duty to defend) and by players (primary carriers) whose policy limits are such that they were (aside from their defense obligations) unlikely to have a significant impact on settlement of global litigation involving mass exposure torts.[251] This decisional framework is changing as both policyholders and excess carriers are more frequently being drawn into litigation regarding the payment obligations of excess carriers in mass exposure tort litigation. Nonetheless, decisions rendered in prior contexts, largely involving defense obligations, are used as guiding precedents for resolution of trigger issues regarding the duty to indemnify. Courts show no recognition of the differences between the duty to defend and the duty to indemnify and do not acknowledge the differences between a primary carrier in control of the defense with a coverage dispute with its policyholder and an excess carrier with no duty to defend. An excess carrier is not in control of the defense, and its coverage obligations (duty to indemnify) are dependent, in part, on an underlying determination of policyholder liability.

Application of an indemnity continuous trigger to access liability coverage complicates coverage determinations and does not encourage early excess carrier involvement, contrary to the expectations of continuous trigger proponents. Coverage determinations are complicated because continuous trigger approaches necessitate the development of rules and principles of loss allocation among carriers—a development that has not been easy and which has contributed to delay.[252] Calling on *excess* carriers, whose policies are prima facially triggered, to contribute up to policy limits before coverage issues are resolved and limiting those carriers to post-contribution actions among themselves for re-allocation of the loss acts, somewhat perversely, to discourage excess carrier involvement in settlement. Giving the carrier an either-or choice—either contribute your limits or litigate that there is *no* coverage—encourages aggressive tactics.[253] Compliance provides little real

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251. Because costs of defense are usually not counted against policy limits, the primary carrier has a financial interest in shifting coverage responsibilities to the excess carriers. Carriers do not have uniform interests, and their diversity of interests may make them adversaries as to particular issues in the same case.

252. George Priest has suggested that the likelihood of settlement decreases as the amount of uncertainty about the litigation increases. *See* George L. Priest, *Measuring Legal Change*, 3 J.L. ECON. & ORG. 193, 207 (1987). This premise was questioned by Robert Gertner. *See* Robert H. Gertner, *Asymmetric Information, Uncertainty, & Selection Bias in Litigation*, 1993 U. CHI. L. SCH. ROUNDTABLE 75, 92-94.

253. Transaction costs for asbestos and pollution insurance coverage litigation have been estimated to average from 75% to 88% of carrier payouts. *See* ADAM RAPHAEL, ULTIMATE RISK 120, 164 (1994) (noting that asbestos coverage claims have averaged 75%, and pollution coverage claims have averaged 88%). As noted by Raphael:

> The issues at the heart of the pollution litigation are so complex, and so bitterly fought, that they are unlikely to be resolved for many years. To

immediate benefits; litigation presents the possibility of escape and the certainty of delay. The indemnity sums involved make litigation costs a reasonable investment. Even if the carrier prevails in only a small number of cases, the benefits of even occasional victories may outweigh what can only be estimated as the added costs of the more frequent defeats. The large stakes make it unlikely that any carrier will ever be required to pay more than its policy limits.[254] Thus, the carrier's upside liability is probably the same whether it contributes its policy limits or litigates coverage. And the carrier can always litigate the postsettlement allocation issue.[255] Hence, litigation has little real downside as long as current litigation costs do not exceed predicted indemnity savings the litigation engenders. It is at best speculative that an indemnity continuous trigger approach applied to excess coverage will in fact encourage the behavior it desires. An indemnity continuous trigger approach rests on the dubious premise that carriers should be encouraged, perhaps even forced, to contribute policy limits before the underlying claims have been concluded. That premise is unlikely to be embraced by carriers.

Professors Charles Silver and Kent Syverud have recently reminded us that insurance law often acts as an unseen force that influences how other substantive and procedural rules are applied.[256] Indeed, without this "dark matter,"[257] that is, insurance law, much of what we see practicing lawyers do would be counterintuitive and inexplicable. The desire to access insurance helps explain why lawyers do what they do. Yet, we should not assume that we are witness to a one-way ratchet. If insurance law influences other areas of the law, then other areas of the law surely influence insurance law. Insurance law, no more than mere mortals, can remain isolated from surrounding events.[258] The issue is always what shall be cause and what shall be effect?

> a layman they appear to be a horrendously expensive exercise in nit-picking semantics, but with so much at stake neither side is willing to settle. As one policyholder attorney told the New York Times: "The volume of dollars on the table is so staggeringly high that no-one can figure out how to compromise."

Id. at 164-65.

254. I am unaware of any cases involving excess policy limits awards against excess carriers.

255. *See generally* OSTRAGER & NEWMAN, *supra* note 33, at 197-217 (discussing the view that one co-insurer may seek allocation of defense costs with other primary, nonperforming co-insurers).

256. *See* Silver & Syverud, *supra* note 135, at 257 (noting the extent to which availability of insurance affects how lawyers practice).

257. Dark matter refers to as yet undetected matter whose presence is necessary or else the universe is unbalanced. According to current theory, scientists presume that dark matter exists because it must exist if the world that we know exists as we know it.

258. *Cf.* JOHN DONNE, *Meditation XVII*:

> No man is an Iland, intire of itselfe; every man is a peece of the continent, a part of the maine; if a Clod bee washed away by the Sea, Europe is the lesse, as well as if a Promontorie were, as well as if a Mannor of thy Friends, or of thine owne were; Any Mans death diminishes me, because I

Shall the desire to maximize coverage cause insurance law to develop trigger of coverage rules that expose carriers to expansive liabilities? Shall the insurance contract, particularly the idea of indemnity for legally recognized and established injury, cause insurance law to develop trigger of coverage rules that limit carriers' liabilities to those probably contemplated at the time the contract incepted?[259] These are not easy questions to answer, and we must be careful in our evaluation and honest in our criticism of the efforts of others, particularly courts, who have struggled with this problem, without significant scholarly assistance.

This article has made a case for a limited continuous trigger, one that applies to the carrier's duty to defend. That obligation is by its very nature dictated by the allegations made by the claimant and the potentiality that one or more of those claims may be covered. A defense continuous trigger is fully consistent with the open nature of the carrier's defense obligations. The case has not been made for an indemnity continuous trigger. Such a trigger is fundamentally inconsistent with the basic theme of the standard occurrence policy, particularly excess policies, that the carrier promises to reimburse the policyholder for actual injury sustained. A continuous trigger effectively substitutes the potentiality of injury for the actuality of injury. While the potential for injury may constitute harm to the policyholder, it does not constitute actual injury. We should be careful here, as elsewhere, not to confuse the concept of harm with that of injury.

This article further notes that adoption of an indemnity continuous trigger requires radical redesign of long-established doctrines such as the known loss rule in a way that encourages policyholders to engage in conduct that is morally hazardous and socially unproductive. The longer a policyholder can delay and defer remediating an existing problem, the more insurance the policyholder can accrue as a bank against claims. Admittedly, a fine line needs to be drawn here, but courts, in their zeal to embrace the indemnity continuous trigger theory, have done so by utterly disemboweling the known loss doctrine. If a sacrifice was required, one would expect that the efforts of the sacrificial victim would at least be acknowledged and factored into the decisional calculus.

Line drawing is always difficult. Considerable arguments have been made, and accepted, in favor of an indemnity continuous trigger. Nevertheless, the line between the carrier's defense and indemnity obligations is well established and serves as a fair boundary along which the issue of trigger of coverage may be demarcated in the mass exposure tort context.

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am involved in Mankinde; And therefore never send to know for whom the bell tolls; It tolls for thee.

reprinted in DEVOTIONS UPON EMERGENT OCCASIONS 87 (McGill-Queens Univ. Press 1975) (1624).

259. *Cf.* Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 513 (1961) (noting that proponents of socialization of risk have increasingly displaced those whose viewpoint is oriented to the private model of insurance regulation).