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DOMTAR BABY: MISPLACED NOTIONS OF EQUITABLE APPORTIONMENT CREATE A THICKET OF POTENTIAL UNFAIRNESS FOR INSURANCE POLICYHOLDERS

Jeffrey W. Stempel[†]

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† Professor of Law, William S. Boyd School of Law, University of Nevada Las Vegas. Thanks to Ken Abraham, Tom Baker, Bob Jerry, Jim Hogg, Ann McGinley, Dean Richard Morgan, Peter Swisher, Carl Tobias, and Alan Widiss for a combination of insightful scholarship on the topic, ideas and support. Particular thanks to Mara Levy and Mary McCormick for research help and to Bob Harvey for technical assistance and processing. This project was supported by the James E. Rodgers Research Grant Fund and by research leave time provided by the Florida State University College of Law.

My learning and analysis on the issue of insurance allocation has also grown out of work I have done while retained as an expert consultant. Although I have been retained by both insurers and policyholders, my inquiry in this specific area has been largely for policyholders, at least one of which could potentially benefit from the changes in Minnesota law advocated in this article. However, this article represents my own analysis of insurance coverage issues and does not necessarily represent the legal position of any entity with which I have consulted. I have not acted as a trial witness for any entity that might benefit from application of the legal position advocated in this article.

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I. INTRODUCTION

Minnesota has an enduring reputation as a progressive, even liberal state hospitable to the underdog and concerned for fairness. This is hardly a surprise for the home state of prominent liberal politicians such as Hubert Humphrey, Walter Mondale, Eugene

McCarthy and Paul Wellstone.¹ The perception of Minnesota liberalism, populism, or pro-plaintiff sympathies extends to the technical legal realm as well. Lawyers know about prominent Minnesota cases favoring claimants. Many are reprinted in casebooks or otherwise disproportionately well-known.² Most recently, Minnesota was again in the news as the state unwilling to join in a proposed national settlement of claims against the tobacco industry and the state pushing furthest down the path to trial (fifteen weeks' worth of it) rather than early settlement of such claims. Perhaps unsurprisingly, the titular leader to the state's onslaught against big tobacco was Attorney General Hubert H. Humphrey III, the son of the famous liberal senator.

The perception of the state as politically progressive and friendly toward underdogs is probably further fueled by the noteworthy gender equality of the Minnesota Supreme Court, which has during the 1990s been majority female and remains more gender balanced than any state supreme court of which I am aware.³ Minnesota's reputation as more legally progressive perhaps also flows in part from the perception that women are more progressive politically, socially, and legally than men. Although this view has more than a few aspects of a stereotype (which is perhaps per se

1. I speak to this issue with less distance from the subject than normally found in a law review article, having grown up largely in Minnesota, both watching and occasionally participating in its politics and public policy debates. In the more distant past, I worked for U.S. Representative Bill Frenzel (Republican-3rd Congressional District; 1976), State Senator Ralph Doty (Democrat-Farmer-Labor Party, Duluth; 1977), and candidate and subsequent U.S. Senator Rudy Boschwitz (1977-78) prior to attending law school. I was admitted to the Minnesota Bar in 1981 and from 1983 to 1986 was an associate at the Minneapolis law firm of Maslon Edelman Borman & Brand prior to becoming a full-time law professor. Minnesota continues to be the only state bar of which I am a member.

2. See, e.g., *Allstate Ins. Co. v. Hague*, 449 U.S. 302 (1981) (affirming a Minnesota Supreme Court decision in which plaintiff was permitted to benefit from application of Minnesota substantive law in a case having relatively scant tangible contact with the state in an automobile accident matter where the parties to the collision were Wisconsin residents and accident took place in Wisconsin); *Rush v. Savchuk*, 444 U.S. 320, 333 (1980) (overturning, as a violation of the defendant's due process rights, a Minnesota case in which the court demonstrated considerable zeal in allowing a Minnesota plaintiff to sue a nonresident defendant); *Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co.*, 366 N.W.2d 271 (Minn. 1985), reprinted in KENNETH S. ABRAHAM, *INSURANCE LAW AND REGULATION: CASES AND MATERIALS* 53 (2d ed. 1995) (endorsing and adopting the view that insurance policies should be construed consistently with objectively reasonable expectations of the policyholder in some cases despite clear policy language to the contrary).

3. See David Margolick, *Women's Milestone: Majority on Minnesota Court*, N.Y. TIMES, Feb. 22, 1991, at B16.

nonprogressive), significant empirical evidence appears to support this generalization.⁴

To a large degree, however, the perception of Minnesota as liberal archetype is probably wrong. Although Minnesota will never be compared politically to Utah or Virginia, neither is it a political Sweden or a state law legal equivalent of the Warren Court. Indeed, to a surprising degree, Minnesota courts, at least in insurance coverage matters, have long been mainstream and in recent years have even been conservative (i.e., pro-insurer) in orientation. Although the state's insurance law doctrine is generally centrist, it provides more limited bad faith remedies than are found in most states in that punitive damages for bad faith breach of the insurance policy are not recoverable absent an independent tort such as fraud. Insurers can in many cases breach contracts and seldom suffer any fate worse than paying the value of policy proceeds that should have been paid in the first place,⁵ although consequential damages from breach are available and can result in considerable insurer liability beyond that required on the face of the policy.⁶ In

4. See John B. Wefing, *State Supreme Court Justices: Who Are They?*, 32 NEW ENG. L. REV. 47, 71 (1997). Wefing found that approximately half the male supreme court justices were Democrats while nearly 70 percent of the women justices were Democrats. See *id.* Although political party affiliation is not perfectly correlated with ideology, it cannot be seriously disputed that Democrats are generally more liberal than Republicans. Certainly, knowledgeable observers hold a general view that women are on average more politically liberal than men. See, e.g., Beverly J. Ross, *Does Diversity in Legal Scholarship Make a Difference?: A Look At the Law of Rape*, 100 DICK. L. REV. 795, 848 (1996) (suggesting that more women judges tend to make the law more sensitive to the perspective of rape victims and others suffering injury); Carrie Menkel-Meadow, *Culture Clash in the Quality of Life in the Law: Changes in the Economics, Diversification and Organization of Layering*, 44 CASE W. RES. L. REV. 621, 653 n.154 (1994) (viewing the increased presence and influence of women in law as having progressive or liberalizing effects, but also noting former Minnesota Supreme Court Justice Rosalie Wahl's observation that the additional number of women judges does not signal inauguration of change in basic legal analysis).

5. Minnesota courts have held that there cannot be recovery of punitive damages for the bad faith performance of a contract, even an insurance contract, unless it is accompanied by an independent tort claim such as one for fraud. See, e.g., *Wild v. Rarig*, 302 Minn. 419, 234 N.W.2d 775 (1975); *Cherne Contracting Corp. v. Wausau Ins. Co.*, 572 N.W.2d 339 (Minn. Ct. App. 1997); *Pillsbury Co. v. National Union Fire Ins. Co.*, 425 N.W.2d 244 (Minn. Ct. App. 1988). Even where bad faith and an independent tort are shown, state law often refuses to award any additional damages for the bad faith conduct of an insurer except to the extent that the damages are different than those available as remedies in the separate tort action required to sustain a bad faith claim. See *Pillsbury Co.*, 425 N.W.2d at 248-49.

6. See *Olson v. Rugloski*, 277 N.W.2d 385, 388 (Minn. 1979) (holding an in-

addition, despite a one-time seeming embrace of the concept of interpreting insurance policies to protect the reasonable expectations of the policyholder, Minnesota law now appears to protect such expectations only when policy language is arguably ambiguous, hidden, or unfairly surprising.⁷

Despite some Minnesota tilt toward insurers on matters of coverage and liability, one would nonetheless be surprised to discover (at least I certainly was) that in a case of multiyear tort claims against a policyholder triggering coverage in many different periods, the policyholder—despite having purchased more than \$60 million of triggered coverage—would be ordered to pay more than three-fourths of a \$2.8 million bill. This result was rendered in *Domtar, Inc. v. Niagara Fire Insurance Co.*,⁸ a 1997 supreme court decision that correctly decided a number of other coverage issues but misassessed the apportionment issue in the case.

In the 1990s, the issue of insurance coverage for environmental and mass tort claims has become prominent, with state law again showing no particular solicitude for policyholders. Although the Minnesota Supreme Court has not been a cheerleader for insurers, neither has it been of much comfort to policyholders. In one important way, Minnesota law has assisted policyholders by eschewing an unrealistic view of the “actual injury” trigger of coverage used to determine when an insurance policy is activated by a particular loss. Minnesota does not require unreasonably concrete or “scientific” proof of damage, particularly in the realm of government-mandated pollution remediation.⁹

surer liable for proximate consequential damages).

7. See, e.g., *Board of Regents v. Royal Ins. Co.*, 517 N.W.2d 888, 891 (Minn. 1994) (refusing to apply the reasonable expectations approach in favor of a policyholder where the policy language was viewed by the court not only as sufficiently clear but also because the court viewed the reasonable expectations approach as inapt unless language defeating coverage was hidden or unfairly surprising). Although this holding can be squared with *Atwater Creamery Co. v. Western National Mutual Insurance Co.*, 366 N.W.2d 271, 278 (Minn. 1985), which contains language to this effect, most observers of the *Atwater Creamery* decision in 1985 anticipated the Minnesota courts would make more aggressive use of the reasonable expectations approach. Jeffrey W. Stempel, *Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role*, 5 CONN. INS. L.J. 181, 196-205 (1998) (discussing Minnesota law and finding that the state has moved away from a seemingly full embrace of the reasonable expectations concept and toward more constricted use of expectations analysis).

8. 563 N.W.2d 724 (Minn. 1997), *aff'g* 552 N.W.2d 738 (Minn. Ct. App. 1996).

9. See *infra* Part II.B (discussing the decision in *Northern States Power Co. v.*

In the particularly problematic area of apportionment of insurer-policyholder responsibility for large losses, Minnesota law emerging from the mass tort coverage matters of the 1990s has taken a distinctly pro-insurer and anti-policyholder turn more reminiscent of Dan Quayle than Hubert Humphrey. In *Domtar*, a case involving decades of undiscovered pollution, the Minnesota Supreme Court held that the policyholder was responsible for all but fourteen of the sixty-four years during which property damage took place.¹⁰

Although the court's allocation of financial responsibility was motivated by concerns of equity in an opinion that correctly decided many issues of the dispute, the apportionment decision of the court in fact worked a considerable unfairness to the policyholder. Worse yet, the *Domtar* approach to apportionment in insurance coverage disputes involving multiple policy periods holds grave potential for unfairness and common law impairment of contract diminishing insurance coverage by operation of law.

Understanding this error of *Domtar* requires a review of the decision itself, as well as the important related high court decisions of *Northern States Power Co. v. Fidelity & Casualty Co.*¹¹ and *SCSC Corp. v. Allied Mutual Insurance Co.*,¹² key environmental insurance coverage cases of the 1990s. After discussing these and other relevant Minnesota cases, this article examines approaches to allocation of coverage in other jurisdictions and then assesses the rationales for and against the proration of coverage responsibility according to time on the risk and absence of insurance for some period of time. An alternative approach revising this aspect of *Domtar* is presented as a more reasonable means of protecting policyholders, insurers, and the public.

Fidelity & Casualty Co., 523 N.W.2d 657 (Minn. 1994)). In addition, one significantly pro-policyholder (and correctly decided) aspect of Minnesota law should be noted: unless otherwise stated in the insurance policy, government-ordered pollution cleanup costs constitute "damages" within the meaning of a liability insurance policy. See *Minnesota Mining & Mfg. Co. v. Travelers Indem. Co.*, 457 N.W.2d 175 (Minn. 1990).

10. See *Domtar*, 563 N.W.2d at 732-33.

11. 523 N.W.2d 657 (Minn. 1994).

12. 536 N.W.2d 305 (Minn. 1995).

II. THE *DOMTAR* DISPUTE, MINNESOTA LAW OF INSURANCE APPORTIONMENT, AND COVERAGE ALLOCATION LAW IN GENERAL

A. Domtar

The roots of Domtar, Inc.'s ("Domtar") dispute with its liability insurers extend to 1924, when Domtar began operating a tar refining facility on the north bank of the St. Louis River in Duluth.¹³ The plant operated on approximately six acres from 1924 to 1929, ceased operations, and renewed operations from 1934 to 1948, when it was closed.¹⁴ The plant was dismantled in the mid-1950s, and Domtar sold the property to Morton Salt Company in 1955.¹⁵ An automobile salvage yard was on the property in 1997 at the time of the supreme court's consideration of the case.¹⁶

Pollution was detected near the plant on the river in 1979.¹⁷ An entire 230-acre parcel of land on which the six acres of coal refining plant was located was declared a hazardous waste site under the federal Superfund law.¹⁸ In 1987, the Minnesota Pollution Control Agency ("MPCA") began investigating the site.¹⁹ In 1991, the MPCA requested responsive cleanup action by Domtar.²⁰ At

13. *See Domtar*, 563 N.W.2d at 728.

14. *See id.*

15. *See id.* at 728-29.

16. *See id.* at 729.

17. *See id.*

18. *See id.* "Superfund" is the popular name for the Comprehensive Environmental Response, Compensation and Liability Act of 1980 ("CERCLA"), as revised in part by the Superfund Amendments and Reauthorization Act of 1986 ("SARA"). *See* 42 U.S.C. §§ 9601-9662 (1994). Under Superfund, the federal government may order the owner or operator of contaminated property to clean up the property or may itself conduct the cleanup and demand repayment from any owners or operators, including owners like Domtar that have not controlled the property for more than 40 years. The government's claims for such CERCLA response costs have been held under Minnesota law to constitute covered damage under the pre-1986 version of the standard Commercial General Liability ("CGL") insurance policy. *See Minnesota Mining & Mfg. Co. v. Travelers Indem. Co.*, 457 N.W.2d 175, 180-81 (Minn. 1990). Nationally, courts have divided on this point, with approximately half the states finding no CGL coverage for government-mandated payments for pollution cleanup, reasoning that these are not "damages" within the technical sense of the law. *See* JEFFREY W. STEMPEL, *LAW OF INSURANCE CONTRACT DISPUTES* § 14.12 (2d ed. 1999). On this point, then, the Minnesota courts would be considered pro-policyholder.

19. *See Domtar*, 563 N.W.2d at 729.

20. *See id.*

this point, Domtar conducted an archaeological search of its records, found several older insurance policies covering some of the time period during which pollution damage took place on the property or to the groundwater in the area, and notified these insurers.²¹ When certain insurers refused to defend the MPCA action and denied coverage, Domtar commenced a declaratory judgment action seeking coverage against those fifteen insurers.²² As a result of settlements, the case proceeded to trial against Continental Insurance Company ("Continental") and Niagara Fire Insurance Company ("Niagara"), both primary insurers during some of the years in question, as well as against Certain Underwriters at Lloyd's of London and World Auxiliary Insurance Company, Ltd. (collectively "Lloyd's"), who were excess insurers during some of this time period.²³

Domtar was unable to find policies in effect prior to 1956 but did produce evidence of occurrence-based Commercial General Liability ("CGL") insurance from 1956 to 1970 "ranging from \$2.1 to \$10.0 million of property-damage coverage per year."²⁴ After 1970, Domtar's CGL carriers, like many liability insurers at that time, added to the policy an endorsement precluding coverage for pollution unless the pollution damage to third-party claimants resulted from a "sudden and accidental" discharge of pollutants.²⁵ In 1973, this exclusionary language and exception for sudden and accidental pollution became part of the standard CGL policy.²⁶ Consequently, Domtar had no CGL coverage for this type of liability after 1970.²⁷ Such coverage was probably completely unavailable after 1970.²⁸

21. *See id.*

22. *See id.*

23. *See id.*

24. *Id.*

25. *See id.* at 729 n.2.

26. *See id.* at 729.

27. *See id.*

28. Although no supreme court opinion has spoken directly to the issue, Minnesota appears to be among the slight majority of states that has interpreted the pollution exclusion using the "sudden and accidental" language (often referred to as the "qualified" pollution exclusion) to bar coverage for pollution-related liability claims unless the discharge of the pollutant is abrupt. Under this exclusion's structure, pollution claims are not covered under the CGL but language in the exclusion creates an exception if the release of the pollutant is "sudden and accidental." *See, e.g., Cincinnati Ins. Co. v. Flanders Elec. Motor Serv., Inc.*, 40 F.3d 146 (7th Cir. 1994) (applying Indiana law); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127 (Utah 1997). These states, like Minnesota

precedent to date, reason that the term "sudden" must mean "abrupt," particularly if the word "accidental" is not to be rendered surplusage. See *Bell Lumber & Pole Co. v. United States Fire Ins. Co.*, 60 F.3d 437, 443-44 (8th Cir. 1995) (applying Minnesota law); *Sylvester Bros. Dev. Co. v. Great Cent. Ins. Co.*, 480 N.W.2d 368, 375 (Minn. Ct. App. 1992). However, both *Bell Lumber* and *Sylvester Bros.* may be suspect as precedent at points because they took the view that whether a policyholder had "expected" a loss or "intentionally" caused damage was to be determined by an objective standard akin to negligence. See *Bell Lumber*, 60 F.3d at 443; *Sylvester Bros.*, 480 N.W.2d at 375. *Domtar* squarely adopted for Minnesota the majority view that the "expected or intended" exclusion to liability coverage applies only if the policyholder subjectively expected the injury to occur or knew that the injury was practically certain to occur. See *Domtar*, 563 N.W.2d at 735. On the issue of abruptness and the qualified pollution exclusion, however, *Domtar* seems tacitly to have endorsed the view of *Sylvester Bros.* since the *Domtar* court found no coverage for *Domtar's* gradual discharge of pollutants even though it also found that the discharge and injury were not intentional. See *Domtar*, 563 N.W.2d at 735-36.

A substantial number of states have interpreted the qualified exclusion to bar only intentional pollution because one dictionary definition of "sudden" is "unexpected" and because insurer representations to some regulators at the time the exclusion was approved suggested that the exclusion was designed only to bar intentional pollution. See, e.g., *Alabama Plating Co. v. U.S. Fidelity & Guar.*, 690 So. 2d 331 (Ala. 1996); *St. Paul Fire & Marine Ins. Co. v. McCormick & Baxter Creosoting Co.*, 923 P.2d 1200 (Or. 1996). See STEMPER, *supra* note 18, § 14.11.

In the mid-1980s, insurers switched to an "absolute" pollution exclusion that does not contain the "sudden and accidental" exception. This exclusion has been effective to bar coverage for environmental degradation claims against policyholders. Courts interpreting the absolute exclusion are divided, however, on whether it also excludes coverage for indoor air pollution, toxic torts, or other claims involving irritants. See William P. Shelley & Richard C. Mason, *Application of the Absolute Pollution Exclusion to Toxic Tort Claims: Will Courts Choose Policy Construction or Deconstruction?*, 33 TORT & INS. L.J. 749, 749-50 nn.1-2 (listing cases refusing to apply and applying the exclusion to bar coverage for toxic tort claims such as lead paint or carbon monoxide poisoning); Jeffrey W. Stempel, *Reason and Pollution: Correctly Construing the "Absolute" Exclusion in Context and in Accordance with Its Purpose and Party Expectations*, 34 TORT & INS. L.J. 1, 3 (1998); see also *League of Minn. Cities Ins. Trust v. City of Coon Rapids*, 446 N.W.2d 419 (Minn. Ct. App. 1989) (holding that absolute exclusion precludes coverage for claims arising out of illness to hockey rink patrons caused by fumes from ice resurfacing machine).

Interpretation of the CGL has also produced a divide among the courts regarding whether government ordered remediation costs for land pollution are "damage" claims covered by the CGL. Minnesota, like the majority of states, has concluded that such cleanup costs are covered. See *Minnesota Mining & Mfg. Co. v. Travelers Indem. Co.*, 457 N.W.2d 175, 180-81 (Minn. 1990); STEMPER, *supra* note 18, § 14.12.

Since the absolute pollution exclusion became part of the standard CGL in 1985, there has been a significant market for Environmental Impairment Liability ("EIL") insurance, which provides coverage for liability resulting from the "sudden and accidental" discharges that were covered under older versions of the CGL. Although this product has had some popularity, it is generally offered only with relatively low policy limits as well as high premiums and deductibles or self-insured retention's ("SIRs"). In addition, these policies may have "burning limits" in which defense cost expenditures reduce the remaining available policy limit.

Despite the ability to use only fourteen years' worth of coverage, Domtar's total liability insurance for the 1956-1970 period exceeded \$60 million.²⁹ Furthermore, the policies in question had no aggregate limit.³⁰ Consequently, this entire \$60 million of CGL insurance coverage remained available for Domtar's benefit if triggered by claims against Domtar arising out of injury inflicted during the 1956-1970 period.

Regarding the 1924-1956 time period, Domtar was unable to obtain coverage because it could not locate specific insurance policies or "definitive evidence of the terms, conditions, and limits of the pre-1956 policies."³¹ However, "Domtar did find considerable evidence that it had purchased general liability insurance covering this type of loss from various insurers in the 1930s and 1940s," including "evidence that Domtar had purchased 'public liability' and 'public liability and property damage' insurance from Continental and Employer's Liability insurance companies continuously from 1938 into the mid-1940s."³²

In the coverage litigation, the issue was not so much whether there was an insured event or whether at least some insurers were responsible.³³ Rather, the issue was whether damage to the adjoining land and groundwater took place during certain policy periods and the respective coverage responsibilities of the insurers over the

As a practical consequence of these broader developments in insurance and risk management, after 1970 Domtar essentially was unable to obtain pollution coverage for the type of liability underlying the coverage litigation.

29. See Appellant's Brief at 7-8, *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724 (Minn. 1997) (Nos. C9-95-2673, C0-95-2626, and C7-95-2638).

30. See *id.* at 8 n.2.

31. *Id.* at 7.

32. *Id.*

33. See *Domtar*, 563 N.W.2d at 735-38. The *Domtar* insurers asserted that the pollution damage was "expected or intended" by Domtar, was not fortuitous, was a "known loss," and that Domtar had failed to give post-loss notice for calculating and paying a retrospective premium adjustment, thus making the insurance contract lapse for want of consideration. See *id.* The *Domtar* court firmly (and in my view quite correctly) rejected these arguments. See *id.* The insurers also challenged the rates charged by Domtar's counsel, a challenge also rejected by the court. See *id.* at 740-41. A more involved issue was the degree to which the costs of remediation and related response were properly characterized as "defense costs." See *id.* at 738-41. The court ruled for Domtar, concluding that such expenses, if reasonable in amount and prompted by the government claim, were defense costs within the meaning of the liability insurance policy. See *id.* at 738-40. However, the insurers were not responsible for Domtar response and defense costs incurred prior to Domtar's tender of the claim to the insurers. See *id.* at 739.

time period during which damage took place.³⁴ There was evidence submitted that the pollution resulted from "routine waste-handling practices and accidental spills and leaks at the plant."³⁵ There was also expert testimony that the primary cause of the pollution was the decommissioning of the plant and the dismantling of storage tanks at the time the property was sold in 1955.³⁶

The parties disputed the means by which the pollution discharges traveled and did damage. Domtar asserted that the damage was indivisible and continued and expanded through the property over the years, while Continental and Niagara contended that the bulk of the damage took place at the time of discharge, with little movement of pollutants thereafter.³⁷ Not surprisingly, a finding of little movement would have placed the time of damage further back in time when another primary insurer, Canadian General Insurance Co. ("Canadian General"), was on the risk.³⁸ The jury verdict determined that property damage began at the site in 1933 and that additional damage took place throughout the 1956-1970 time period.³⁹ The jury also found a breach of the duty to defend by Continental and Niagara.⁴⁰ Based on this, the trial court entered judgment in favor of Domtar for more than \$1.15 million in defense costs (both engineering and remediation expenses as

34. See *id.* at 731-34.

35. *Id.* at 729.

36. See *id.* According to a 1948 inventory by Domtar, approximately 50,000 gallons of "sludge or residual muck" remained in the tanks at the time the plant was decommissioned. *Id.* A base on which these tanks rested remained on the property at the time of sale and was ultimately found to have a "two-to-three foot layer of coal tar derivatives" sitting atop the base. *Id.* at 730.

37. See *id.* at 730.

38. See *id.* at 734-35. Canadian General was Domtar's primary insurer from 1956 to 1965, with Lloyd's as excess insurer during that time period. See *id.* at 730 n.4. Continental and Niagara were primary insurers during the 1966 to 1970 time period, with Lloyd's continuing as excess during the 1966-1969 time period. See *id.* at 730. Canadian General contested the personal jurisdiction of Minnesota courts over it and was not part of the trial reviewed by the supreme court in the *Domtar* decision discussed in this article. After the verdict and in a separate decision, the court found personal jurisdiction existed over Canadian General. See *Domtar, Inc. v. Niagara Fire Ins. Co.*, 533 N.W.2d 25, 34-35 (Minn. 1995). The *Domtar* litigation remains pending. Domtar and its insurers also are involved in other insurance coverage litigation involving other sites.

39. See *Domtar*, 563 N.W.2d at 730. The jury was not asked to specifically assess whether damage took place from 1934 to 1956 because there was no insurance coverage dispute for that time period. See *id.* However, the logical deduction from the jury verdict is that the 1933 pollution continued to do damage until the time of remediation.

40. See *id.* at 730.

well as counsel fees) and \$1.68 million in legal expenses incurred in litigating the coverage action against the insurers.⁴¹

Many aspects of the *Domtar* opinion are well-reasoned. The court continued to apply the actual injury trigger in a manner sensitive to the realities of pollution coverage litigation, as it had in *Northern States Power Co. v. Fidelity & Casualty Co.* (“*NSP*”),⁴² by holding that all insurers between the time of onset of pollution injury and its discovery or remediation were triggered.⁴³ *Domtar* held that remediation expenses were covered “defense” costs under a CGL responding to government-mandated cleanup orders.⁴⁴ *Domtar* also rejected insurer suggestions that the cost of the cleanup was not insurable on fortuity-related grounds,⁴⁵ and it rejected insurer efforts to quibble over the costs incurred by the policyholder in vindicating its rights under the policies.⁴⁶

As to the nub of the case, the trial court determined that where pollution damage does not result from a single, discrete event and is continuous and indivisible, responsibility for the soil remediation:

should be allocated evenly from 1933 (when damage began) to the year in which clean-up efforts begin. The trial court’s formula absolved the defendants of liability for costs allocated outside of their policy periods; *Domtar* would bear the costs allocated to the years before 1956 and after 1970.⁴⁷

The trial court apportionment formula, affirmed by the court of appeals, was based on the supreme court’s 1994 decision in *NSP*,

41. *See id.* In other words, it cost *Domtar* more to sue to obtain insurance coverage (for which it had already paid premiums) than to adjudicate the pollution remediation action. Irrespective of the merits of the coverage decision, these costs suggest an excessively daunting path for the policyholder attempting to collect insurance.

42. 523 N.W.2d 657 (Minn. 1994).

43. *See Domtar*, 563 N.W.2d at 731-32. The *Domtar* court was somewhat vague, however, regarding whether the date of the discovery of pollution or date of cleanup should serve as the end of the triggered period. *See id.* The implications can be significant. For example, in *Domtar* itself, the pollution was detected in 1979 but remediation did not occur until the 1991-1996 period. *See id.* at 729.

44. *See id.* at 738-39.

45. *See id.* at 736-37.

46. *See id.* at 739-41.

47. *Id.* at 730.

discussed at greater length below,⁴⁸ which stated that in multiyear occurrences triggering multiyear policy periods, the respective responsibilities of the triggered insurers should be allocated according to the insurers' respective time on the risk.⁴⁹

Before the supreme court was the question of whether financial responsibility for the pollution cleanup could be assigned to Domtar for years outside the 1956-1970 period in which Domtar possessed liability insurance and which was at issue in the coverage litigation.⁵⁰ Domtar contended that allocation to the policyholder was both unfair and inconsistent with the insurance policy contract language, which stated that the insurers were to be responsible for "all sums" of liability against the policyholder for covered claims.⁵¹ As might be expected, the insurers supported the allocation decision because it had the effect of forcing Domtar to pay for nearly three-fourths of the cleanup in that Domtar was insured for only fifteen years of the 64-year time period (1933-1996) during which property damage took place.⁵²

Domtar argued that each insured policy "triggered" by the occurrence of covered property damage during its policy period should be responsible for indemnifying Domtar for the damage (up to each insurer's respective policy limit) if the amount of damage was sufficient, so long as Domtar did not obtain double recovery or overindemnification.⁵³ The insurer argument both invoked the *NSP* precedent's general principle of temporal allocation of liability responsibility and argued that allocation across all years during which damage took place was fair in that it forced Domtar, as a polluter, to shoulder its share of the responsibility for the environ-

48. See *infra* Part II.B.

49. See *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 664 (Minn. 1994).

50. See *Domtar*, 563 N.W.2d at 731-32.

51. See *id.*

52. See *id.* at 731 (describing respective positions of the parties).

53. See *id.* at 732. The primary policies of Continental and Niagara both contained the "all sums" language relied upon by *Domtar*. See *id.* The Lloyd's excess insurance policies were "follow-form" policies that committed themselves to providing excess insurance when underlying primary insurance was exhausted according to the coverage terms of the primary policy. See *id.* at 731. Excess insurance generally follows-form to the primary policy, with perhaps some additional exclusions. However, if the excess insurer does not wish to cover every matter encompassed in the primary policy, the excess insurer must include a clear, unambiguous, and specific exclusion. See generally EUGENE R. ANDERSON ET AL., *INSURANCE COVERAGE LITIGATION* ch. 13 (1997); STEMPER, *supra* note 18, § 16.1 (describing nature of excess insurance).

mental damage.⁵⁴ In addition, the insurers argued that the language of their policies, which provide for coverage of damages taking place during the policy period, limited their respective coverage liability.⁵⁵

The parties to the dispute had significant allies. The insurers were joined by amicus the Insurance Environmental Litigation Association ("IELA"), "a trade association of major property and casualty insurers."⁵⁶ Also siding with the *Domtar* insurers was an amicus consortium of insurers that were parties to a case styled *First State Insurance v. Minnesota Mining & Manufacturing Co.*,⁵⁷ in which the insurers sought a declaration of no coverage or limited coverage in connection with claims against Minnesota Mining & Manufacturing Co. ("3M") arising out of the sale of silicon breast implants by a 3M subsidiary during the 1977-1985 period.⁵⁸ Policyholder 3M also pursued amicus participation because of potential overlap between *Domtar* coverage issues and legal issues in the *First State* matter.⁵⁹ In addition, the State of Minnesota partici-

54. See *Domtar*, 563 N.W.2d at 732.

55. See *id.*

56. Brief of Amicus Curiae Insurance Environmental Litigation Association ("IELA") at 1, *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724 (Minn. 1997) (Nos. C9-95-2673, C0-95-2626, and C7-95-2638). IELA submitted the brief on behalf of member insurers "AIG Insurance Companies, American States Insurance Co., Chubb & Son, Inc., Envision Claims Management Corporation, Fireman's Fund Insurance Companies, Hanover Insurance Company, Hartford Insurance Group, Liberty Mutual Insurance Company, Royal Insurance Company, Selective Insurance Company of America, State Farm Fire & Casualty Company, The Travelers Indemnity Company, and United States Fidelity & Guaranty Company." *Id.* at 1 n.1. Although CNA Insurance Companies is also an apparent IELA member, the amicus brief was expressly not submitted on its behalf because of CNA's affiliation with defendants Niagara and Continental. In addition, the amicus brief was not submitted for apparent IELA member Allstate and other members who were part of a group of "3M Insurers" who participated as amicus curie. See *id.* at 1 n.1.; see also *infra* notes 58-59 and accompanying discussion. However, several of the IELA members signing on to the IELA brief were also 3M Insurers signing on to the amicus brief of the 3M insurers.

57. *First State Ins. Co. v. Minnesota Mining & Mfg. Co.*, No. C3-94-12780 (Ramsey Co. Dist. Ct. Sept. 22, 1994).

58. See *id.* The "3M Insurers," numbering 44, are too numerous to bear listing but include such prominent insurers as First State, AIG, Royal, and Chubb. See Appendix to Brief of Amicus Curiae Certain Insurers of 3M at 1-5, *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724 (Minn. 1997) (Nos. C9-95-2673, C0-95-2626, and C7-95-2638).

59. See Brief of Amicus Curiae Minnesota Mining & Mfg. Co. at 1-2, *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724 (Minn. 1997) (Nos. C9-95-2673, C0-95-2626, and C7-95-2638). 3M had first sought amicus participation, engendering its insurers' request to participate as amicus in *Domtar*.

pated as amicus.⁶⁰ IELA and the 3M insurers argued for a strict rule of proration by time in cases of multiple triggered coverage periods, including allocation of coverage responsibility to the policyholder.⁶¹ 3M and the State of Minnesota argued that allocation among insurers or to the policyholder, although perhaps apt in certain cases, should not be universally required in all cases where consecutive periods of insurance are triggered.⁶²

Although responding in part to the 3M and Minnesota amici by resisting a per se rule of allocation as to the *Domtar* matter itself, the supreme court to a large degree appeared to embrace the insurers' position on apportionment of liability and coverage responsibility.⁶³ Noting the obvious similarity with *NSP*, the *Domtar* court stated:

Based on the facts of this case, *NSP* is the starting point for analyzing whether *Domtar* is responsible for self-insured periods. Like *Domtar*, the insured in *NSP* was prompted by the MPCA to respond to environmental contamination. The contamination arose from *NSP*'s operation of two coal-tar gasification facilities; operations ceased sometime after 1933, the entire property was sold by 1978, and *NSP* sought coverage from its 1946-1985 insurers. On appeal, we considered allocation and related issues with respect to *NSP*'s 1958-1973 CGL insurer. Like the CGL policies in this case, the policies at issue in *NSP* covered occurrences "during the policy period," but also promised to pay "all sums which the insured shall become legally obligated to pay as damages because of injury or destruction of" property. The policy limits applied to "each occurrence or series of occurrences" arising out of one event.

Domtar believes that *NSP* did not indicate whether an insured is liable for self-insured periods, but its reading of our decision is too narrow. *NSP* made three rulings rele-

60. See Brief of Amicus Curiae State of Minnesota at 1, *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724 (Minn. 1997) (Nos. C9-95-2673, C0-95-2626, and C7-95-2638).

61. See Brief of Insurance Environmental Litigation Association ("IELA") at 14-17, *Domtar* (Nos. C9-95-2673, C0-95-2626, and C7-95-2638); Brief of Minnesota Mining & Mfg. Co. at 5-8, *Domtar* (Nos. C9-95-2673, C0-95-2626, and C7-95-2638).

62. See Brief of Minnesota Mining & Mfg. Co. at 5-8, *Domtar* (Nos. C9-95-2673, C0-95-2626, and C7-95-2638); Brief of State of Minnesota at 12-17, *Domtar* (Nos. C9-95-2673, C0-95-2626, and C7-95-2638).

63. See *Domtar*, 563 N.W.2d at 734-37.

vant to continuous and indivisible environmental contamination cases: (1) we established a guiding principle for triggering standard CGL policies—a policy is triggered if property damage occurred during the policy period; (2) we indicated that, in such cases, an insurer's liability is limited to property damage occurring during its policy period or periods—insurers become consecutively liable rather than concurrently liable; and (3) we recommended a fair method for allocating losses among CGL insurers who are consecutively liable for continuing property damage, in the absence of applicable policy language—pro rata by time on the risk. In these cases, the insured bears the burden of proving that a policy has been triggered, but if the insured proves when the contamination began and when it ended or was discovered, then the trial court should presume that property damage was continuous from its initiation until the time of clean-up or discovery. The burden of proof then shifts to any party seeking to demonstrate that no appreciable damage occurred during a particular time period. All policies in effect when damages occurred are triggered, and liability is allocated to each policy according to the proportion of time each was on the risk.⁶⁴

Although the jury had not specifically been asked to determine if pollution and property damage took place between 1933 and 1956, the court found that this was both the jury's implicit conclusion and a fact the court could determine on the record as a matter of law.⁶⁵ In addition, the court in essence found that Domtar either had waived the right to contend that no damage took place during the 1934-1955 era⁶⁶ or that Domtar was estopped from so arguing on appeal.⁶⁷

On the matter of apportionment, however, the *Domtar* court delivered a sweeping victory for the insurers, requiring the policyholder to shoulder seventy-five percent of the cleanup costs even

64. *Id.* at 732 (citations omitted).

65. *See id.* at 733. The court noted, "The jury concluded that property damage commenced in 1933 and nothing in the record supports the conclusion that it abruptly discontinued at any point before 1956 or after 1970." *Id.*

66. *See id.* at 733. The court stated, "Any party believing that no appreciable damage occurred during a particular time period bears the burden of proving that fact." *Id.*

67. *See id.* at 733. The court stated, "Domtar's own expert testified that his opinion as to continuing damage was the same after 1970." *Id.*

though the policyholder had ample insurance for a 14-year period during which covered loss took place.⁶⁸ However, the *Domtar* court suggested some cautionary limitations on judicial resort to pro rata allocation of coverage responsibilities in multi-year tort and insurance coverage matters:

[T]he defendants' reading of *NSP* is too broad. *It is inaccurate to conclude that a CGL insurer is never liable for damages occurring outside of the policy period.* CGL policies come in many forms and it is a mistake to read our case law as if the scope of coverage has been resolved for all such policies, no matter what their language. The proper scope of coverage also will depend on the facts of the case. *When environmental contamination arises from discrete and identifiable events, then the actual-injury trigger theory allows those policies on the risk at the point of initial contamination to pay for all property damage that follows.* This interpretation of the policies is in accord with the common understanding of the terms "occurrence" or "accident." *It is only in those difficult cases in which property damage is both continuous and so intermingled as to be practically indivisible that NSP properly applies.* *NSP* provides a judicially manageable way for trial courts to adjudicate certain pollution-coverage disputes when it is difficult to determine when an "event" or "occurrence" or "damage" giving rise to legal liability has occurred. *NSP* does not establish hard-and-fast rules; it offers a practical solution in the face of uncertainty.⁶⁹

The *Domtar* holding, although in the main correctly decided and fair to policyholders, is thus something of a mixed blessing for policyholders. As noted above, the *Domtar* court rejected strained insurer coverage defenses and ruled, in a natural extension of prior precedent,⁷⁰ that the CGL without an absolute pollution exclusion provides coverage for the engineering and investigative fees required to defend a Superfund claim as well as the costs of actual remediation.⁷¹ The *Domtar* allocation holding, however, works a

68. See *id.* at 734.

69. *Id.* at 733-34 (emphasis added) (citations omitted).

70. See *supra* note 33. Cf. *Minnesota Mining & Mfg. Co. v. Travelers Indem. Co.*, 457 N.W.2d 175 (Minn. 1990) (holding that payment of government-mandated environmental remediation costs are "damages" within meaning of CGL).

71. See *Domtar*, 563 N.W.2d at 734.

significant injustice to the policyholder by reducing otherwise applicable coverage on the basis of a formula seemingly drawn from the court's visceral but misplaced sense of fairness. Where there is triggering injury, multiple insurance policies are implicated—but overall insurance is reduced pro rata where any time period during the damage period lacks collectible insurance.

This allocation portion of *Domtar* is clearly a victory for insurers, albeit one the *Domtar* court states is limited to the “difficult” and “uncertain” context of multiyear pollution claims.⁷² If *Domtar* is so limited in the future, its worst traits can be confined to a subset of coverage claims that appears to have reduced potential for mischief and where the special facts of pollution liability may make allocation by time closer to a fair trade in return for broad, virtually continuous application of the injury trigger. Pollution liability and cleanup claims of this type may be a decreasing proportion of coverage litigation. In addition, the advent of the “absolute” pollution exclusion designed to foreclose coverage for CERCLA claims tends to remove coverage for almost all cases like *NSP* and *Domtar*, thereby making allocation issues moot. Because the advent and progression of soil and water pollution is difficult to prove and trace, insurers can argue with some force that policyholders have been accorded a significant benefit through the broad trigger rules used in cases like *Domtar*. In return for such trigger liberality benefitting the policyholder, insurers might argue that a temporal allocation rule is necessary to restore equilibrium by benefitting insurers. Although this argument is ultimately unpersuasive, it is most forceful in the pollution context.⁷³

However, even if confined to pollution claims—or even if confined only to Superfund-style pollution claims—*Domtar's* approach strongly favors insurers on the issue of allocation of responsibility where bodily injury or property damage is not caused by a single, discrete, and identifiable event. If the pollution is lengthy enough in duration, undiscovered for a significant period of time, or slow to be rectified, a substantial portion of the liability is imposed on the policyholder, even if the insured bought and paid for more

72. See *id.* at 733-34.

73. See *infra* Part III.A.11 (discussing the relationship of trigger and allocation and concluding that liberal application of actual injury trigger does not work an inequity upon insurers and consequently does not justify countervailing inequity for allocating coverage responsibility pro-rata to the policyholder for periods of exhausted, uncollectible, unavailable, or unpurchased coverage).

than enough insurance to cover the claims. The *Domtar* approach can work grave unfairness upon policyholders despite its professed aim of equity in the face of uncertainty.⁷⁴

If *Domtar* allocation is applied to product liability or toxic tort claims, its allocative unfairness is multiplied both in frequency and in magnitude. Adding products claims and coverage matters to environmental cleanup cases obviously expands the number of cases where allocation by time can work its mischief upon the policyholder. In addition, there is no justification for a trigger-allocation tradeoff as might be the case for pollution matters. For most product claims, information as to the onset and progression of injury is more readily available and the time of product-related injury is likely to be considerably shorter than is the case for pollution claims even if the alleged injury or property damage from the policyholder's product spans more than one discrete event. Although the worst aspects of *Domtar* may be confined to *Domtar*-like matters, the potential for harm to policyholders remains substantial.

B. Contemporary Minnesota Insurance Coverage Law on Allocation

To some extent, *Domtar* cannot be fully understood unless read in conjunction with *Northern States Power Co. v. Fidelity & Casualty Co.*,⁷⁵ decided in 1994, and *SCSC Co. v. Allied Mutual Insurance Co.*,⁷⁶ decided in 1995. As noted above, and by the *Domtar* court, the *NSP* case was quite similar in that it involved clean up of property damage caused by multi-year pollution.⁷⁷ *SCSC* also involved pollution, but with a more limited causal occurrence.⁷⁸ The distinction resulted in crucial differences in the cases and crucial differences in coverage consequences under this emerging Minnesota law. The *Domtar* decision, although perhaps a natural extension of these decisions, emphasized the degree to which this aspect of Minnesota coverage law has significant potential for negative consequences.

74. See *infra* Part III.A.11.

75. 523 N.W.2d 657 (Minn. 1994). The official published *NSP* opinion is a revised version of the *NSP* opinion that first appeared at 517 N.W.2d 918 (Minn. 1994). See *infra* Part II.C. The revised official *NSP* opinion differs primarily from the first opinion in that the revised opinion eliminated certain language stating the policyholder is to be allocated a percentage of the coverage burden based on any time periods where the policyholder had no applicable insurance coverage. See *id.*

76. 536 N.W.2d 305 (Minn. 1995); see *infra* Part II.C.

77. See *Domtar*, 563 N.W.2d at 732.

78. See *SCSC*, 536 N.W.2d at 309.

NSP involved a MPCA order to clean up property contaminated by operations of a coal-tar gasification site purchased by *NSP* in 1924.⁷⁹ Prior to the *NSP* purchase, an oil and gas processing plant had operated on the site since 1873.⁸⁰ After the purchase, *NSP* built another coal gasification facility in 1928 and operated the site for several years, selling both sites by 1978.⁸¹ Groundwater pollution was discovered in 1981, with *NSP* investigating and remediating the site from 1984 to 1987, notifying its insurers the same year.⁸² A 1988 consent order required *NSP* to pay \$1.6 million in response costs to the MPCA and continuing monitoring costs of \$40,000 per year.⁸³

Trigger of coverage was a significant issue in the *NSP* matter. Minnesota has consistently applied an “actual injury” trigger in which liability insurance coverage is activated when a third-party claim alleges that the claimant was injured by policyholder actions and that the injury took place during the period of insurance coverage.⁸⁴ In pollution cases, insurers commonly argue that the policyholder must prove through direct evidence or very strong circumstantial evidence precisely what damage took place at what time. The *NSP* application of the injury trigger implicitly rejected so painstaking a requirement and instead found it sufficient “if the insured shows damage began on a particular date, X, and ended on, or was discovered at, a later date, Y, which period of time includes the policy periods for the policies at issue.”⁸⁵

79. See *NSP*, 523 N.W.2d at 658-59.

80. See *id.* at 659. From 1873, the site was operated by the Faribault Gas Light Company, which consolidated with the Faribault Electric Light Company in 1889. See *id.* The plant was rebuilt in 1897 and purchased by the Consumers Power Company in 1910. See *id.*

81. See *id.* The record was apparently sketchy as to the operations of the *NSP*-owned plant. It perhaps ceased operations as early as 1933 and the exact date of sale was identified as taking place by 1978. See *id.*

82. See *id.*

83. See *id.* (giving a more complete description of the background of the pollution and cleanup history).

84. See *Singsaas v. Diederich*, 307 Minn. 153, 15-56, 238 N.W.2d 878, 880-81 (1976); *Industrial Steel Container Co. v. Fireman's Fund Ins. Co.*, 399 N.W.2d 156, 159 (Minn. Ct. App. 1987). The actual injury or “injury-in-fact” trigger of coverage is most widely accepted. See *STEMPEL*, *supra* note 18, § 14.09. Other coverage triggers applied to pollution claims include exposure (when the person or property is exposed to the pollutant), manifestation (when the alleged damage from the pollution becomes apparent), and a “continuous” or “triple” trigger in which any degree of exposure, injury, or manifestation triggers policies on the risk at the time of the exposure, injury, or manifestation. See *id.* § 14.09.

85. *NSP*, 523 N.W.2d at 663-64.

This application of the actual injury trigger is something of a hair trigger, in which the policyholder's burden of proof is not onerous. The actual injury trigger is satisfied so long as the policyholder can demonstrate damage at the beginning and the end of the time in question.⁸⁶ Under *NSP*, the court as a matter of law found actual injury during the vast middle of this time period.⁸⁷ However, under the facts of pollution claims and insidious disease claims such as asbestos, the actual facts of occurrence and progression of such injuries are almost certainly consistent with this approach even if the policyholder might not be able to show the quantum of injury during a specific time. Furthermore, the language and structure of the CGL does not require the policyholder to demonstrate a precise quantum of injury in order to obtain coverage. It is sufficient if the third party claimant alleges or proves any injury during the policy period.

Prior to the court's decision, *NSP* had settled with many of the insurers.⁸⁸ *NSP* also did not produce evidence of coverage during many of the years in question. In fact, the pollution at issue began well before there was any existence of insurance and continued past the time of the insurance in dispute.⁸⁹ Nonetheless, the *NSP* opinion did not expressly allocate to *NSP* Company any of the burden of payment.⁹⁰ The opinion reads as though coverage responsibility was prorated solely among the triggered and applicable *NSP* insurers in the action.⁹¹ In the supreme court action, five CGL policies issued by the St. Paul Companies were at issue.⁹² Under the trigger approach used in *NSP*, insurers covering *NSP* from 1958 to 1970 were considered triggered and had no defense to providing coverage.⁹³ Each policy contained the standard CGL language stating that the policy would pay on behalf of the insured "all sums which the insured shall become legally obligated to pay as damages because of injury or destruction to tangible property."⁹⁴ Each pol-

86. *NSP*, 523 N.W.2d at 662-63; *Westling Mfg. Co., Inc. v. Western Nat'l Mut. Ins. Co.*, 581 N.W.2d 39, 44 (Minn. Ct. App. 1998).

87. *See NSP*, 523 N.W.2d at 664.

88. *See id.* at 659.

89. *See id.* at 658-59.

90. *See id.* at 664.

91. *See id.* at 661.

92. *See id.* at 659.

93. *See id.* at 662-64.

94. *Id.* at 659.

icy also had a \$5 million policy limit.⁹⁵ After 1973, the policies contained the qualified “sudden and accidental” pollution exclusion that was found in the *Domtar* policies after 1970, precluding coverage.⁹⁶

Thus, the *NSP* court was required to determine the respective coverage responsibilities of the insurers on the risk from 1958 through 1973.⁹⁷ The policyholder argued that all carriers from 1946 through 1985 were liable to the full extent of their policy limits because all these policies promised to pay “all sums” for which the policyholder might be held responsible.⁹⁸ Implicitly, this would give *NSP* the right to tap the full policy limits of any triggered insurers in the order sought by the policyholder. *NSP* had initially argued that it could do this and “make a claim for damage under that policy, paying only one deductible and obtaining the policy’s full limits,” with the insurer then required to seek contribution from other carriers.⁹⁹ As to the insurers’ responsibilities vis-a-vis

95. *See id.* The 1958-1970 policies also imposed on *NSP* a \$25,000 self-insured retention (“SIR”). *See id.* From 1970 to 1973, the SIR was \$100,000. *See id.*

96. *See id.*; *see also supra* notes 25-28 and accompanying discussion about “sudden and accidental” pollution exclusions.

97. *See NSP*, 523 N.W.2d at 659-61.

98. *See id.* at 659. The Court referred to this as *NSP* seeking a finding of “joint and several” liability of its insurers. *See id.* However, the term joint and several liability is misleading in the insurance coverage context. As the term is generally used in tort law, tortfeasor defendants found jointly and severally liable are each responsible for the full amount of the plaintiff’s damages regardless of each joint tortfeasor’s relative degree of fault. A defendant who is only one percent at fault may pay 100 percent of an award if the plaintiff comes to that defendant first for satisfaction of the judgment. However, even courts receptive to the arguments of policyholders that each insurer is responsible without apportionment for triggered damage have limited the insurer’s responsibility to the amount of unexhausted policy limits remaining for the triggered policy. Consequently, calling the result sought by the policyholder joint and several liability is something of a misnomer implying that a triggered insurer might be forced to pay more than its “fair” share. *See STEMPER*, *supra* note 18, § 14.10. A similar point and criticism of the loose use of the “joint and several liability” term is made by two commentators strongly supporting allocation. *See William R. Hickman & Mary R. DeYoung, Allocation of Environmental Cleanup Liability Between Successive Insurers*, 17 N. KY. L. REV. 291, 314-15 (1990).

99. *NSP*, 523 N.W.2d at 660 n.4. The court’s description implies that *NSP* backed away from this position by the time the matter reached the court. However, the opinion does not clearly state exactly what *NSP* wanted on appeal, or at least what the court thought *NSP* wanted. If *NSP* argued for so-called “joint-and-several” liability, this implicitly suggests that a single insurer can be called upon to pay the claim so long as the policy limits are not breached. Because the policy tapped by *NSP* (St. Paul’s 1957 policy) had \$5 million in limits, this was presumably sufficient to fully satisfy *NSP*’s liability of approximately \$1.6 million plus moni-

one another, "NSP further argued that the trial court should apportion the damages between carriers 'pro rata by [policy] limits.'" ¹⁰⁰ As the court put the apportionment issue:

The question therefore becomes, how may a court allocate damages consistent with the "actual injury" trigger theory? One option would be to apportion the damages as proven; in other words, each policy would cover only those damages that are allocable to harm which occurred during the policy period. This is the approach followed by the court of appeals in this case. A second option would allocate damages pro rata by each insurer's "time on the risk." These two options provide the same result when, as may be the case here, the damages are continuous over all policy periods.

The primary advantage of the first option, allocating damages to each policy "as proven," is that it is completely consistent with CGL policy language limiting liability to damages incurred "during the policy period." Practically, however, this option is unattractive given the scientific complexity of the issues involved, the extended period of time over which damages may have occurred before discovery, and the number of parties potentially involved

. . . .

Where it is scientifically possible to prove the amount of harm occurring during each policy period, it may be nonetheless too expensive to do so in cases involving relatively small total damages. At the same time, the extremely fact-dependent nature of such an allocation scheme may reduce the likelihood of settlement. Finally, as a public policy matter, this court cannot ignore the enormous difficulty insureds would face if, as is generally the case, they had the burden of proving the amount of damages for each policy at issue.

By contrast, a "pro rata by time on the risk" allocation scheme could reduce the costs of litigation because it is a more or less a per se rule. This method assumes that the damages in a contamination case are evenly distributed (or continuous) through each policy period from the first

toring costs. *See id.* at 659.

100. *Id.* at 660 (footnote omitted).

point at which damages occurred to the time of discovery, cleanup or whenever the last triggered policy period ended. Each triggered policy therefore bears a share of the total damages proportionate to the number of years it was on the risk relative to the total number of years of coverage triggered. While such an allocation scheme is attractive for its simplicity, we recognize that damages are by nature fact-dependent and that trial courts must be given the flexibility to apportion them in a manner befitting each case.¹⁰¹

The *NSP* court gave unduly short shrift to the possibility of apportioning insurer liability according to policy limits, finding that:

The essence of the actual injury trigger theory is that each insurer is held liable for only those damages which occurred during its policy period; no insurer is held liable for damage outside its policy period. Where the policy periods do not overlap, therefore, the insurers are consecutively, not concurrently liable. A "pro rata by limits" allocation method effectively makes those insurers with higher limits liable for damages incurred outside their policy periods and is therefore inconsistent with the actual injury trigger theory.¹⁰²

Domtar appears to recede from this statement regarding the insurer's limited liability for damages mounting after the close of its policy period. However, both *NSP* and *Domtar* reflect a fundamental misunderstanding of the degree of the liability insurer's contractual commitment. In addition, the supreme court's preoccupation with time on the risk rather than consideration of the nature of the risk assumed led the court to turn its back on an apportionment program that, in many cases, would more fairly reflect both the insurers' obligation and the policyholder's purchase.¹⁰³

The *NSP* court also held that the policyholder was responsible for each policy period's deductible or SIR in cases of multiyear occurrences and the triggering of successive policies.¹⁰⁴ The court re-

101. *Id.* at 662-63 (citations and footnote omitted).

102. *Id.* at 662.

103. *See id.* at 662.

104. *See NSP*, 523 N.W.2d at 664 ("Because at least one occurrence was required to invoke the coverage of each triggered policy, it seems apparent that *NSP*

jected any role for any "other insurance" clauses contained in the policies, holding that "other insurance" clauses are to be utilized for coordinating coverage only where two or more policies are concurrently triggered and provide coverage for damage taking place during the same time period.¹⁰⁵ According to the *NSP* court, where the triggered policies cover different policy periods, the other insurance clauses are inapplicable for allocating coverage among successively triggered insurers.¹⁰⁶ The court was strongly influenced by a law review article authored by insurer counsel William Hickman and Mary DeYoung that advocated proration by time on the risk.¹⁰⁷

As discussed further below, the Hickman & DeYoung article, although a worthwhile contribution to the allocation debate, is not only partial to the insurer cause but also problematic in some aspects of its analysis.¹⁰⁸ It has not been widely influential.¹⁰⁹ The *NSP* court also appears to have been strongly influenced by the amicus position of IELA, the insurer organization that successfully argued for allocation to reduce insurer coverage responsibility in *Domtar*.¹¹⁰ IELA has worked hard to influence judicial decisions on insurance coverage matters and has been quite successful, perhaps undeserv-

is responsible to the extent of its applicable retained limit in connection with each triggered St. Paul policy."). The *NSP* court felt strongly enough on this point to overrule this aspect of *Jostens, Inc. v. CNA Insurance/Continental Cas. Co.*, 403 N.W.2d 625, 630-31 (Minn. 1987) (permitting the policyholder to average the retained limits of two consecutively triggered policies). See *NSP*, 523 N.W.2d at 664.

105. See *id.*

106. See *id.* at 663.

107. See *id.* at 660-63 (citing Hickman & DeYoung, *supra* note 98, at 293).

108. See *infra* 413-14 and accompanying discussion.

109. As of October 5, 1998, the LEXIS "Mega" database of state and federal court decisions reveals only four cases citing the Hickman & DeYoung article. See *Chemical Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co.*, 978 F. Supp. 589, 605 (D.N.J. 1997); *Transamerica Ins. Co. v. Thomas M. Durkin & Sons*, No. 90-0968, 1991 U.S. Dist. LEXIS 14318, at *7 (E.D. Pa. Oct. 1, 1991); *Domtar, Inc. v. Niagara Fire Ins. Co.*, 552 N.W.2d 738, 744 (Minn. Ct. App. 1996), *aff'd in part and rev'd in part*, 563 N.W.2d 724 (Minn. 1997); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 994 (N.J. 1994). Only three law review articles in the LEXIS database cite the article. See Michael G. Doherty, Comment, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. 257, 285 (1997); Rob S. Register, Comment, *Apportioning Coverage Responsibility of Consecutive Insurers When the Actual Occurrence of Injury Cannot be Ascertained: Who Has to Contribute in a Settlement?*, 49 MERCER L. REV. 1151, 1160 (1998); Tung Yin, *Nailing Jello to a Wall: A Uniform Approach for Adjudicating Insurance Coverage Disputes in Products Liability Cases with Delayed Manifestation Injuries and Damages*, 83 CAL. L. REV. 1243, 1246 (1995).

110. See *supra* notes 56-58 and accompanying discussion.

edly so in light of the merits of the insurance coverage matters.¹¹¹ In addition to its typical strong brief on behalf of insurers,¹¹² IELA was aided in *NSP* by the absence of any countervailing policyholder organization's amicus participation. With the field comparatively to itself in *NSP*, IELA and the Hickman & DeYoung *Allocation* article¹¹³ appear to have had substantial impact in bending the court to its view of the wisdom of allocation and the notion that it is somehow unfair to insurers if allocation is not imposed to limit the insurer's coverage responsibility.¹¹⁴

There is also the intriguing "missing language" episode of *NSP* and the alteration of the opinion prior to final publication, although one's first reading of this chronology would not have foreshadowed the *Domtar* holding. In the first *NSP* opinion entered June 30, 1994¹¹⁵ but later withdrawn for replacement with a superceding opinion, the court stated:

The trial court should also hold the insured liable for its pro rata share of any uninsured or self-insured periods.

....

Consistent with our decision regarding the appropriate method of allocating damages in these types of cases, we believe that "other insurance" clauses of the policies at issue are irrelevant and therefore only affirm the court of appeals' result. The court of appeals followed this court's analysis in *Integrity Mut. Ins. v. State Auto & Cas. Underwriters Ins. Co.*, 307 Minn. 173, 239 N.W.2d 445 (1976). In *Integrity*, we considered the problem of allocating damages between multiple insurance policies concurrently liable for damages arising out of a single, discrete occurrence.

111. See Stempel, *supra* note 28, at 22-26 (describing the apparent impact of the IELA amicus brief in an important Florida Supreme Court case addressing the application of a CGL pollution exclusion); Jeffrey W. Stempel, *Unreason in Action: A Case Study in the Wrong Approach to Construing the Liability Insurance Pollution Exclusion*, 50 FLA. L. REV. 463 (1998) (discussing *Deni Associates of Florida, Inc. v. State Farm Fire & Cas. Ins. Co.*, 711 So.2d 1135 (Fla. 1998), and *E.C. Fogg, III v. Florida Farm Bureau Mut. Ins. Co.*, 711 So.2d 1135 (Fla. 1998), in greater detail).

112. See Stempel, *supra* note 28, at 22-24. IELA is active in many coverage cases. Its briefs are largely drafted by the noted Washington, D.C. law firm of Wiley, Rein & Fielding.

113. See Hickman & DeYoung, *supra* note 98, cited in *NSP*, 523 N.W.2d at 660-63.

114. See *NSP*, 523 N.W.2d at 662-64.

115. 517 N.W.2d 918 (Minn. 1994), *withdrawn and superceded*, 523 N.W.2d 657 (Minn. 1994).

We conclude that the *Integrity* analysis is inappropriate for this case. Because we hold that the insurers in this type of case are liable only for damages incurred during their respective policy periods, no insurer is concurrently liable with any other. The other insurers in this case did not anticipate becoming liable for damages incurred during St. Paul's policy periods. Applying the "other insurance" clauses as St. Paul advocates would make the other insurers liable for damages occurring outside their policy periods.¹¹⁶

The court later granted a request for rehearing and on August 24, 1994, the supreme court issued a revised *NSP* opinion that did not contain the quoted language regarding allocation to the policyholder and the court's purported bright line distinction between concurrent and consecutive insurer liability and the consequent immateriality of "other insurance" clauses in the latter situation.¹¹⁷ The first sentence of the omitted language, stating that policyholders were responsible for some portion of coverage in multiyear torts for periods of self-insurance or no insurance was of course highly favorable to insurers seeking to reduce liability by allocating some responsibility to the policyholder.¹¹⁸ On September 6, 1994, St. Paul Fire and Marine Insurance filed a "Request for Clarification" pointing out the absence of the quoted language and seeking its reinstatement. The court issued a slightly revised version of the August 24 opinion on September 30, 1994 that reinserted in different form the language regarding the disutility of the "other insurance" clauses in cases of consecutive triggering,¹¹⁹ but did not rein-

116. 517 N.W.2d at 924 (citations omitted) (citing Hickman & DeYoung, *supra* note 98, at 307 n.45).

117. See Northern States Power Co. v. Fidelity & Cas. Co., 523 N.W.2d 657, 657 (Minn. 1994).

118. See Northern States Power Co. v. Fidelity & Cas. Co., 517 N.W.2d 918, 924 (Minn. 1994), *withdrawn and superseded*, 523 N.W.2d 657 (Minn. 1994).

119. The final version of this language in *NSP* read as follows:

Because we have determined the appropriate method of allocating damages in these types of cases and because the record does not indicate that there was "other insurance" in effect during the period of time a St. Paul policy was in effect, we affirm the result, but modify the discussion offered by the court of appeals with regard to "other insurance" clauses. In our view, an application of *Integrity Mut. Ins. v. State Auto & Cas. Underwriters Ins. Co.*, 307 Minn. 173, 239 N.W.2d 445 (1976) to the facts presented is inappropriate. *Integrity* involved an allocation problem between

state the language stating that the “trial court should also hold the insured liable for its pro rata share of any uninsured or self-insured periods.”¹²⁰ This is the “final” *NSP* opinion.¹²¹

Although inferences from omissions are problematic, the supreme court’s removal of the initial quoted language and its declination to reinstate it at the request of an insurer suggest that the court, prior to *Domtar*, was uncertain about the matter of allocating either indemnity or defense costs to a policyholder because of uninsured periods. Allocation of defense costs is more problematic and potentially unfair to the policyholder because of the breadth of the defense responsibility that insurers themselves assumed by contract as well as the industry custom and practice of ordinarily shouldering broad defense obligations without seeking apportionment until the matter is resolved or where apportionment does not affect policyholder rights.

In addition, prior to *Domtar* it was also reasonable to conclude that the court realized that its original *NSP* language suggesting that no two liability insurers could be concurrently liable for a long but hidden loss was incorrect as a matter of sound insurance law and actual application of the facts. It would at least seem plausible that several insurance policies can be triggered during a long-tail tort with a lengthy period of loss, making it inevitable that there will be some overlap of insurers responsible for injuries occurring at a given time. There is no obvious reason to limit one insurer’s responsibility simply because injury continues in the future and implicates other insurers. Even if a court were to conclude that only one insurer can be liable for the discrete loss occurring at a given juncture (assuming one could calculate the moment of injury so precisely), this alone does not suggest that allocation to the policyholder is apt.

The second key Minnesota case which provided the backdrop for *Domtar* was *SCSC Corp. v. Allied Mutual Insurance Co.*¹²² *SCSC*,

multiple insurance policies concurrently liable for damages arising out of a single, discrete occurrence, not the factual setting presented here where there is no concurrent liability.

NSP, 523 N.W.2d at 664.

120. Northern States Power Co. v. Fidelity & Cas. Co., 517 N.W.2d 918, 924 (Minn. 1994), *withdrawn and superseded*, 523 N.W.2d 657 (Minn. 1994).

121. See Northern States Power Co. v. Fidelity & Cas. Co., 523 N.W.2d 657 (Minn. 1994).

122. 536 N.W.2d 305 (Minn. 1995).

formerly known as Schloff Chemical and Supply Company, operated a dry cleaning and laundry supply distribution facility in St. Louis Park, Minnesota from 1976 through 1988.¹²³ As part of this business, it handled perchloroethylene ("PCE" or "perc"), a dry-cleaning chemical.¹²⁴ Perc is a volatile organic compound and pollutant.¹²⁵ In late 1988, the MPCA detected perc in groundwater near the SCSC facility.¹²⁶ From 1988 to 1990, SCSC was required to remediate perc damage to groundwater.¹²⁷ SCSC sought reimbursement of these costs from its insurers, filing a declaratory judgment action when it could not obtain a satisfactory coverage response from the insurers.¹²⁸ Total remediation costs paid, incurred, and estimated to complete the project exceeded \$1.2 million.¹²⁹ During the time periods at issue, SCSC had primary CGL insurance from Allied Mutual Insurance Company in the amount of \$100,000 per occurrence (with \$100,000 aggregate limits), first-layer excess/umbrella coverage from Tower Insurance Company in the amount of \$1 million (occurrence and aggregate), and \$1 million of second-layer excess/umbrella coverage provided by Allied.¹³⁰

In the trial of the coverage action, SCSC obtained a favorable jury verdict, with the jury concluding that property damage took place due to an episodic spill in August 1977 and was not intentionally caused.¹³¹ Judgment was entered for SCSC and the court of

123. *See id.* at 308.

124. *See id.*

125. *See id.*

126. *See id.* at 309

127. *See id.*

128. *See id.* at 310.

129. *See id.*

130. *See id.* at 308-09. Excess insurance is coverage that attaches when primary insurance is exhausted. Because most claims can be successfully defended and settled by the primary insurer, excess insurance is generally available at higher limits and lower premiums than primary insurance. If an excess policy also provided umbrella coverage, it acts as a "gap filler" and gives coverage for certain claims that are not within the scope of coverage accorded by the primary policy. If the first layer of excess insurance is exhausted by a claim, the second layer excess policy attaches. Large commercial policyholders may have four or five layers of excess insurance. *See Jostens, Inc. v. Mission Ins. Co.*, 387 N.W.2d 161, 165 (Minn. 1986).

131. *See SCSC*, 536 N.W.2d at 310. Because the jury found that damage was not expected or intentionally caused and resulted from a single discharge incident, the "expected or intended" exclusion to the policy did not preclude coverage nor did the policy's qualified pollution exclusion due to the jury's finding of a "sudden and accidental" discharge. *See id.* The excess insurance at issue "followed form" of the primary policy and thus was subject to the same provisions and jury findings. *See id.*

appeals affirmed.¹³² The supreme court resolved a number of issues in favor of SCSC.¹³³ On the matter of allocation of responsibility for payment of the remediation costs, one insurer attacked the verdict form as directing the jury to find only a snapshot of damage by asking for the “date” on which damage arose, thus inhibiting the jury from finding that damage continued past August 1977.¹³⁴ The court rejected this attack due to the broad discretion granted trial judges in framing the verdict form.¹³⁵ Further, the opinion stated:

Tower also argues that the trial court’s policy triggering and damage allocation schemes were erroneous. The trial court chose to trigger the policies “vertically,” by year, beginning with the policies in effect in 1977. Allied’s 1977 \$100,000 limit was triggered first, and once that was exhausted, Tower’s 1977 \$1,000,000 excess policy was triggered. This is what is known as a “vertical trigger” scheme.

Tower argues that this court should adopt the “pro rata by time on the risk” theory of allocation first used by this court in . . . [NSP]. According to Tower, this would involve allocating proportional damages to Allied for all the years its primary policies were on the risk. Under this scheme, Tower’s excess policies would be triggered proportionally, for the years it was on the risk, only after Allied’s primary policy limit of \$100,000 per year is exhausted for all apportioned policy years. This would be a “horizontal trigger” of the primary and excess policies.

. . . .

. . . Although in *NSP* we adopted a “pro rata by time on the risk” trigger method for continuous groundwater contamination cases, we also noted that trial courts must be given flexibility in apportioning damages “in a manner befitting each case.”

Under the facts of the present case, we reject the multiple-year vertical triggering approach taken by the trial court. *We also decline Tower’s invitation to apply NSP’s pro rata by time on the risk triggering approach. In NSP, the dam-*

132. See *id.* The court of appeals did not affirm the lower court’s decision of an enhanced award of attorney’s fees. See *id.*

133. See *id.* at 318.

134. See *id.* at 317.

135. See *id.*

ages occurred over multiple policy periods, and without evidence to the contrary, we concluded that such damages must be assumed to be continuous. Our decision in *NSP* was an equitable decision based upon the complexity of proving in which policy periods covered property damage arose. In the present case, however, we have sufficient evidence indicating that the damage arose from a single event in 1977. The jury found that the damage was not divisible and that it was the result of a sudden and accidental occurrence. Based on these findings, the only covered "occurrence" was the 1977 spill. The continual leaching of the chemicals from the soil into the groundwater did result in damages to SCSC because of property damage. However, only Allied's 1977 \$100,000 primary policy and Tower's 1977 \$1,000,000 excess policy are triggered. Damages in excess of the \$1,100,000 aggregate limit of the primary and excess policies on the risk in 1977 are not covered. The result is consistent with the actual injury theory.¹³⁶

Where the injury is deemed continuous rather than the result of a discrete identifiable event, the important *NSP-SCSC-Domtar* trilogy of cases thus embraces pro rata allocation of multiple insurer responsibility according to the insurers' relative time covering the risk at issue. For pollution-related injury extending over several years, the Minnesota Supreme Court has announced a clear preference for temporal proration in the face of uncertainty and complexity. However, the court has also stressed the fact-dependent, policy-dependent, and equity-dependent nature of the inquiry.¹³⁷ SCSC established the inapplicability of allocation when the injury underlying the coverage dispute was discrete and identifiable.¹³⁸ Where a triggering event is isolated, rather than part of a continuous pattern of injury-producing conduct, the triggered policy is responsible for providing coverage and cannot terminate coverage responsibilities if continuation of the injury extends beyond the end date of the policy.¹³⁹ For example, in *Westling Manufacturing Co. v. Western National Mutual Insurance Co.*,¹⁴⁰ a case decided subsequent to SCSC and *Domtar*, the court of appeals affirmed a jury ver-

136. *Id.* at 317-18 (citations omitted) (emphasis added).

137. *See* Northern States Power Co. v. Fidelity & Cas. Co., 523 N.W.2d 657, 663 (Minn. 1994).

138. *See* SCSC, 536 N.W.2d at 312.

139. *See id.* at 317-18.

140. 581 N.W.2d 39 (Minn. Ct. App. 1998).

dict and trial court finding that injury resulted from a single, sudden and accidental release of pollutants.¹⁴¹ As a result, the triggered policy was responsible for covering the claim and could not seek to allocate its coverage responsibility among other insurers.¹⁴²

Taken together, these cases suggest that Minnesota courts, particularly the supreme court, appear to be seeking to treat complex insurance coverage matters as much like garden-variety coverage disputes as possible. Where an underlying claim can reasonably be construed to arise from a single injury-causing event rather than a series of events or progressive injury, the court will attempt to decide the complex CERCLA pollution case in a manner similar to its decision in other cases.¹⁴³ However, where the underlying claim is one of multiple, rolling, or progressive injury, the *NSP/Domtar* allocation formula is applied.

C. *Revisiting Antecedent Minnesota Allocation Law*

Several aspects of Minnesota law prior to *NSP* and *Domtar* argue against direct allocation to the policyholder because of proration. Indirectly allocating coverage expense to the policyholder by failing to take account of the availability of insurance in cases (such as *NSP*) where the apportionment is only between insurers and periods of insurance rather than across all years in which damage may have taken place is also discouraged by Minnesota law.¹⁴⁴

In addition, whatever the merits of allocation of indemnity claims, it would appear that on the question of defense costs, there can be no such precise calibration because defense obligations are determined by third party claimant allegations and behavior rather

141. See *id.* at 44, 49.

142. See *id.* at 44-45.

143. See *Westling Mfg.*, 581 N.W.2d at 44. "Unlike situations involving continuous-trigger contamination, if it is shown that property damage was the result of single-trigger contamination, only the policies that were on the risk in the year the damage occurred are triggered, and those insurers remain liable for all resulting damages." *Id.*; see also *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 733 (Minn. 1997); *SCSC*, 536 N.W.2d at 318.

144. For example, in a case like *NSP* where there is no direct allocation of responsibility upon the policyholder, the policyholder might nonetheless be forced to pay claims out of its own pocket due to the exhaustion of its insurance during some policy periods or because some insurers are insolvent. In these situations, the practical effect of course is to apportion some coverage responsibility to the policyholder. This regime is hard to defend when other policies for other periods remain triggered, unexhausted, collectible, and unreachable because of a pro-rata allocation scheme. See *infra* Parts III.B.4-8 and IV.

than any cosmically true facts. Attempting to allocate defense costs so finely based on the nuances of different pleadings and proceedings is considerably more difficult if not impossible.

Upon re-examination, the *Integrity Mutual Insurance Co. v. State Automobile & Casualty Underwriters Insurance Co.*¹⁴⁵ opinion rejected by the NSP court because it involved use of "other insurance" clauses to coordinate concurrent coverage responsibility, demonstrates a perfectly sensible approach to allocation notwithstanding its seeming rejection by both the initial and final NSP opinions.¹⁴⁶ In *Integrity*, the court noted that Minnesota's approach to allocating coverage responsibility among overlapping insurers was neither the piecing together of the precise texts of "other insurance" clauses nor the default rule of proration by policy limits where such clauses are in conflict.¹⁴⁷ Rather, the Minnesota approach "has traditionally been more complex" with a view that:

[T]he better approach is to allocate respective policy coverages in light of the total policy insuring intent, as determined by the primary policy risks upon which each policy's premiums were based and as determined by the primary function of each policy. The Minnesota courts examine the policies and determine whether the insurers are concurrently liable on the risk, or one is primarily liable and another only secondarily liable. If they are concurrently liable, each must pay a pro rata share of the entire loss. On the other hand, if one insurer is primarily liable and the other only secondarily, the primary insurer must pay up to its limit of liability, and then the secondary insurer must pay for any excess up to its own limit of liability. . . .

The nub of the Minnesota doctrine is that coverages of a given risk shall be "stacked" for payment in order of their closeness to the risk. That is, the insurer whose coverage was effected for the primary purpose of insuring that risk will be liable first for payment, and the insurers whose

145. 307 Minn. 173, 239 N.W.2d 445 (1976).

146. See *id.* at 176-77, 239 N.W.2d at 447-48.

147. See *id.*; *Lamb-Weston, Inc. v. Oregon Auto. Ins. Co.*, 341 P.2d 110 (Or. 1959) (applying proration by limits as formula for allocation notwithstanding language of other insurance clauses). *Lamb-Weston* is a key case and required proration by limits often known as the "*Lamb-Weston* rule." This approach goes beyond other cases that prorate by limits where "other insurance" clauses are ambiguous or in conflict.

coverage of the risk was the most incidental to the basic purpose of its insuring intent will be liable last. If two coverages contemplate the risk equally, then the two companies providing those coverages will prorate the liability between themselves on the basis of their respective limits of liability.¹⁴⁸

Minnesota, therefore, has a rather lengthy history of taking what might be termed a functional or purpose-oriented approach to insurance policy construction and resolution of coverage disputes. This approach, often referred to as a “closest to the risk” or “total policy insuring intent” approach, has been noted with approval by a least one extensive commentary addressing the problem of concurrent coverage.¹⁴⁹ The *Integrity* case, in particular, was supported because (perhaps ironically in light of the *NSP* court’s criticism) it eschewed “clause matching” and instead looked to the market realities and implicit equities of the situation.¹⁵⁰ Other Minnesota cases were similarly set forth as examples of a correct functional approach to the problem of coordinating coverage.¹⁵¹ Although it is correct that concurrent coverage and consecutive coverage are not the same thing, the *NSP* court never really goes beyond this observation to explain why the same functional approach used in construing concurrent insurer liability could not be used in cases of consecutive insurer liability.

Applied to a multiyear pollution or product liability claim, one could regard all triggered liability insurers as “concurrent” within the meaning of *Integrity* in that all successive liability insurers accepted the risk of potentially large liability exposure resulting from industrial pollution (absent a pollution exclusion or application of the intentional act exclusion) or from a mass produced and distributed product causing injury over a number of years. Conse-

148. *Integrity*, 307 Minn. at 175-76, 239 N.W.2d at 446-47 (citations omitted).

149. See Susan Randall, *Coordinating Liability Insurance*, 1995 WIS. L. REV. 1339, 1370-71 nn.132-36 (1995) (citing with approval Minnesota cases taking this approach).

150. See *Integrity*, 239 N.W.2d at 449; see also Randall, *supra* note 149, at 1371-72.

151. See, e.g., *Auto Owners Ins. Co. v. Northstar Mut. Ins. Co.*, 281 N.W.2d 700, 704 (Minn. 1979); *United States Fire Ins. Co. v. Fireman’s Fund Ins. Co.*, 461 N.W.2d 230, 235 n.3 (Minn. Ct. App. 1990). See Randall, *supra* note 149, at 1371 n.133 (“The approach adopted by the Minnesota courts, although rooted in contract, bridges the contract and market paradigms. It minimizes or avoids problems associated with the contract-based resolution of ‘other insurance’ litigation and points in the direction of a broader understanding of coordination issues.”).

quently, the primary and excess insurers across the years in effect were equally proximate to the risks associated with third-party claims for pollution or defective design or manufacture.

Of course, as the *NSP* court noted, *Integrity* and similar cases dealt with multiple policies applicable to a single time period rather than a time series.¹⁵² But regardless of whether the overlapping is in Year 1 or upon an occurrence that spans several years, the principal of proration by policy limits and closeness to the risk is as sound as any proration formula. The *NSP* court turned its figurative back on significant Minnesota precedent that held in favor of including policy limits as an element of a proration formula.¹⁵³ The argument for proration by years is that it more accurately corresponds to the relative risks taken by a series of insurers in a multiyear occurrence case since changing conditions may make policy limits and premiums difficult to compare.¹⁵⁴ Although this argument has a certain persuasiveness, it seems no more accurate than proration by limits or premiums. Furthermore, the *NSP* court for some reason did not even consider prorating by both time on the risk and policy limits, an approach that would have at least introduced some cognizance of the cost of insurance purchased and promised.

Another earlier Minnesota case, *Jostens, Inc. v. Mission Insurance Co.*,¹⁵⁵ involved the issue of allocating insurer responsibilities among covered and uncovered claims.¹⁵⁶ The court used closest-to-the-risk functional analysis in dealing with a CGL insurer and an umbrella carrier.¹⁵⁷ Because Mission, as the umbrella carrier, provided some coverage not provided by the CGL, Mission's responsibility was primary as to certain claims but secondary as to those covered by the CGL.¹⁵⁸ The court found both insurers on the risk as to some claims.¹⁵⁹

152. See *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 664 (Minn. 1994).

153. See *id.* at 663-64.

154. See *id.* at 663.

155. 387 N.W.2d 161 (Minn. 1986).

156. See *id.* at 165.

157. See *id.*

158. See *id.* at 166.

159. See *id.* at 167. At that point, the court rendered its view that where there is disputed coverage and an insurer acts to protect the policyholder by providing a defense, the responsible insurer has no action for contribution against the other insurer that shirked its defense costs responsibility. See *id.* This rule was "adopted" by the supreme court in *Iowa National Mutual Insurance Co. v. Universal Underwriters*

Where no insurer volunteers, however, the insurers may litigate the issue of the division of costs between different varieties of covered claims (e.g., those as to which the umbrella policy is primary and those as to which the CGL is primary). The *Jostens v. Mission* court concluded that:

[T]he record establishes as a matter of law that Wausau's [CGL] policy covered [plaintiff] Wepler's defamatory and disparaging claims and that the wrongful discharge and fraud claims, at least insofar as unintentional conduct was involved, were solely within [umbrella insurer] Mission's broader coverage. Consequently, Jostens is entitled to its costs in defending these latter two claims from Mission.¹⁶⁰

However, despite this finding as a matter of law, the *Jostens v. Mission* court remanded to the trial court:

to apportion the [plaintiff] Wepler['s] defense costs between Wausau and Mission. If defense costs for the two sets of claims are so inextricably intertwined they cannot be fairly sorted out, the costs may be equally divided. . . .

. . . Basic fairness, we think, dictates that both insurers having been found obligated to provide a defense, both should share equally the expense for having to be told their responsibilities.¹⁶¹

In another and potentially more relevant Josten's coverage case, the supreme court in *Jostens, Inc. v. CNA Insurance/Continental Casualty Co.*,¹⁶² specifically refused to allocate defense costs to particular claimants or time periods.¹⁶³ Said the court:

In the present case, allocation of defense costs based on

Insurance Co., 276 Minn. 362, 367-68, 150 N.W.2d 233, 237 (1967), and enjoys some support in other states but is seen as the minority rule nationally.

160. *Jostens v. Mission*, 387 N.W.2d at 168 (footnote omitted).

161. *Id.* at 168.

162. 403 N.W.2d 625, 631 (Minn. 1987), *overruled by* Northern States Power Co. v. Fidelity & Cas. Co., 523 N.W.2d 657 (Minn. 1994). Although *NSP* overruled this decision in part, the overruling was limited to whether the policyholder must pay a deductible or SIR for each policy period triggered. See *supra* note 104 and accompanying discussion.

163. See *Jostens v. CNA*, 403 N.W.2d at 631.

a percentage of the uncovered settlement amounts or time periods is not merited. It appears likely that a great deal of the defense costs were incurred in general defense preparation and cannot be separated by claimants or time periods. Requiring CNA to be responsible for defense costs is also consistent with the strong policy in favor of requiring defense where there is even arguable coverage. CNA cites to *Jostens, Inc. v. Mission Insurance Co.*, 387 N.W.2d 161 (Minn. 1986), for the proposition that defense costs must be allocated. That case is inapplicable, however. There, we examined the issue of allocating defense costs between two insurers. The present case involves an insured party and an insurer which originally breached its duty to defend. We therefore hold that CNA is responsible for all costs for defense.¹⁶⁴

164. *Id.* Although a portion of the *NSP* opinion disapproved of a portion of *Jostens v. CNA*, the above passage and analysis was not implicated by *NSP*'s modification. In a short paragraph near the close of the *Jostens v. CNA* opinion, the court averaged out the policyholder's retained limit over a seven-year period by weighting the \$25,000 limit in effect for three years with the \$10,000 limit in effect for four years. *See Jostens v. CNA*, 403 N.W.2d at 631. The court then used the resulting weighted average as the policyholder's self-insured retention to be deducted from the amounts otherwise owed the policyholder for the claims falling under the seven years' worth of implicated policies (a three-year policy period and a four-year policy period). *See id.*

In *NSP*, the court held:

[T]here has been one occurrence during the policy period of each applicable [insurance] policy and *NSP* must assume the retained limit with respect to each of these policies. [The insurer] is liable for the excess portion of the damages allocated to each policy up to the policy limit for one occurrence. To the extent then that [*Jostens v. CNA*] conflicts with our decision here, it is overruled.

NSP, 523 N.W.2d at 664 (citation omitted).

In effect, this portion of *NSP* took the view that if a policy is triggered and the policyholder obtains the benefit of coverage during that policy period, it must also pay the applicable SIR or deductible for that policy period even though the loss-creating event spanning several policy periods is in essence one event. *See id.* For purposes of tapping insurance coverage, each triggering portion of a multiyear event is considered an occurrence for the policy triggered. This portion of the *NSP* opinion seems correct and in retrospect, *Jostens* appears to have enjoyed a mild windfall by being required to pay only one averaged SIR (and not the higher SIR at that) even though it effectively tapped two policies.

The SIR portions of both opinions are perfectly consistent with taking an aggregate and blended approach to the issue of apportioning defense cost responsibilities among insurers. CNA in fact took just such a blended approach through its weighted average methodology but erred in undercounting the number of occurrences requiring policyholder satisfaction of an SIR obligation. Nothing in

Taken together, the *Jostens* cases suggest that courts ordinarily will eschew an attempt to separate and apportion defense claims with a common core. The *Jostens v. CNA* court refused to attempt to assign intertwined defense costs to the respective claims falling within the CGL or the umbrella policy.¹⁶⁵ The *Jostens v. Mission* court, although remanding for apportionment between substantive claims (and not individual cases within the same overall substantive claim occurrence as would occur if mass tort defenses are apportioned between case-specific and generic defense costs) expressly stated that if the “two sets of claims” are sufficiently intertwined so as to preclude fair apportionment, the defense costs should be prorated equally between the two applicable insurers.¹⁶⁶

This treatment is consistent with the apparently longstanding Minnesota approach to apportionment reflected in *Integrity*¹⁶⁷ and its predecessors and progeny. Unless one claim is clearly distinct from another or unless one insurer is clearly distinct from another, the insurers’ responsibilities will be either equally divided or apportioned prorata by policy limits (perhaps weighted by time on the risk). Prior to *NSP*, there was little indication that time on the risk was the be-all-and-end-all factor necessary to fair and reasonable apportionment of insurers’ coverage responsibility.

D. Allocation Law Outside Minnesota

Courts have divided on the question of the necessity for allocation and the manner of apportionment. Although it is correct, as suggested by insurers and the *Domtar* court, that allocation has enjoyed substantial support, it is equally correct that many courts have rejected allocation outright, forbid allocation from reducing benefits otherwise available to the policyholder, or refused to apportion coverage responsibility to the policyholder where there are extenuating circumstances such as a practical unavailability of insurance.

Courts generally view the respective obligations of coinsurers as more in the nature of equity than particularized contract rights:

NSP’s correction of this aspect of *CNA* disapproves weighted averaging by time and policy limits as a means of apportioning responsibility among insurance policies when defense costs are part of an essentially integrated defense effort.

165. See *Jostens v. CNA*, 403 N.W.2d at 630-31.

166. See *Jostens v. Mission*, 387 N.W.2d at 168.

167. 307 Minn. 173, 239 N.W.2d 445 (1976).

[T]here is no disagreement between the parties that a growing number, if not a majority, of jurisdictions recognize that "[t]he respective obligations as between several insurers who have covered the same risk do not arise out of contract, but are based upon equitable principles designed to accomplish ultimate justice in the bearing of a specific burden."¹⁶⁸

The equitable and functional underpinnings of allocation among insurers are also reflected in the line of cases that resolves overlapping insurance conflicts by treating the insurer closest to the risk as primary and other insurers as secondary, with costs generally prorated by limits among insurers at the same level of proximity to the risk.¹⁶⁹

168. *General Accident Ins. Co. v. Safety Nat'l Cas. Corp.*, 825 F. Supp. 705, 707 (E.D. Pa. 1993). Numerous other courts have made similar statements. *See, e.g.*, *Signal Cos. v. Harbor Ins. Co.*, 612 P.2d 889, 895 (Cal. 1980). Relative insurer responsibility turns on "particular policies of insurance, the nature of the claim made, and the relation of the insured to the insurers." *Id.* at 895. For instance, there is no obligation on the excess insurer to participate in the defense of a policyholder where the policyholder incurred costs prior to exhaustion of primary policy and without proper notice to excess insurer as required by the policy. *See id.* at 894-95. *But see General Accident*, 825 F. Supp. at 708-09 (holding that, where excess insurer follows form and primary policy provides for pro rata sharing if other insurance applicable, excess insurer must contribute pro rata with primary insurer in paying for defense costs); *Regent Ins. Co. v. Insurance Co. of N. Am.*, No. 92-2113-EEO, 1993 WL 191344, at *3-*4 (D. Kan. 1993) (holding that where the contract language does not require contribution by an excess insurer, nothing inequitable about requiring primary carrier to shoulder all defense costs); *Home Indem. Co. v. General Accident Ins. Co.*, 572 N.E.2d 962, 965 (Ill. Ct. App. 1991) (holding that equitable contribution is inapplicable regarding obligations of primary and excess insurers).

169. *See, e.g.*, *Liberty Mut. Ins. Co. v. United States Fidelity & Guar. Ins. Co.*, 756 F. Supp. 953, 956 (S.D. Miss. 1990). Where competing policies provide primary coverage and are prorated, the intent of the policyholder and insurer are more informative than whether one policy is more "specific" to the risk or the other policy more "general" in relation to risk. *See id.*; *see also Federal Ins. Co. v. Prestemon*, 278 Minn. 218, 153 N.W.2d 429 (1967). In *Prestemon*, a garage owner loaned a car to a customer who subsequently had an accident. *See Prestemon*, 278 Minn. at 219, 153 N.W.2d at 430-31. The driver had an insurance policy with an "excess apportionment" clause but the garage policy had a textually trumping "escape" clause regarding other insurance. *See id.* at 220, 231-32, 153 N.W.2d at 431, 437-38. The court affirmed, holding that the garage owner was entitled to coverage under the guaranty policy and "the excess clause contained in the [driver's] Federal policy prevails over the escape clause contained in the [garage's] Guaranty policy." *See id.* at 232, 153 N.W.2d at 438. *Accord Randall*, *supra* note 149, at 1342-42 (endorsing the view that insurers should bear indemnity and defense obligations in relation to the market pricing of their respective commitments). Al-

1. Cases Adopting or Endorsing Allocation Formula

In the 1980s and 1990s, a number of cases have endorsed allocation. Beginning with *Insurance Co. of North America v. Forty-Eight Insulations*,¹⁷⁰ a number of courts have apportioned the coverage responsibilities of triggered insurers according to a formula, typically proration by time on the risk.¹⁷¹ A smaller number have adopted a default rule of proration that involves consideration of both time

though Prof. Randall's analysis clothes itself in economic analysis, it is largely an endorsement of a functional approach to coordinating coverage that in fact seeks to place greatest responsibility on the insurer(s) closest to the risk.

170. 633 F.2d 1212 (6th Cir. 1980) (applying New Jersey and Illinois law and prorating by years).

171. See, e.g., *LaFarge Corp. v. Hartford Cas. Ins. Co.*, 61 F.3d 389, 401 (5th Cir. 1995) (applying Texas law); *Stonewall Ins. Co. v. Asbestos Claims Management Corp.*, 73 F.3d 1178, 1202 (2d Cir. 1995) (applying New York and Texas law); *Gulf Chem. & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, 1 F.3d 365, 371-72 (5th Cir. 1993) (applying Texas law); *Ray Indus., Inc. v. Liberty Mut. Ins. Co.*, 974 F.2d 754, 764-68 (6th Cir. 1992) (applying Michigan law); *Commercial Union Ins. Co. v. Sepco Corp.*, 918 F.2d 920, 922 (11th Cir. 1990) (applying Alabama law); *Budd Co. v. Travelers Indem. Co.*, 820 F.2d 787, 790 (6th Cir. 1987) (applying Michigan law); *Ducre v. Halter Marine, Inc.*, 752 F.2d 976, 981-83 (5th Cir. 1985) (applying Louisiana law); *Porter v. American Optical Corp.*, 641 F.2d 1128, 1145 (5th Cir. 1981) (applying Louisiana law and following *Forty-Eight Insulations*) (prorating based on periods of no insurance and prorating by time); *Scottsdale Ins. Co. v. American Empire Surplus Lines Ins. Co.*, 811 F. Supp. 210, 216-18 (D. Md. 1993); *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1387 (E.D.N.Y. 1988); *Stonewall Ins. Co. v. City of Palos Verdes Estates*, 54 Cal. Rptr. 2d 176, 206-07 (Cal. Dist. Ct. App. 1996) (refusing to adopt a universal bright line rule of allocation, but finding apportionment by "qualified time on the risk" preferable "unless another method would be more equitable"); *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690 (Cal. Dist. Ct. App. 1996) (allocating coverage responsibility among insurers according to time on risk but refusing to allocate liability to policyholder for any uninsured periods); *Gulf Ins. Corp. v. Continental Cas. Co.*, 464 So. 2d 207, 209-10 (Fla. Dist. Ct. App. 1985) (where legal malpractice claim spans multiple years, proration by policy limits appropriate means of apportionment); *Sentinel Ins. Co. v. First Ins. Co.*, 875 P.2d 894, 918-19 (Haw. 1994); *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 670 N.E.2d 740, 747-49 (Ill. Ct. App. 1996) (allocating some responsibility to policyholder for periods of no insurance); *United States Gypsum Co. v. Admiral Ins. Co.*, 643 N.E.2d 1226, 1258-59 (Ill. Ct. App. 1994) (using allocation among self-insuring policyholder and insurers by time on risk); *Continental Cas. Co. v. Medical Protective Co.*, 859 S.W.2d 789, 792 (Mo. Ct. App. 1993) (holding that where damages giving rise to third-party medical malpractice claim span multiple years, proration by time on risk is the most apt means of apportioning relative responsibility and that apportionment by policy limits is only apt for multiple insurers covering risk concurrently). See also *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386, 1396 (8th Cir. 1996) (applying Minnesota law). *Diocese of Winona* was, of course, heavily influenced by the *NSP* decision because the federal appellate court was required to follow Minnesota law.

and policy limits.¹⁷² A few cases have allocated by policy limits alone.¹⁷³ In addition to the common methods of proration by policy limits, by time on the risk, or by some combination of these two primary methods, courts may also apportion in equal shares between insurers or on the basis of premiums paid.¹⁷⁴

Interpretation of the case law requires some caution because different cases may have focused on defense costs or liability coverage or both. Because the duty to defend is broader than the duty to indemnify, one can make a strong case that, whatever the merits of allocation for liability coverage, there should be no allocation—at least not to policyholders—of defense costs since the CGL normally states that the insurer will defend “suits” against the policyholder, implying that the defense responsibility cannot be thrown back upon the policyholder merely because the claims giving rise to the suit straddle some periods of self-insurance or exhausted insurance.¹⁷⁵

In addition, subsequent developments in relevant state law may undermine or even vitiate the authority of some precedents. For example, California appellate cases requiring allocation, at

172. See, e.g., *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 987-90 (N.J. 1994) (adopting proration by time and limits as a default means of allocation, including allocation to the policyholder for uninsured periods but adopting a preferred method of trial court making findings of fact, preferably by formula or model, as to when particular injuries took place). Proration by time appears the more popular allocation method, although proration by both time and limits has substantial support in scholarly commentary. See, e.g., Yin, *supra* note 109, at 1244-45. See also *infra* note 216 and accompanying text (listing cases); *Carter-Wallace, Inc. v. Admiral Ins. Co.*, 712 A.2d 1116 (N.J. 1998).

173. This was the approach, for example, of the trial court that was subsequently overruled in *Continental Casualty Co. v. Medical Protective Co.*, 859 S.W.2d 789, 790-93 (Mo. Ct. App. 1993), which endorsed time on the risk.

174. See *Insurance Co. of Texas v. Employers Liab. Assurance Corp.*, 163 F. Supp. 143, 147, 151 (S.D. Cal. 1958) (apportioning on basis of premiums paid); *Stonewall*, 54 Cal. Rptr. 2d at 199 (summarizing leading methods of proration). Apportionment according to premium appears to have become significantly less popular during the past three decades, as evidenced by the status of the 1958 *Insurance Co. of Texas* case as the leading citation for this method. The criticism of proration by premiums, one that has never seemed particularly persuasive to the author, is that the amount of premium results from many factors in addition to risk assumed. Although this is true, an insurer's policy limits and willingness to insure at all also stem in large part from factors other than pure risk.

175. But see *Buss v. Superior Court*, 939 P.2d 766, 776 (Cal. 1997) (permitting insurer to seek reimbursement from policyholder for costs of defending claims in suit where insurer can satisfy burden of persuasion that certain claims were not even potentially within coverage and are sufficiently separate from covered claims to make reimbursement fair and practical).

least allocation to the policyholder, appear to have been effectively overruled by more recent state supreme court precedent.¹⁷⁶ The California Supreme Court forcefully rejected allocation to the policyholder in *Aerojet-General Corp. v. Transport Indemnity Co.*¹⁷⁷ *Aerojet-General* also rejected the *NSP/Domtar* view that triggered liability insurance somehow becomes “untriggered” simply because the policy term ends while damage from the triggering event continues.¹⁷⁸

a. *The Illustrative Stonewall Decision*

Stonewall Insurance Co. v. Asbestos Claims Management Corp.,¹⁷⁹ the Second Circuit’s decision in a lengthy asbestos-coverage litigation, is known primarily for its continuation of a broad injury-in-fact trigger that in effect produces a continuous trigger for alleged insidious internal diseases related to chemicals or devices in the body.¹⁸⁰ As the court noted:

Under this trigger of coverage, an asbestos-related bodily injury claim typically will implicate multiple policies in effect during the multi-year period of the injury process. Each of these triggered policies promises to pay “all sums” that [the policyholder] becomes liable to pay to the underlying claimants as a result of bodily injury occurring during the policy period. Thus, for any single asbestos-related bodily injury claim, there may be several policies each independently responsible under their explicit terms for paying “all sums” that [the policyholder] becomes liable to pay to the claimant.¹⁸¹

176. See *Aerojet-General Corp. v. Transport Indem. Co.*, 948 P.2d 909 (Cal. 1997).

177. See *id.* at 930-31. More specifically, *Aerojet* rejected allocation to the policyholder where an insurance policy was triggered. See *id.* at 931-32. In California after *Aerojet*, the insurer may avoid coverage only if there is no triggering of coverage, which effectively makes the policyholder responsible for liability in that time period. See *id.* Although the *Aerojet* court in portions of the opinion refers to this as allocation of costs to the insured, this is not allocation so much as it is a finding of no coverage. See *id.* at 929-30. Where coverage is found by triggering due to injury that begins during the policy period, the fact that injury continues into other periods was expressly found not to justify imposing costs upon the policyholder via allocation. See *id.* at 928-930.

178. See *id.*; see also *infra* Part III.A.1.a (regarding the proper interpretation of the “during the policy period” language of the CGL).

179. 73 F.3d 1178 (2d Cir. 1995) (applying New York and Texas law).

180. See *id.* at 1201-02.

181. *Id.* at 1201.

Stonewall also dealt at some length with issues of allocation among insurers and the policyholders' relative responsibility.¹⁸² The trial court had prorated by time on the risk, an approach accepted in large part because neither the policyholder nor the insurers objected to the temporal proration formula as applied to the insurers.¹⁸³ The trial court had also prorated responsibility to the policyholder for periods where there was no insurance either because "it had been uninsured or its insurance had been consumed by prior payment during any portion of the time period of a particular claimant's injury."¹⁸⁴

The *Stonewall* court noted that the policyholder:

observes that the policies available to it in the 1950s had low aggregate limits, and that no coverage was available for asbestos claims after 1985. Because the injuries suffered by the claimant population have progressed well into these uninsured policy years, prorating [the policyholder] NGC's liability evenly to each triggered policy year and to each uninsured year enables the Insurers to reallocate an increasingly large percentage of asbestos liabilities back to [the policyholder] NGC.¹⁸⁵

Thus, *Stonewall*, despite favoring allocation in general, refused to allocate policyholder responsibility to years when insurance was unavailable.¹⁸⁶

182. See *id.* at 1201-04.

183. See *id.* at 1202. The opinion explained that when:

[c]onfronted with multiple insurance policies covering the same claim, the District Court decided, on motion for summary judgment, that the triggered policies' obligations were to be prorated based upon the policies' respective triggered time periods. Specifically, the District Court ruled that each triggered policy was responsible for only a pro rata share of NGC's liability as to a particular claimant. The share was determined by multiplying the judgment or settlement by a fraction that has as its denominator the entire number of years of the claimant's injury, and as its numerator the number of years within that period when the policy was in effect.

Id. at 1202.

184. *Id.* at 1202.

185. *Id.*

186. See *id.* at 1203.

Notwithstanding the potential shift of financial burden to the policyholder, *Stonewall* approved the general assessment that:

[I]n the context of multiple policies triggered for continuous injuries, proration-to-the-insured is a sensible way to interpret insurance policies that do not squarely resolve the allocation issue. Perhaps the leading opinion in the field, and surely one of the best reasoned, is Justice O'Hern's opinion for the New Jersey Supreme Court in *Owens-Illinois*. He begins by rejecting both sides' contentions based on the wording of the CGL policy. The "all sums" language relied on by the insured, he points out, "was never intended to cover apportionment when continuous injury occurs over multiple years." And the insurers' reliance on language limiting their coverage to injury "which occurs during the policy period" ignores their obligation to indemnify for subsequent damages attributable to an injury occurring during the relevant policy period. He then relates the allocation issue to the continuous trigger approach and argues for an allocation formula that provides incentives to increasing available resources and internalizing costs. He concludes that a fair method of allocation appears to be one that is related both to time on the risk and the degree of risk assumed. When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable.

We agree with the analysis of the New Jersey Supreme Court and think it likely that New York and Texas will also agree. We also note that proration-to-the-insured, in the context of continuous triggering, has been approved . . . [in other cases].

We agree with [trial court] Judge Martin that proration-to-the-insured is a sensible way to adjust the competing contentions of the parties in the context of continuous triggering of multiple policies over an extended span of years. We agree that such proration is appropriate as to years in which [the policyholder] NGC elected not to purchase insurance or purchased insufficient insurance, as demonstrated by the exhaustion of its policy limits. However, we do not agree with the District Judge's subsidiary ruling that proration-to-the-insured should be ap-

plied to years after 1985 when asbestos liability insurance was no longer available. Judge Martin applied proration-to-the-insured even after 1985. His rationale was that [the policyholder] "bargained away coverage by accepting asbestos exclusion clauses." We think that is not a realistic view of the situation. There is no reason to believe that any bargaining occurred with respect to the asbestos exclusion clauses.

Moreover, we note that judges who have endorsed proration-to-the-insured have done so only to oblige a manufacturer to accept a proportionate share of a risk that it elected to assume, either by declining to purchase available insurance or by purchasing what turned out to be an insufficient amount of insurance. Thus, Justice O'Hern's opinion in *Owens-Illinois* explicitly contrasts its proration approach to "periods when coverage for a particular risk is not available." Similarly, Judge Wald [in his concurrence in *Keene Corp. v. Insurance Co. of North America*, 667 F. 2d 1034, 1058 (D.C. Cir. 1981)] endorsed proration-to-the-insured only "prior to the time when such coverage could no longer be obtained." Judge Martin's opinion appears to be the only one applying proration-to-the-insured to years when asbestos liability insurance was no longer available.

We therefore modify the judgments so as not to apply the proration-to-the-insured approach to years after 1985, the point at which asbestos liability insurance ceased to be available.¹⁸⁷

The *Stonewall* court then discussed two different versions of its modified allocation formula.¹⁸⁸ The court assumed a claimant with an asbestos injury spanning from 1981 through 2005 but insurance only for 1981 through 1984, with the policyholder self-insuring for 1985 and no coverage available after 1985.¹⁸⁹ Under one operationalization of the circuit court's modified proration to the policyholder, proration would be based upon the number of years (five years) where coverage was an option among the insurers and the policyholder, forcing the policyholder to accept one-fifth or twenty

187. *Id.* at 1202-04 (citations and footnotes omitted).

188. *See id.* at 1204.

189. *See id.*

percent of the responsibility.¹⁹⁰ Under another possible approach considered by the Second Circuit, the twenty-five-year period would be apportioned among the insurers as to twenty-four of the twenty-five years since occurrence-based policies standing alone would encompass the entire injury period (1981/82/83/84 through 2005) and because coverage was not available after 1985.¹⁹¹ *Stonewall* adopted the former approach imposing more responsibility on the policyholder rather than the latter approach more forgiving to the policyholder.¹⁹² *Stonewall* justified selection of this more onerous version of its modified allocation principle on the ground that if the policyholder had:

purchased a policy from Insurer C in 1985, that insurer would have been liable for 1/5th of the claim (since no proration-to-the-insured is being allowed for the years after 1985). Our solution imposes that same 1/5th share on [the policyholder] for the one year when it was uninsured due to its own choice.

We therefore implement proration-to-the-insured by obliging [the policyholder] to pay a share of each claim represented by a fraction that has as its denominator the number of years of the injury up to 1985, and as its numerator the number of those years in which [the policyholder] was uninsured (either because it purchased no insurance or its policy limits were exhausted).¹⁹³

190. *See id.*

191. *See id.*

192. *See id.*

193. *Id.* (footnote omitted). In a footnote appended to this last quoted language, the *Stonewall* court noted in passing the other financial burdens on the policyholder as a result of the confluence of asbestos claims and the unavailability of insurance. *See id.* at 1204 n.19 ("This decision, of course, does not alter NGC's obligation, without insurance indemnification, to pay for claims based on exposures occurring after 1985. As to such claims, none of the Insurers is 'on the risk,' and no issue of proration arises.")

Prior to criticizing *Stonewall*'s allocation approach, a point developed at greater length below, I note that the entire *Stonewall* allocation discussion proceeds as if claims liability is something of a hybrid between case-specific costs and generic liability costs due to asbestos manufacture. On one hand, it appears that apportionment takes place on a per claim basis for each of the insurers triggered by a particular claim. On the other hand, the court treats the liability as "generic to the claim" in that no attempt is made to link any quantity of damage to a particular claimant or to any particular policy or insurer. The same approach could be used for defense costs but a policyholder seeking to characterize defense costs as generic would have a strong argument for less individual treatment than is ap-

2. *Cases Rejecting Allocation Formula*

A well-known case early in the asbestos coverage litigation determined that court-imposed allocation was not necessary and permitted the policyholder to select among triggered policies in claiming indemnity or defense costs.¹⁹⁴ This has been misnamed “joint and several” liability.¹⁹⁵ Notwithstanding being saddled with a

plied to indemnity issues. The manner and fruits of defense in Case X will have significant impact in all other asbestos claims against the policyholder. Although this is somewhat true for judgments and settlements as well (since in a mass tort, settlement of a case within the mass tort has ripple impact on other cases), the overarching interrelatedness among components of the occurrence are more pronounced for defense costs.

194. See *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034, 1049 (D.C. Cir. 1981) (applying generic law or basic principles of insurance found in the states with interests in the litigation and stating “if a plaintiff’s damages are caused in part during an insured period, it is irrelevant to [the policyholder’s] legal obligations and therefore, to the insurer’s liability that they were also caused, in part, during another period”). Something akin to the *Keene* approach predates the asbestos coverage litigation and is found in property insurance disputes, although there are comparatively few cases on the topic. See, e.g., *Gruol Constr. Co. v. Insurance Co.*, 524 P.2d 427, 430-31 (Wash. Ct. App. 1974) (holding that the dry rot of a home which spanned multiple policy periods requires apportionment by timespan of structure’s deterioration). See also *Skinner Corp. v. Fireman’s Fund Ins. Co.*, No. C95-995WD, 1996 WL 376657, at *2-3 (W.D. Wash. Apr. 3, 1996) (applying Washington law and following *Gruol*); *American Nat’l Fire Ins. v. B & L Trucking & Const. Co.*, 951 P.2d 250, 254, 256-57 (Wash. 1998) (affirming the continued validity of *Gruol* in Washington, adopting continuous application of the injury trigger, and rejecting insurer arguments favoring proration).

195. Joint and several liability is a misnomer in that it suggests that co-parties are equally liable even though one party may have displayed only minimal fault while the other was largely responsible for the loss or legal liability. Although refusal to apportion insurer responsibility according to the liability damage accrued during multiple policy periods has some superficial resemblance to tort law’s joint and several liability, the similarity is ultimately misleading. Under a *Keene* approach, an insurer who issued an untapped, high limits policy during the last year of multiple years of loss, could be called upon to pay its full limits even though it arguably insured less risk than low limits insurers at the early years of the loss. However, unlike the joint tortfeasor situation, the last insurer has entered into a contract in which the insurer agreed to pay all of its limits if necessary for a single claim exhausting the limits so long as a covered occurrence caused some damage during the policy period. The insurer is under no greater burden of unfairness when tapped first by a *Keene*-style policyholder than it would have been if the last person injured by the offending product or policyholder conduct had been the one claimant with the best lawyer, the most favorable forum, and an ultra-large jury verdict. In addition, of course, no insurer ever pays more than its policy limits absent bad faith. The policy limits are a ceiling on liability. By contrast, the true joint tortfeasor is potentially subject to unlimited liability in a large loss case irrespective of the deep pocket joint tortfeasor’s relative fault. See also *supra* note 98 and accompanying text (addressing inappropriate use of “joint and several liability” label in this context).

label that erroneously creates the appearance that insurers might pay more than their "fair" share of responsibility under this method, many courts have followed this general approach to both the issue of continuous trigger and the question of whether the responsibilities of triggered insurers should be determined by judicial formula or policyholder prerogative.¹⁹⁶ Although there is scholarly commentary favoring allocation,¹⁹⁷ there is also scholarly criticism of allocation and support refusing to apportion coverage responsibility to the policyholder.¹⁹⁸

196. See, e.g., *Air Prods. & Chems., Inc. v. Hartford Accident & Indem. Co.*, 25 F.3d 177, 180-81 (3d Cir. 1994) (applying Pennsylvania law); *New Castle County v. Hartford Accident & Indem. Co.*, 933 F.2d 1162, 1181-82 (3d Cir. 1991) (applying Delaware law); *Eli Lilly & Co. v. Home Ins. Co.*, 794 F.2d 710, 713-14 (D.C. Cir. 1986) (applying Indiana law after certification to state supreme court); *Acands, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 975-76 (3d Cir. 1985) (applying Pennsylvania law); *Eli Lilly & Co. v. Home Ins. Co.*, 653 F. Supp. 1, 8-9 (D.D.C. 1984) (applying Indiana law through prediction and holding the ambiguity of the policy regarding apportionment precludes apportionment adversely affecting the policyholder under the rule of *contra proferentem*); *Monsanto Co. v. C.E. Heath Compensation & Liab. Ins. Co.*, 652 A.2d 30, 35 (Del. 1994) (applying Missouri law); *Zurich Ins. Co. v. Raymark Indus.*, 514 N.E.2d 150, 150 (Ill. 1987); *Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467, 470 (Ind. 1985) (answering certified question from the District of Columbia Circuit Court of Appeals); *J.H. France Refractories v. Allstate Ins. Co.*, 626 A.2d 502, 506 (Pa. 1993). In *Sandoz, Inc. v. Employer's Liability Assurance Corp.*, 554 F. Supp. 257, 266 (D.N.J. 1983), the court stated:

If injuries were sustained during the policy period and there is no way of distinguishing those injuries from ones sustained prior or subsequent thereto, then the insurer would be liable for the full amount. In those circumstances the liability of each insurer would be joint and several.

The court rejects the automatic pro rata allocation adopted in *Forty-Eight Insulations* in a claim by the insured. It may be an appropriate standard in considering claims among the insurers, but not in considering a claim by the insured. The pro rata method is an arbitrary one that assumes that the occurrence of bodily injury mirrors exposure to the harmful substance.

Id. Further, in *Lac D'Amiante Du Quebec, Ltee. v. American Home Assurance Co.*, 613 F. Supp. 1549, 1562 (D.N.J. 1985), the court held, "[A]ny proration of liability as against the insured would contravene the policies' dominant purpose of protection There is nothing here, that provides for a reduction in liability if an injury occurs only in part during a policy period." *Id.* Proration over years is particularly pernicious in that it raises possible application of multiple deductibles, further stripping a policyholder of purchased coverage.

197. See, e.g., *Hickman & DeYoung*, *supra* note 98 and accompanying discussion; *infra* Part IV.

198. See, e.g., *Garrett G. Gillespie, The Allocation of Coverage Responsibility Among Multiple Triggered Commercial General Liability Policies in Environmental Cases: Life After*

Typical of the assessment made by courts rejecting allocation is the analysis in *Monsanto Co. v. C.E. Heath Compensation & Liability Insurance Co.*:¹⁹⁹

Missouri courts have recognized that insurance companies may effectively limit their coverage obligations with an explicit pro rata provision in the terms of the policy

. . . Conversely, the Missouri Court of Appeals has held that where a policy is silent on proration, the insurance company is jointly and severally liable to the full extent of the policyholder's loss (i.e. "all sums"). . . .

. . . .

A policy is activated by bodily injury or property damage that takes place "during the policy period." The triggering language in the Monsanto insurance policies does not define the extent of coverage. Once a policy is on the risk, the unambiguous policy language requires the insurance company to pay "all sums" for which the policyholder shall become liable, up to the policy limits. That language defines ESLIC's duty under its policies as the obligation to pay "all sums" for which Monsanto becomes liable—not a proportionate share.

The majority of courts have held that without a pro rata clause in the policies, the insurance companies cannot limit their obligations to a pro rata share or a portion of Monsanto's liabilities.²⁰⁰

In its discussion of basic insurance principles, the *Monsanto* court invoked a treatise of long standing for the proposition that:

[w]ithout an express proportional limitation in the policy, an insurance company is responsible for the entire loss up to its limits of liability, but the policyholder is limited to a single recovery for that loss: But where there is no provision in a policy of insurance providing for prorating if other insurance exists upon the same subject matter, a company against whom suit is brought after loss cannot

Owens-Illinois, 15 VA. ENVTL. L.J. 525, 570-71 (1996).

199. 652 A.2d 30 (Del. 1994).

200. *Id.* at 34-35 (citations and footnote omitted).

insist upon prorating the loss with other companies thereon, even though the insured may be limited to the recovery of a single indemnity.²⁰¹

In something of a hybrid between the *Keene* approach (so-called joint-and-several liability) and a rigid proration, insurance policies are subject to a continuous trigger but the policyholder is required to tap the applicable coverage in serial order beginning with the first triggered policy, working vertically through excess layers, and then moving to any additional policy years after the first triggered year's coverage is exhausted.²⁰²

3. *The Duty to Defend and Allocation*

Where a court determines that allocation is apt, it generally allocates defense costs in the same manner prevailing for allocation of indemnity responsibility even where the court has noted distinctions between the defense obligations and the indemnity obligations of the insurer. While "an intent by coinsurers to apportion indemnity loss equally does not control the division of defense costs as a matter of law, that intent is an important factor of reference with respect to such division."²⁰³

201. See *id.* at 35 n.7 (citing 6 JOHN A. & JEAN APPLEMAN, INSURANCE LAW & PRACTICE § 3905, at 436-37 (rev. ed. 1972 & Supp. 1993)); see also *Tinsley v. Aetna Ins. Co.*, 205 S.W. 78, 81 (Mo. Ct. App. 1918) ("[P]olicy sued upon contains no 'pro rata clause.' And in the absence of a provision in the policy to the contrary, it is held the insured may recover the full amount of his loss from any insurer, leaving the latter to seek contribution."). *Tinsley* was relied upon heavily by the *Monsanto* court. See *Monsanto*, 652 A.2d at 34-35. On the question of modern Missouri law, the *Monsanto* court noted the preference for allocation in *Continental Casualty Co. v. Medical Protective Co.*, 859 S.W.2d 789 (Mo. Ct. App. 1993), but found *Medical Protective* inapposite to the issue of coverage for a multiyear tort. See *id.* at 35. *Monsanto* noted that *Medical Protective* "prorated the policyholder's loss among the three insurance companies" and that "inter-insurer apportionment, of course, had no bearing upon the insurers' obligations to their policyholder who had already been made whole." *Id.* at 35 n.8.

202. See, e.g., *Cole v. Celotex Corp.*, 599 So. 2d 1058, 1061 n.5, 1074-80 (La. 1992); *Air Prods. & Chems., Inc. v. Hartford Accident & Indem. Co.*, 707 F. Supp. 762, 769 (E.D. Pa. 1989) (applying the Pennsylvania Court of Common Pleas decision of *J.H. France Refractories Co. v. Allstate Insurance Co.*, No. 3933 (Phila. Ct. C.P. Apr. 18, 1996), which was subsequently affirmed in part and reversed in part, 626 A.2d 502 (1993)). Due to the change in Pennsylvania law resulting from the supreme court decision in *J.H. France*, the Third Circuit Court of Appeals vacated and remanded the district court decision. See *Air Prods. & Chems., Inc. v. Hartford Accident & Indem. Co.*, 25 F.3d 177, 181 (3d Cir. 1994).

203. *Federal Ins. Co. v. Cablevision Sys. Dev. Co.*, 662 F. Supp. 1537, 1541

Cases like this, however, despite the endorsement of what might be termed a presumption of sameness in apportioning defense and indemnity payments, illustrate the judicial reluctance to automatically or absolutely adopt indemnity allocation rules for defense allocation. One court found proration by policy limits to be the ordinary New York rule for indemnity apportionment but did not find the rule "compelling" for defense costs in view of the different functions of defense and indemnity and also rejected apportionment according to premiums received since the portion of a premium could not be easily divided among defense obligations and indemnity risk.²⁰⁴ Similarly, an inability to allocate premiums according to defense and liability implies a corresponding inability to allocate defense activity to particular claims or claimants, particularly in the interrelated world of mass torts.

In many cases, however, courts have required equal sharing of defense costs by insurers whose indemnity liability is allocated according to policy limits.²⁰⁵ According to a more recent Second Circuit decision, "[u]nder New York law, insurers are obligated to contribute in equal shares to defense when two such policies provide primary coverage."²⁰⁶

But allocation of defense costs in the case law differs from allocation of indemnity responsibility for large scale torts in an empirical sense. As noted above, most of the courts endorsing allocation among multiyear liability insurers have endorsed proration by time on the risk.²⁰⁷ However, in the average case of defense cost apportionment, the claim at issue falls within one time period but multiple insurers are implicated. Consequently, in non-mass tort, non-latency cases, proration by time on the risk has historically

(E.D.N.Y.), *aff'd*, 836 F.2d 54 (2d Cir. 1987). *Accord* *Twin City Fire Ins. Co. v. Home Indem. Co.*, 650 F. Supp. 785, 792 (E.D. Pa. 1986); *Liberty Mut. Ins. Co. v. United States Fidelity & Guar. Co.*, 232 F. Supp. 76, 84 (D. Mont. 1964); *National Indem. Co. v. St. Paul Ins. Co.*, 724 P.2d 544, 545 (Ariz. 1986); *Liberty Mut. Ins. Co. v. Home Ins. Indem. Co.*, 351 A.2d 891, 895 (N.H. 1976).

204. *See Cablevision*, 662 F. Supp. at 1540.

205. *See, e.g., Emons Indus., Inc. v. Liberty Mut. Fire Ins. Co.*, 481 F. Supp. 1022, 1027 (S.D.N.Y. 1979); *Mission Ins. Co. v. United States Fire Ins. Co.*, 517 N.E.2d 463, 467-68 (N.Y. 1988); *Atlantic Mut. Ins. Co. v. Atlantic Nat'l Ins. Co.*, 326 N.Y.S.2d 438, 439 (N.Y. App. Div. 1971). In the Second Circuit's opinion in *Cablevision*, equal division of defense costs was required. *See Federal Ins. Co. v. Cablevision Sys. Dev. Co.*, 836 F.2d 54, 58-59 (2d Cir. 1987).

206. *United States Fidelity & Guar. Co. v. Executive Ins. Co.*, 893 F.2d 517, 520 (2d Cir. 1990).

207. *See supra* Part II.D.1.

taken a back seat to other methodology. The majority approach appears to be proration among insurers according to respective policy limits.²⁰⁸ A significant number of courts use equal shares apportionment in this situation.²⁰⁹ It is important to note, however, that many of the cases on this issue involve concurrent responsibility of multiple insurers when more than one policy during the same policy period is triggered, rather than consecutive responsibility when policies in series are triggered over time.

In addition to utilizing the equal shares method as an alternative to proration by policy limits or time on the risk, a number of cases hold that in cases of multiple applicable policies, each insurer is independently liable to the policyholder for defense cost obligations.²¹⁰ But insurers usually have apportionment rights vis-a-vis each other regarding defense costs. As one court put it:

[W]hile liability may never eventuate, defense costs are inevitable.

Here, where it has been determined that each insurer is fully liable to plaintiff for indemnification, "it follows" that each is fully liable for defense costs without proration to the insured and subject to contribution or in accordance with any "other insurance" clauses in the policies. Unless a complaint on its face precludes the possibility that any portion of the continuous process of injury fell within the policy period of a policy, that policy creates an obligation for the entire cost of defense against the claim. When more than one insurer was on the risk during this period of continuous injury, they are jointly and severally liable to plaintiff for costs of defending the suit.²¹¹

208. See BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE DISPUTES*, § 6.02[a] (8th ed. 1995).

209. See *id.* § 6.03. It appears that one insurer has defended to conclusion (and even paid the judgment or settlement) and then sought contribution from another implicated insurer rather than the policyholder. See *id.* §§ 6.01-6.03. The only cases not fitting this generalization are the cases involving long-length losses such as asbestos or pollution where the insurers have successfully argued that self-insured policyholders should bear proportional responsibility for defense costs when the loss encompasses both insured and self-insured periods. See *id.* § 6.02[a][2].

210. See, e.g., *Transamerica Ins. Group v. Empire Mut. Ins. Co.*, 327 A.2d 734, 735 (Conn. 1974); *Argonaut Ins. Co. v. Maryland Cas. Co.*, 372 So. 2d 960, 963 (Fla. Dist. Ct. App. 1979); *Associated Mut. Ins. Co. v. Fireman's Fund Ins. Co.*, 436 N.E.2d 1333 (N.Y. 1982), *aff'd* 439 N.Y.S.2d 706, 707 (N.Y. App. Div. 1981).

211. *Lac D'Amiante Du Quebec, Ltee. v. American Home Assur. Co.*, 613 F.

This is in accord with the general view that the duty to defend (or duty to reimburse reasonable defense costs) is both broader than the duty to indemnify and cannot be avoided unless the insurer can demonstrate as a matter of law that the third-party claim cannot fall within coverage.²¹²

This nonapportionment position also squares with that part of duty to defend law that considers insurers responsible for defending the entire case so long as any one of the allegations (regardless of the truth of the allegations) falls within coverage.²¹³ Logically, if an insurer cannot confine defense costs to the covered aspects of a claim, it should not be able to obtain a reduction or limitation in its defense obligations simply because other insurers are also implicated. Under the governing contract with the policyholder, each insurer is obligated to defend or pay for defense costs. In light of this ironclad truth of insurance law, it would make little sense to attempt to identify defense expenses as generic or case-specific and to attempt to apportion them when the insurer is typically not permitted even to apportion responsibility between covered and uncovered aspects of a given case.

Other cases permit apportionment of defense costs among insurers as a matter of equity, but appear not to perform the allocation at the outset of the litigation but after defense and payment—by at least one applicable insurer—has taken place.²¹⁴ However, to the extent that courts differ on defense and indemnity allocation, there is some tendency for courts to resist allocating defense costs

Supp. 1549, 1563 (D.N.J. 1985) (applying pre-*Owens-Illinois* New Jersey law).

212. See, e.g., *John Deere Ins. Co. v. Shamrock Indus.*, 929 F.2d 413, 417 (8th Cir. 1991) (applying Minnesota law); *Avondale Indus., Inc. v. Travelers Indem. Co.*, 887 F.2d 1200, 1205 (2d Cir. 1989) (applying New York law); *Centennial Ins. Co. v. Applied Health Care Sys. Inc.*, 710 F.2d 1288, 1292 (7th Cir. 1983) (applying California law); *United States v. United States Fidelity & Guar. Co.*, 601 F.2d 1136, 1141 (10th Cir. 1979) (applying Oklahoma law); *Villa Charlotte Bronte, Inc. v. Commercial Union Ins. Co.*, 476 N.E.2d 640, 641 (N.Y. 1985). See also *Federal Ins. Co. v. Cablevision Sys. Dev. Co.*, 662 F. Supp. 1537, 1539 (E.D.N.Y. 1987) (“Indemnification liability is inherently limited, whereas the duty to defend is essentially limitless.”).

213. See, e.g., *Foreman v. Continental Cas. Co.*, 770 F.2d 487, 489 (5th Cir. 1985); *Continental Cas. Co. v. Synalloy Corp.*, 667 F. Supp. 1523, 1545 (S.D. Ga. 1983); *Seaboard Sur. Co. v. Gillette Co.*, 476 N.E.2d 272, 275-76 (N.Y. 1984).

214. See, e.g., *National Grange Mut. Ins. Co. v. Continental Cas. Ins. Co.*, 650 F. Supp. 1404, 1413 (S.D.N.Y. 1986); *State Farm Fire & Cas. Co. v. LiMauro*, 482 N.E.2d 13, 17 (N.Y. 1985).

even where the court is receptive to allocation generally.²¹⁵ When allocation is utilized, proration by policy limits or equal shares proration appears comparatively more popular than proration by time, at least as compared to the indemnity allocation cases.²¹⁶

4. Allocation to the Policyholder Specifically

Notwithstanding judicial reluctance to divide and apportion defense costs, at least at the outset of the case, significant case law supports allocation to the policyholder for self-insured or uninsured periods for defense costs as well as indemnity.²¹⁷ For the most part, courts endorsing allocation of insurer coverage responsibilities by time on the risk, like the *Domtar* court, have also, when forced to decide the issue, endorsed allocating pro rata coverage burden to the policyholder. However, as noted above, case law is almost evenly divided regarding the wisdom of pro rata allocation by time even among triggered insurers.²¹⁸ Many courts hold that the policyholder should not be restricted in tapping applicable insurance even where the policyholder is not itself required to pay a portion of covered claims.²¹⁹

215. See, e.g., *Ray Indus., Inc. v. Liberty Mut. Ins. Co.*, 974 F.2d 754, 769-70 (6th Cir. 1992) (applying Michigan law) (refusing to allocate defense cost obligations of multiple insurers and policyholder at outset of litigation but suggesting that allocation to policyholder for self-insured periods is apt).

216. See, e.g., *Federal Ins. Co. v. Cablevision Sys. Dev. Co.*, 836 F.2d 54, 57-58 (2d Cir. 1987) (applying New York law and utilizing equal share proration); *Continental Cas. Co. v. Aetna Cas. & Sur. Co.*, 823 F.2d 708, 712 (2d Cir. 1987) (applying Connecticut law); *Transport Indem. Co. v. Home Indem. Co.*, 535 F.2d 232, 238-39 (3d Cir. 1976) (applying Pennsylvania law and prorating based on policy limits, the default rule absent other factors suggesting different formula); *United States Fidelity & Guar. Co. v. Thomas Solvent Co.*, 683 F. Supp. 1139, 1173 (W.D. Mich. 1988) (utilizing equal share proration); *National Grange*, 650 F. Supp. at 1413; *Liberty Mut. Ins. Co. v. Pacific Indem. Co.*, 557 F. Supp. 986, 989-90 (W.D. Pa. 1984) (utilizing equal share allocation among two primary insurers under Pennsylvania law prior to *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993)). See also *J.H. France*, 626 A.2d at 508-09 (holding each insurer responsible for defense cost without apportionment until policy limits exhausted by judgment or settlement but defense cost obligations accrue seriatim from date of first loss).

217. See, e.g., *Gulf Chem. & Metallurgical Corp. v. Assoc. Metals & Minerals Corp.*, 1 F.3d 365, 372-73 (5th Cir. 1993) (applying Texas law and prorating by time, including to policyholder for periods of self-insurance); *Commercial Union Ins. Co. v. Sepco Corp.*, 918 F.2d 920, 924-25 (11th Cir. 1990) (applying Alabama law and prorating defense obligations by time, including proration to policyholder for self-insurance time periods).

218. Compare Part II.D.1 and Part II.D.2.

219. See *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034, 1048 (D.C.

A variant on the "allocation to the policyholder" approach has held that the policyholder is responsible not according to a proration formula but according to the evidence as to the amount of injury actually taking place during periods of self-insurance or no insurance.²²⁰ This approach, of course, has been rightly rejected by both *NSP* and *Domtar* as too difficult, too expensive, too time-consuming, and too likely to fail to achieve reliable determinations.²²¹

III. ERRONEOUS ALLOCATION: PROBLEMS OF THE *DOMTAR* APPROACH

A. *The Deficiencies of Domtar*

Although there is much that is sound about the *Domtar* opinion, its assessment of the apportionment issue is unpersuasive as a matter of law, policy language, the nature of insurance, the factual context of multiyear claims, and the equitable concerns that purport to animate the *Domtar* decision. What began in *NSP* as a commendable but perhaps misapplied concern for efficient resolution of inter-insurer disputes,²²² morphed in *Domtar* into an unrec-

Cir. 1981); *SCSC Corp. v. Allied Mut. Ins. Co.*, 515 N.W.2d 588, 601 (Minn. Ct. App. 1994), *aff'd in part, rev'd in part*, 536 N.W.2d 305 (Minn. 1995); *Dayton Indep. Sch. Dist. v. National Gypsum Co.*, 682 F. Supp. 1403, 1410-11 (E.D. Tex. 1988), *rev' sub nom. W.R. Grace & Co. v. Continental Cas. Co.*, 896 F.2d 865 (5th Cir. 1990) (holding lack of jurisdiction).

220. See, e.g., *IMCERA Group, Inc. v. Liberty Mut. Ins. Co.*, 50 Cal. Rptr. 2d 583, 608-09 (Cal. Ct. App. 1996).

221. See *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 732 (Minn. 1997); *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 662-63 (Minn. 1994).

222. *NSP's* result is clearly more defensible than that of *Domtar*. *NSP* utilized a prorata by time approach to allocate insurer responsibility and did not reduce the policyholder's insurance benefits because of the length of time involved in the tortious conduct at issue. See *NSP*, 523 N.W.2d at 663-64. But *NSP's* reasoning and rigid temporal apportionment of coverage responsibility could easily operate to deprive the policyholder of coverage for which it paid if one or more of the triggered insurers is insolvent or its policy limits have previously been drawn down or exhausted by other covered claims. In that case, the reduction in each insurer's coverage liability because of proration could leave the policyholder without full insurance even though the policyholder had purchased what would have been adequate insurance but for the court's proration. Consequently, even though *NSP* did not directly impose coverage responsibility upon the policyholder, it has that potential and is erroneous to that degree. See *infra* Part III.B.6 (discussing the need to adjust proration among insurers according to insolvencies, collectability problems, and prior exhaustion of some triggered policies).

essarily imposed mathematical formula that can work to strip policyholders of valid coverage.

1. Domtar Misunderstands the Meaning of the Policy Language

Ironically, the *Domtar* court seems to misunderstand the CGL policy language despite the fact that it is so obviously concerned with vindicating traditional contract principles that are applied to insurance coverage disputes. In hanging on a few words in the *Domtar* policies, the court committed the classic analytic mistake of focusing on a tree while failing to see the forest. At the same time, ironically, the court paid virtually no attention to the words of the policy invoked by the policyholder in opposition to the proposed allocation.

a. The "During The Policy Period" Language of the CGL is Designed as a Marker and Triggering Point, Not as a Limitation on the Scope of Coverage

In particular, the *Domtar* court seized on the provision of the CGL that promised to pay on the policyholder's behalf "all sums which the insured shall become legally obligated to pay as damages because of injury to or destruction of tangible property, including loss of use."²²³ The *Domtar* policies also contained the typical CGL language that the insurance applies only if the bodily injury or property damage claimed by the third party occurs "during the policy period."²²⁴

Following the wrong fork taken on the jurisprudential road in *NSP*, the *Domtar* court seized on the "during the policy period" language to hold that a triggered insurer in multiyear torts somehow is no longer responsible for the damages resulting from a covered occurrence.²²⁵ This interpretation of the "within the policy period" or "during the policy period" language of a CGL is clearly wrong-headed, as everyday insurance events illustrate.

For example, assume a policyholder's truck driver runs a red

223. *Domtar*, 563 N.W.2d at 731.

224. *Id.* at 732. Today this language is found in the standard occurrence CGL in essentially the same form as was found in the *Domtar* policies. See Insurance Services Office, Commercial General Liability Policy, Form No. CG 00 01 01 96, Section I.A.1.b (1994), reprinted in ALLIANCE OF AMERICAN INSURERS, THE INSURANCE PROFESSIONALS' POLICY KIT: A COLLECTION OF SAMPLE INSURANCE FORMS 347 (1997-98 ed.).

225. See *Domtar*, 563 N.W.2d at 732-33.

light and collides with another car, whose driver sues. The claim is covered under the policyholder's CGL because the injured driver is claiming actual injury resulting from a covered occurrence (employee negligence) that was allegedly inflicted on the third party claimant during the policy period. However, as we all know, the bodily injury damage to the third party claimant may extend for years past the termination of the policy period during which the auto accident took place. If the claimant was seriously injured (e.g., confined to a wheelchair), the damages from the covered occurrence could extend for decades. No CGL insurer involved in this situation would assert that its coverage responsibility ceased at the conclusion of the policy period. The insurer would, quite rightly, continue to pay medical bills, economic loss, pain-and-suffering, and other valid damages so long as the policy limits had not been exhausted.²²⁶

This scenario and variants of it are so common and so clear that the "during the policy period" language cannot mean what the

226. Even a leading case favoring proration in complex multiyear matters recognizes that the "during the policy period" language cannot be read in the manner set forth by the *NSP* court where conventional coverage matters are involved. See *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 988-89 (N.J. 1994). In *Owens-Illinois*, the New Jersey Supreme Court observed that:

As to the Insurance Companies' argument that all injury (or damages) must occur in the policy period or that indemnity is awarded for only the part of the injury that occurs during the policy period, consider the simple case of an automobile accident in 1994 with a definite prognosis that an injured occupant's spine will deteriorate in 1996 resulting eventually in paralysis. The policy in effect during 1994 must indemnify for all damages attributable to the 1994 accident even though the full extent of the damages or the injury will not take place until a future date.

Id.

However, the *Owens-Illinois* court nonetheless found allocation to the policyholder by time and policy limits justified for asbestos claims (as a default rule if specific factfinding could not be accomplished) both because of the significance of policyholder periods of self-insurance and because of its view that the ultimate total of damages to the claimant from different asbestos "hits" over several years would be comprised of different amounts of damage from different triggering injuries. See *id.* at 995. The *Owens-Illinois* court apparently thought that it was unfair for a triggered policy period to be responsible for all damages in the multiyear asbestos context when some of the damage must have resulted from injury during other policy periods. See *id.* at 992-93. Although this view is defensible, it is ultimately not persuasive in view of the CGL policy language, the function of liability insurance, the expectations of the parties, and the comparative unfairness of allocating to the policyholder when other triggered coverage remains yet to be fully used.

NSP court suggested it meant (that the insurer was not responsible for any damages taking place after the policy term but stemming from an injury that began during the policy term).²²⁷ The *Domtar* court acknowledged this, but imperfectly, when it observed that “[i]t is inaccurate to conclude that a CGL insurer is never liable for damages occurring outside of the policy period.”²²⁸ Also, *SCSC* would appear to apply to the auto accident hypothetical. There is a discrete, identifiable event and damages flowing from the event.²²⁹ Even though damage continues into another policy period, the triggered policy will, under *SCSC*, continue to be responsible.²³⁰

Notwithstanding *SCSC* and the discrete and identifiable event exception to the application of *NSP* and *Domtar*, the illustration above—and the *SCSC* case itself—demonstrates that the “during the policy period” language of the CGL cannot mean what *NSP* and *Domtar* suggest it means. In fact, under the language of the standard liability insurance policy—and virtually all liability policies—the time period during which injury takes place is irrelevant once the policy is triggered. Liability insurers, at least until *NSP*, routinely paid for losses extending beyond the end of the policy period in which injuries triggered application of the policy. The routine is so firmly established that there is literally no pre-1980s case law supporting the *Domtar* insurers’ position.²³¹ In cases other than high-stakes pollution and product liability claims such as *NSP* and *Domtar*, this continues to be the norm. Only where there is a great deal of money at stake coupled with an opportunity to impose some of this cost on other insurers or the policyholder does one find insurers advocating pro rata temporal allocation of coverage responsibility. Although the argument is couched in terms of the distinction between less visible continuous injury and more visible

227. See *supra* notes 101-02 and accompanying text (quoting relevant language in *NSP*).

228. *Domtar*, 563 N.W.2d at 733. The court then unnecessarily muddled this welcome clarification of *NSP* by stating that the scope of the time period of coverage will vary according to policy language and the facts of the case. See *id.*

229. Cf. *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 318 (Minn. 1995) (holding a sudden and accidental occurrence triggered only CGL policies on the risk during the year the damage arose).

230. See *id.*

231. There is, to be sure, case law that states that liability insurance is not triggered until a third party alleged injury during the policy period and that the policyholder’s negligence during the policy period does not trigger coverage unless injury also takes place. See *infra* notes 248-57 (discussing *Singsaas*). However, as detailed in that discussion, these are cases simply about whether triggering injury takes place—they do not support the proposition that a policy is detripped as to any injury that has not terminated by the end of the policy period.

between less visible continuous injury and more visible episodic injury, one retains the suspicion that the insurer coverage position is driven by economic stakes rather than legal distinctions.

If the auto accident hypothetical is turned into a product liability hypothetical, the point becomes plainer. Assume that a customer uses a widget in Year 1 through Year 5. During each year, the widget gives off carcinogenic fumes that gradually destroy the user's pancreatic function, eventually requiring removal of the organ and serious physical consequences for the user. Although the pancreas may not have been diagnosed as malfunctioning until Year 5, there certainly has been some new actual injury to the pancreas during Years 1 through 5. The Year 2, Year 3, Year 4, and Year 5 injury is not the continuous progression of the Year 1 injury but instead represents new injury that triggers each year's CGL. However, under *NSP* and *Domtar*, the coverage responsibility is to be divided. If the policyholder had no insurance during a given year or if some of the policies are exhausted, the effect of the allocation is to reduce available coverage. By contrast, if all the widget fumes are released during the first three months of use, only the Year 1 policy is triggered and the policyholder is entitled to the full benefits of this policy. This policyholder's insurance coverage will not be reduced by forced allocation.

Thus, it should not be surprising that when confronted with allocation arguments such as those presented by the *Domtar* insurers, the California Supreme Court emphatically rejected the notion that a triggered insurer could somehow become untriggered simply because damage stemming from the triggering injury was ongoing.²³² Summarizing the correct construction of the CGL, the court observed:

In pertinent part, standard comprehensive or commercial general liability insurance policies provide that the insurer has a duty to indemnify the insured for those sums that the insured becomes legally obligated to pay as damages for a covered claim It is triggered if specified harm is caused by an included occurrence, so long as at least some harm results within the policy period. It extends to all specified harm caused by an included occurrence, even if some such harm results beyond the policy

232. See *Aerojet-General Corp. v. Transport Indem. Co.*, 948 P.2d 909, 919-20 (Cal. 1997).

period. In other words, if specified harm is caused by an included occurrence and results, at least in part, within the policy period, it perdures to all points of time at which some such harm results thereafter. To illustrate by a hypothetical similar to the present [groundwater pollution] case: Insurer has a duty to indemnify Insured for those sums that Insured becomes legally obligated to pay as damages for property damage caused by its discharge of hazardous substances, up to a limit of \$1 million. Insured discharges such a substance. It thereby causes property damage to Neighbor's land, in the amount of \$100,000 (determined by the cost of returning the soil to its original condition), within the policy period of year 1. It causes further damage of this sort as the substance spreads under the surface, in the amount of \$100,000 annually, in year two through year thirty. Insured must pay Neighbor \$3 million in damages under judgment. Insurer must pay Insured the limit of \$1 million for indemnification.²³³

In a footnote to this section, the court added:

In *Montrose*, we also made plain that "successive" insurers "on the risk when continuous or progressively deteriorating [property] damage or [bodily] injury first manifests itself" are separately and independently "obligated to indemnify the insured." "[W]here successive . . . policies have been purchased, bodily injury and property damage that is continuing or progressively deteriorating throughout more than one policy period is potentially covered by all policies in effect during those periods."²³⁴

The California Supreme Court recognized that this was not "joint and several" liability imposed upon the insurers but was simply holding insurers to the terms of their contractual understandings with the policyholder.²³⁵ When coverage is triggered, insurers

233. *Id.* at 919-20 (citations and footnotes omitted). *Accord* *Montrose Chem. Corp. v. Admiral Ins. Co.*, 913 P.2d 878, 901 (Cal. 1995) ("[A]n insurer on the risk when continuous or progressively deteriorating [property] damage or [bodily] injury first manifests itself remains obligated to indemnify the insured for the entirety of the ensuing damage or injury.").

234. *Id.* at 920 n.10 (citations omitted) (alterations in original).

235. *See id.* at 920 n.10 (applying the regime adopted in California, "successive insurers are not 'jointly and severally liable'").

must provide coverage up to the applicable unexhausted policy limits and may exempt themselves from coverage only if they can prove that the third party claim "did not even possibly embrace any triggering harm of the specified sort within its policy period"²³⁶

Essentially, the *Domtar* and *NSP* courts have it backwards. The general rule is not that the insurer's liability is limited to only the damage taking place within the policy period. Rather, the insurer is usually responsible for *all* damages that proximately flow from an injury beginning during the policy period. This is why liability insurers in ordinary tort claim coverage actions do not even think of arguing that their responsibility ends merely because the calendar has turned a page. For the normal tort and insurance claim, this is the indisputable case. SCSC accepts this view for such "normal" claims where the injury stems from a single, discrete, isolated event.²³⁷ Most courts (except, unfortunately, perhaps the *NSP* and *Domtar* courts) would find such insurer argument sanctionably frivolous in the ordinary tort claim. If a CGL carrier cut off its policyholder on December 31 of the policy year while there remained multimillion dollar mounting injuries by a paraplegic plaintiff arising out of an injury during the year, most courts would rightly consider this an act of bad faith by the insurer. Somehow, *NSP* and *Domtar* lost sight of this common sense notion of the meaning of the typical liability insuring agreement. The court studied the "during the policy period" language like a horticulturist examining a tree, or perhaps a leaf on a tree—and failed to view the forest.

Read as a whole and with some appreciation for application of the text of the insuring agreement to normal torts and coverage disputes, it is clear that the damage "during the policy period" provision of the CGL must mean that the damage is required to begin during the policy period.²³⁸ Once this happens, the insurer re-

236. *Id.* at 929. The *Aerojet* court at times refers to this principle as one that permits the insurer to "allocate" responsibility for the tort to the policyholder. *See id.* A more accurate description is that the insurer can avoid coverage by proving lack of trigger if the insurer can demonstrate that no part of a multiple year injury could have possibly occurred during its policy term. But this is not really allocation, it is simply the defeating of coverage. Under California law, once coverage is established, none of it can be imposed back upon the policyholder through allocation due to the length of time that injury took place. *See id.* at 931-32.

237. *See* SCSC Corp. v. Allied Mut. Ins. Co., 536 N.W.2d 305, 312 (Minn. 1995).

238. Although much of the CGL pollution coverage litigation may be behind the courts due to the insurance industry's use of the absolute pollution exclusion, the issue of insurance industry attempts to cut off coverage obligations remains a live issue. The current standard CGL language continues to state that the insurer

mains responsible for all of the resulting damage from a covered matter until the liability limit is exhausted.

This is the only reasonable interpretation of the CGL policy's "during the policy period" language. Any other view would make coverage turn on the mere happenstance of the time of the incident creating injury or the vagaries of an injury. For example, if the hypothetical auto accident discussed above took place on January 1, the insurer would probably pay for most of the resulting liability, even under the *NSP/Domtar* view of the insurer's temporal responsibility. But if the accident took place late on December 31, the insurer would be largely absolved of coverage responsibility under the *NSP/Domtar* rationale.²³⁹ Surely this is an absurd result by any standard.

Another variant of this hypothetical illustrates the absurdity of *NSP/Domtar* view of insurer responsibility when injuries extend for several years. If in the hypothetical auto accident above, the other driver was instantly killed by the Policyholder's truck, the insurer would, even under *NSP/SCSC/Domtar*, be responsible for the entire amount of the third party claim for wrongful death because the damage has been incurred in total at the time of the accident.²⁴⁰ But if the victim is only maimed rather than killed, he lives for years

ance applies "only if" the injury "occurs during the policy period." See Insurance Services Office, Commercial General Liability Policy, Form No. CG 00 01 01 96, Section I.A.b.2 (1994), *reprinted in* ALLIANCE OF AMERICAN INSURERS, THE INSURANCE PROFESSIONALS' POLICY KIT: A COLLECTION OF SAMPLE INSURANCE FORMS 347 (1997-98 ed.) As a matter of literal construction, the current language continues to be better read as resisting any apportionment that reduces coverage, even if one is a strict textualist. In the hypothetical negligence claim discussed in this article, for example, there is no question that injury has "occurred during the policy period." This remains the case (and the policy remains triggered and applicable) even if the costs of the occurring injury continue to mount in subsequent years.

239. If the accident takes place at 11:30 p.m. or so, the insurer has the best of all possible worlds. Coverage is triggered by the injury during the policy period, but the resulting "damage" of any calculable amount does not take place until the next year (even the emergency room medical bills are incurred outside the policy period). The succeeding insurer will have no liability because the injury preceded its policy period. Thus, under *NSP/Domtar* as applied to a simple but serious auto accident with a third party claimant confined to a wheelchair for 50 years thereafter, the only triggered insurer pays perhaps a few thousand dollars of this multi-million dollar claim. No reasonable auto insurer would take such a coverage position and no sane court would endorse it.

240. Of course, under *NSP/Domtar*, it is also possible that notwithstanding the immediate death of the third party, the court would hold that the damages from this wrongful death (economic loss to the decedent's family) took place after the end of the policy period. Such an application of the *NSP/Domtar* construction of the CGL's "during the policy period" language would be doubly absurd.

to come and incurs damages that become choate after the conclusion of the policy period, thus allowing the triggered insurer to prorate its coverage responsibility lower with each passing year. This sort of result from *NSP/Domtar* proration would also be absurd. It would harken back to the days before a cause of action for wrongful death existed and where, from a tort liability standpoint, the tortfeasor was better off killing his victim rather than injuring him.²⁴¹ If *NSP/Domtar* proration were applied to such cases, the absurdity would merely be reversed: serious injury, bringing higher tort damages overall, would impose dramatically lower insurance coverage responsibility while death, because of its immediacy, would result in full coverage responsibility. From an insurance coverage standpoint under *Domtar*, the policyholder is better off making a product that kills users instantly than a product that is alleged to cause gradual and recurring injury over time.

One possible means of reducing this type of absurdity from use of the *NSP/Domtar* approach in other insurance matters is to utilize the concept of an endpoint that is set forth in these cases but never really explained. Both *NSP* and *Domtar* held that the time for pro rata allocation of coverage responsibility ceased upon discovery of the loss or completion of remediation efforts, although it was unclear which date was the preferred endpoint.²⁴² The date on which the injury becomes expected may serve as an endpoint because at that point, the injury ceased to be an insurable event.²⁴³ Although using this endpoint can prevent the types of absurd results outlined

241. Even after the enactment of wrongful death statutes, the absurdity often continued because the maximum statutory amount recoverable under wrongful death statutes was not increased according to inflation, while the costs of medical expenses, economic loss, and pain and suffering continued to be calculated according to contemporary standards in serious injury cases. As a result, it long remained the case (and may still be the case today) that from a financial standpoint a tortfeasor is better off killing the victim rather than seriously injuring the victim, so long as the tort does not spur criminal prosecution for manslaughter. In addition, the deadly tortfeasor has the practical advantage at trial of not having to face a live but maimed plaintiff who can both give testimony and serve as a reminder to the jury of the seriousness of the injury.

242. See *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 732 (Minn. 1997); *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 662-64 (Minn. 1994).

243. *Accord* *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386, 1390-91 (8th Cir. 1996) (applying Minnesota law and allocating the coverage responsibility of insurers only over the period of time when sexual abuse by a priest took place rather than over the period of ensuing years during which the victims of abuse continued to suffer damage, suggesting that, once triggered, an insurer remained on the risk for time of ensuing damage).

in the auto accident hypothetical above, it does not comport with the *NSP/Domtar* pronouncements of the meaning of the “during the policy period” language.²⁴⁴ The *NSP* and *Domtar* courts stated that the proper reading of the CGL policy language was that insurers were only liable for the damage that took place during the insurer’s policy period.²⁴⁵ If this is the meaning attached by the court, lack of trigger or fortuity in subsequent years may avoid proration but does not undo the incorrect interpretation of the CGL language.

Similarly, a defender of the *NSP* and *Domtar* decisions could argue that prorata allocation takes place only where more than one insurer is triggered due to continuous injury, thereby muting the really absurd result of having a single triggered liability insurer have its coverage responsibility lopped off on December 31 even though large damages continue to flow from a clearly triggered incident. But if this is the case, there nonetheless is no basis for assigning coverage responsibility to the policyholder merely because the injury spans years. As the *SCSC* decision indicates, *NSP* and *Domtar* appear to concede that under Minnesota law a policyholder suffers no reduction in coverage from a large loss from a single episodic event where significant damage becomes realized entirely within the policy period from one triggering event.²⁴⁶ However, a policyholder incurring liability exposure because of several triggering events across the years is thrust into the position of the policyholder with the truck accident claim: coverage is reduced because of the multiyear nature of the injuries. Unless the coverage purchased by the policyholder is fully tapped, this result, too, is absurd in that it deprives the policyholder of coverage because it had the misfortune of dying from a thousand cuts rather than a single slashing blow.

The general rule that a triggered insurer is responsible for all losses flowing from the claim (until exhaustion of policy limits) also has the jurisprudential advantage of avoiding the absurd results that would exist if the *NSP/Domtar* view of the meaning of the term were applied to ordinary tort and insurance claims.²⁴⁷

244. See *Domtar*, 563 N.W.2d at 731-33; *NSP*, 523 N.W.2d at 662-64.

245. See *Domtar*, 563 N.W.2d at 732-33; *NSP*, 523 N.W.2d at 662-64.

246. See *supra* notes 122-36 and accompanying text (discussing the *SCSC* decision).

247. Imagine, for example, if the *NSP/Domtar* view were the rule for the hypothetical truck collision discussed above. Knowing that insurance would cease at the end of the policy period, the prudent policyholder would seek to settle all

Upon reflection, the “during the policy period” language properly interpreted merely amplifies the actual injury trigger of coverage, no more and no less. CGL coverage is triggered by a claim of negligence-induced injury that took place during the policy period. If the damages from the injury continue beyond the policy period, the insurer remains responsible. This is an inarguable norm of insurance law (and tort law) that argues against any allocation to the policyholder. The insurer by contract has assumed the risk of damages levied against the policyholder for covered occurrences causing injury during the policy term. The fact that the injury is not cabined within a given year is irrelevant.

An insurance policy that did not operate in this manner would be a materially different product—and a much less valuable one unlikely to be purchased by any sane policyholder, except perhaps at salvage yard, bargain basement rates. But the *NSP/Domtar* interpretation of the “during the policy period” language effectively converts a normal liability policy into this type of inferior product with dramatically but silently reduced coverage varying according to the nature of the third-party claim. Furthermore, the insurer already utilizes many other, more legitimate means of delimiting its exposure: policy limits (both occurrence and aggregate); specific exclusions; self-insured retentions; refusal to renew; extended tail coverage; and use of the claims-made form.

The *NSP/Domtar* misinterpretation of the “during the policy period” language appears to result in part from a misinterpretation of an inarguably correct Minnesota precedent: *Singsaas v. Diederich*.²⁴⁸ In *Singsaas*, the policyholder in Year 1 (when it had li-

claims instantaneously because its insurance coverage, like Cinderella’s carriage, was to turn into a pumpkin at the stroke of midnight. This type of policyholder behavior, of course, is not to be encouraged as it would often result in settlement of meritless claims or overpayment of claims.

In most CGL policies, the insurer controls the defense and settlement of the matter. Although this may obviate the above problem, it creates another problem: horrendously intricate bad faith cases. What if the insurer-controlled counsel defends a claim vigorously and refuses an early settlement offer? Is this bad faith because the insurer knows that all it need do is “run out the clock” on the policy period and then walk away from the defense? Clearly, the insurer would have this incentive if the *NSP/Domtar* rationale were seriously applied to regular tort claims. Only a hyperactive, nitpicking, look-over-your-shoulder type of bad faith law would prevent these incentives from creating mischief. This could, at least in theory, protect policyholders, but it would also impose significant costs and inefficiencies upon the insurance industry.

248. 307 Minn. 153, 238 N.W.2d 878 (1976).

ability insurance from Insurer A) performed negligent work.²⁴⁹ In Year 2, the policyholder ceased business and canceled its insurance.²⁵⁰ Later in Year 2, a third person was injured and rendered a paraplegic due to the negligence.²⁵¹ The policyholder argued that the Year 1 coverage was triggered by the negligent acts taking place during Year 1.²⁵² The supreme court correctly rejected this argument because the CGL policy language provided that it was triggered by "bodily injury" during the policy period rather than "negligence" during the policy period.²⁵³ Even if the Year 1 actions of the policyholder created a "time bomb" of sorts, CGL coverage did not become effective until the bomb went off, which happened in Year 2, a time when the policyholder had no insurance in force.

Unfortunately, the *NSP* court lost sight of the simple, elegant, correct interpretation and holding of *Singsaas* by focusing on the language of *Singsaas* and other cases that the CGL is triggered and the insurer responsible only for damages taking place during the policy period.²⁵⁴ When *Singsaas* and similar cases are read carefully rather than merely seized upon for a sound bite-like quotation, it is clear that what *Singsaas* meant by this statement was that injury rather than negligence is the trigger of coverage.²⁵⁵ *Singsaas* never intended its statement that insurers are liable only for damage taking place during the policy period to mean that insurer responsibility for an injury beginning "on its watch" ends when the policy period expires. There remain the litigation and financial consequences to the policyholder because of the triggering injury—and these can go on for years. Properly read, *Singsaas* stands for the proposition that CGL coverage is triggered by injury during that policy period and that the triggered policy is responsible for the damages flowing from the triggering injury.²⁵⁶ As in the automobile accident hypothetical above, there is no termination of insurer responsibility merely because the year of the injury ends. For example, in *Singsaas* itself, if there had been applicable CGL coverage in Year 2, the CGL would not only have been triggered by the

249. See *id.* at 155, 238 N.W.2d at 879-80.

250. See *id.* at 155, 238 N.W.2d at 880.

251. See *id.*

252. See *id.* at 156, 238 N.W.2d at 881.

253. See *id.* at 155-56, 238 N.W.2d at 880.

254. See *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 662 (Minn. 1994).

255. See *Singsaas*, 307 Minn. at 155-56, 238 N.W.2d at 880.

256. See *id.*

Year 2 injury but the CGL insurer would have been required to defend the ensuing litigation (undoubtedly extending beyond Year 2) and the lifetime of damages incurred by the paraplegic claimant (during Years 3, 4, and beyond) until policy limits were exhausted.²⁵⁷

The supreme court appears to have recognized this in other contexts. For example, in *SCSC*, the court stated that the language of the CGL "requires the insurer to pay all damages causally related to an item of property damage under the policy definitions."²⁵⁸ In other cases since *Singsaas* (and since *NSP* for that matter), the court has focused on whether actual injury took place during the policy period, not whether all of the damage from the injury took place during the policy period.²⁵⁹ Cases prior to *NSP* may use language supporting the strange construction of the "during the policy period" language. On closer examination, however, it is clear that these cases involve the onset of injury during the policy period (which must take place during the policy period if there is to be coverage) rather than damage from the injury (which need not be confined to the policy period for coverage to apply).²⁶⁰ The same is true of authorities or cases outside of Minnesota that because of imprecise language can be quoted as suggesting limits on the cov-

257. See *id.* at 157-58, 238 N.W.2d at 880-81.

258. *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 312 (Minn. 1995) (citing *Federated Mut. Ins. Co. v. Concrete Units, Inc.*, 363 N.W.2d 751, 757 (Minn. 1985)).

259. See, e.g., *Fairview Hosp. & Health Care Serv. v. St. Paul Fire & Marine Ins. Co.*, 535 N.W.2d 337, 341-42 (Minn. 1995) (stating that a CGL policy is triggered when the actual injury occurs). See also *SCSC*, 536 N.W.2d at 312-13 (distinguishing between injury and damages from the injury implicitly).

260. See, e.g., *Jostens, Inc. v. CNA Ins./Continental Cas. Co.*, 403 N.W.2d 625, 630 (Minn. 1987), *overruled by* *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657 (Minn. 1994). The court in *Jostens* stated that: "*Singsaas* compels the conclusion that damages awarded for work experience accrued outside of the policy period are not covered by the policy but are instead damages for which *Jostens* is solely responsible." *Id.*; see also Brief of Amicus Curiae Minnesota Mining & Mfg. Co. at 8, *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724 (Minn. 1997) (Nos. C9-95-2673, C0-95-2626, and C7-95-2638).

Reading the *Jostens v. CNA* case as a whole, it is clear that the court referred to distinct injury caused by job discrimination (the underlying claim at issue in *Jostens*), and not to the damages flowing from an incident or practice of job discrimination. See also *Reliance Ins. Co. v. Arneson*, 322 N.W.2d 604, 607 (Minn. 1982), cited in Brief of Amicus Curiae Insurance Environmental Litigation Association at 16 n.17, *Domtar* (Nos. C9-95-2673, C0-95-2626, and C7-95-2638) (stating *Reliance* stands for the proposition that the "insurer has no duty to indemnify for harm taking place after expiration of policy").

erage responsibility of a triggered insurer.²⁶¹

b. *The “All Sums” Language in the Domtar CGL Buttresses the Case Against Allocation But is Not Essential to It*

In view of the *Domtar* court’s narrow and hyperliteral construction of the “during the policy period” text of the policy, it is most odd that the court placed almost no emphasis on the “all sums” text of the policy.²⁶² The *Domtar* CGL stated that the insurer would pay “all sums which the insured shall become legally obligated to pay” because of the covered matter.²⁶³

Either one is a textual literalist or one is not. If the “during the policy period” language is entitled to literal application, so is the “all sums” language. But the *Domtar* court gave the former preferential treatment while essentially ignoring the latter.²⁶⁴

A more reasonable and nuanced interpretation of the contract terms would read the words of both provisions in the context of the entire policy and its purpose. So read, it is the case that the CGL insurers did indeed commit themselves to paying all damages flowing from an injury taking place during the policy term so long as

261. See, e.g., Brief of Amicus Curiae Insurance Environmental Litigation Association at 16 n.17, *Domtar* (Nos. C9-95-2673, C0-95-2626, and C7-95-2638) (citing *Wrecking Corp. of Am., Va., Inc. v. Insurance Co. of N. Am.*, 574 A.2d 1348, 1351 (D.C. Cir. 1990); *Continental Cas. Co. v. Medical Protective Co.*, 859 S.W.2d 789, 791 (Mo. Ct. App. 1993); 9 MARK S. RHODES, COUCH ON INSURANCE 2D § 39:203, at 648 (rev. 1985)). The IELA brief referred to *Wrecking Corp.* for the proposition that “coverage is limited to damage occurring while the policy is in effect,” and used *Medical Protective* for the notion that “none of the [insurers] agreed to pay damages . . . which occurred before the inception of coverage or after the termination of coverage.” See *id.* However, the quotation from *Wrecking Corp.* is wrested from context. In that case, much as in *Singsaas*, the policyholder’s negligence prior to cancellation of the liability policy resulted in injury—but the injury did not take place until after cancellation of insurance. The *Wrecking Corp.* court merely applied the standard rule that it is injury rather than negligence that triggers CGL coverage. See *Wrecking Corp.*, 574 A.2d at 1349. *Wrecking Corp.* does not support the view that coverage flowing from trigger terminates when the policy period expires. See *id.* at 1351.

In addition, *Medical Protective* does require proration because of the cumulative impact of the injury (flowing from forty-eight visits to the doctor defendant in a malpractice case). See *Medical Protective*, 859 S.W.2d at 790-92. However, the allocation imposed by the *Medical Protective* court was only between insurers and nothing was imposed upon the policyholder. See *id.* at 792. Consequently, neither of the cases cited by IELA stands for the proposition for which it is advanced.

262. See *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 731-32 (Minn. 1997).

263. *Id.*

264. See *id.* at 732.

the damages, whenever realized or reduced to monetary form, were proximately related to the covered injury. "All" does not mean even the most attenuated of damages or damages that are otherwise subject to a specific and well-understood exclusion from coverage. "All sums", however, read reasonably as part of the entire CGL, strongly suggests that each triggered insurer's responsibility for coverage is restricted only by policy limits or specific exclusions rather than any accidents of time, medicine, or litigation after the occurrence of the triggering event.

Using this approach, the subsequent change in standard CGL language from "all sums" (the language that prevailed until the 1980s) to "those sums" (the current language found in the standard CGL) does not make a difference in case outcomes.²⁶⁵ Rather than hanging on hyperliteralisms, construction of the CGL should be based on a reasonable interpretation that accomplishes the purpose of the CGL consistent with party intent and expectations. Resisting attempts to reduce the policyholder's bought-and-paid-for triggered coverage is a worthy judicial goal that should not be defeated by inordinate attachment to the "during the policy period" language. Similarly, undue emphasis on the "all sums" language should not run roughshod over other aspects of insurance policy construction. But in cases like *Domtar*, the "all sums" language of the CGL has teeth that should not have been defanged by the court, particularly a court so fixated on the misleading "during the policy period" language.

- c. *Although the Ambiguity Principle Should Not Be So Broadly Construed as to Uniformly Require Insurer Liability, Insurers Must Be Held Responsible for Their Choice of Policy Provisions and Text*

To restate the obvious: insurance policies are normally drafted by insurers. Although on relatively rare occasion brokers (who usually act as agents of the policyholder) or policyholders themselves may draft policy language, insurance policies are in the main standardized policies written by the insurance industry. Although large policyholders may have wealth, sophistication about insurance matters, and the advice of brokers and counsel, the choice of

265. See, e.g., Insurance Services Office, Commercial General Liability Policy, Form No. CG 00 01 01 96, Section I.A.1 (1994), reprinted in ALLIANCE OF AMERICAN INSURERS, THE INSURANCE PROFESSIONALS' POLICY KIT: A COLLECTION OF SAMPLE INSURANCE FORMS 347 (1997-98 ed.).

even these “sophisticated” policyholders is generally limited to selecting among policy language options offered by the insurance industry. The insurer may permit the policyholder to add a particular endorsement (for an additional premium), but the policyholder almost never is permitted to draft the endorsement.²⁶⁶

The insurer’s effective control over policy language is, of course, the reason that insurance policies are particularly subject to the standard contract law rule of *contra proferentem*—ambiguous contract language is construed against the drafter—unless the ambiguity can be resolved by reference to other aspects of the policy or extrinsic evidence of party intent or purpose of the contract, including any customary meaning accorded to the terminology.²⁶⁷

A corollary of the ambiguity principle is that it is particularly apt to apply *contra proferentem* in interpreting insurance policies where any ambiguous policy language could easily have been more clearly drafted by the author of the policy.²⁶⁸ Regarding apportionment of liability, insurers have long been in an excellent position to set forth—in the text of the CGL—any desired apportionment scheme applicable to multiyear, multioccurrence torts. Having failed to do so, any uncertainty as to whether apportionment is required and the means of apportionment should be construed in a manner more favorable to policyholders than to insurers. A substantial vice of the *NSP* and *Domtar* decisions is their insistence on taking exactly the opposite approach—despite the strong recent precedent applying ambiguity analysis to determine that pollution cleanup costs ordered by the government constitute damages within the meaning of the pre-1986 CGL.²⁶⁹ In the face of uncertainty, *NSP* and *Domtar* reward the insurers and punish the

266. See Jeffrey W. Stempel, *Reassessing the “Sophisticated” Policyholder Defense in Insurance Coverage Litigation*, 42 DRAKE L. REV. 807, 849 (1993) (concluding that the sophistication of the policyholder does not justify a departure from the use of the *contra proferentem* rule of construing ambiguous language against the drafter since even sophisticated policyholders are seldom the authors of insurance policy language).

267. See generally STEMPEL, *supra* note 18, at ch. 5 (discussing the ambiguity doctrine at length).

268. See *George Backer Management Corp. v. Acme Quilting Co.*, 385 N.E.2d 1062, 1065 (N.Y. 1978) (“Had that been their [the contract authors’] intention, surely no problem of draftsmanship would have stood in the way of its being spelled out.”).

269. See *Minnesota Mining & Mfg. Co. v. Travelers Indem. Co.*, 457 N.W.2d 175, 180-81 (Minn. 1990) (explaining that it is consistent with the reasonable expectations of the insured that cleanup costs will be recovered under the policy).

policyholders.

Perhaps the best evidence of the insurance industry's ability to address the multiyear allocation problem and failure to do so is the "other insurance" clause found in most liability policies.²⁷⁰ The standard CGL and other liability policies typically contain an "other insurance" clause that speaks to the issue of respective coverage responsibility when more than one policy applies.²⁷¹ Non-liability policies, such as first-party medical insurance or workers compensation policies have a functionally equivalent provision that may be labeled either an "other insurance" or "coordination of benefits" clause.²⁷² The "other insurance" clause in liability policies generally provides that the instant policy shall either be excess to any other triggered policy, prorated by policy limits with other applicable policies, or perhaps may seek to absolve the insurer should other insurance be applicable (the so-called "escape" clause).²⁷³ Where "other insurance" clauses conflict, jurisdictions vary in their approach.²⁷⁴ Many prorate coverage responsibility while others have a hierarchy of policy provisions.²⁷⁵

The "other insurance" clause of the CGL could be treated as an allocation provision for multiyear coverage matters. Indeed, the important decision in *Keene*,²⁷⁶ suggested that the "other insurance"

270. See Insurance Services Office, Commercial General Liability Policy, Form No. CG 00 01 01 96, Section IV.4 (1994), reprinted in ALLIANCE OF AMERICAN INSURERS, THE INSURANCE PROFESSIONALS' POLICY KIT: A COLLECTION OF SAMPLE INSURANCE FORMS 355 (1997-98 ed.).

271. See *id.*

272. See STEMPER, *supra* note 18, ch. 13 (regarding coordination of coverage generally)

273. See *id.* § 13.02 (describing types of clauses).

274. See *id.* § 13.03.

275. See *id.* (describing the treatment of conflicting or inconsistent "other insurance" clauses by the courts). Where two excess or escape clauses conflict, proration is normally ordered. See *id.* Many courts, particularly in the latter part of the twentieth century, have found any conflict to require proration, either by equal shares or according to policy limits. See *id.* The leading case of this genre is *Lamb-Weston, Inc. v. Oregon Automobile Insurance Co.*, 341 P.2d 110, 119 (Or. 1959), which holds that when any "other insurance" clause conflicts with that of another insurer, the clause should be completely rejected.

Where a proration clause and an excess or escape clause are present and a *Lamb-Weston* approach is not used, the insurer with the proration clause usually must pay first. However, some courts refuse to enforce escape clauses on public policy or unconscionability grounds, reasoning that the application of the clause renders the coverage illusory by removing it merely because another insurance policy is also triggered. See STEMPER, *supra* note 18, § 13.03 n.19.

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

clauses be used in assigning coverage responsibility among insurers.²⁷⁷ The *NSP* court, following the lead of the Hickman and DeYoung article on allocation,²⁷⁸ found that “other insurance” clauses apply only where insurers are concurrently responsible for coverage.²⁷⁹ In cases of consecutive insurer responsibility, *NSP* and *Domtar* turned instead to their rule of proration by time on the risk as a matter of law.²⁸⁰ Even if not strictly applicable, however, the “other insurance” provisions might be used as a guide. Interestingly, the standard other insurance clauses (excess, pro rata, and escape) do not attempt to assign any coverage responsibility to the policyholder—all such clauses speak only of dividing the coverage burden among insurers. Only “other insurers” are expected to shoulder a triggered insurer’s burden of coverage.

The *NSP* and *Domtar* courts, and the commentators on whom they rely, may have committed a classification error in dividing cases of multiple coverage into the fixed realms of “concurrent” and “consecutive” triggering. Although the string of insurers triggered by years of asbestos or pollution injury are in a different position than two automobile policies triggered by an accident involving two separate vehicles, the distinctions are not especially dramatic. In each case, the task before the court is to ensure that all parties to the loss event pay their fair share. In the case of concurrent insurer responsibility from the auto accident, the clear rule is that the insurers divide up the responsibility in some form. The fully insured drivers are not responsible except for deductibles and amounts exceeding the applicable policy limits. There is no good reason that this same general principle of fairness and fidelity to

277. See *id.* at 1050.

278. See *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 660-63 (Minn. 1994) (citing Hickman & DeYoung, *supra* note 98, at 293); see also *supra* notes 107-09 and accompanying discussion.

279. See *NSP*, 523 N.W.2d at 664 (disapproving court of appeals discussion of “other insurance” clauses because “other insurance” provisions apply only where there is an “allocation problem between multiple insurance policies concurrently liable for damages arising out of a single, discrete occurrence” but not “where there is no concurrent liability”); see also Hickman & DeYoung, *supra* note 98, at 305-06 (taking the position that other insurance clauses have no application to issue of apportioning coverage responsibility for consecutively triggered policies); *supra* notes 107-09 and accompanying text (discussing *NSP* court’s reliance on Hickman & DeYoung article as authoritative and problematic aspects of that reliance).

280. See *supra* notes 64, 101-06 and accompanying discussion; see also *NSP*, 523 N.W.2d at 662-64 (describing its choice of a seemingly fixed apportionment method as one born of equity and convenience).

the insuring agreement should not prevail in the context of multiyear (or consecutive) triggering. In each case, the policyholder should be entitled to full insurance benefits purchased to protect the policyholder from the financial consequences of such triggering events.

As a matter of classification, the multiyear triggering brought about by the nature of asbestos and pollution injuries is perhaps more accurately described as “overlapping” coverage or triggering, rather than “consecutive” triggering. The latter term implies some passing of the baton from one insurer to another. But as the examples above illustrate, the baton should not be passed along a string of insurers as much as new batons are added to the load because new triggering injury keeps taking place over the years. Consequently, the insurers’ responsibilities do overlap, much like the “concurrent” coverage responsibilities of automobile, property, and general liability insurers for single event losses involving multiple policies.

As the *NSP* court correctly noted, determining how much of the damage total stems from the Year 1 injury, the Year 2 injury, and so on is a daunting and perhaps scientifically impossible task.²⁸¹ But as the *NSP* court also correctly noted, the difficulty of the calculation should not impose undue burdens on the policyholder or the courts.²⁸² A presumptive rule of apportionment makes sense for these types of overlapping coverages extending over several years—but only if the policyholder is required to pay only after applicable insurance has been collected. Anything else promotes the absurd result of punishing the policyholder because it faced more strung out liability rather than less compressed liability claims. In effect, *Domtar’s* application of *NSP* gives less to the policyholder that needs more (and has paid for more).

Aside from suggesting that proration to the policyholder was never intended (at least not *ex ante*) by insurers and that this is antithetical to the insurer-policyholder relationship, the “other insurance” clauses of the CGL are important for another reason. These clauses demonstrate beyond doubt that insurers realized the potential of multipolicy triggering and the possibility of drafting policy language to address such situations. Indeed, the standard CGL includes the “other insurance” clause for just this purpose. Insurers

281. See *NSP*, 523 N.W.2d at 663.

282. See *supra* note 101 and accompanying discussion.

could have included language addressing the issue of respective coverage responsibility when there is consecutive triggering of different CGLs in different policy periods due to a multiyear or insidious damage claim. But instead of drafting such language and including it in the CGL, insurers said nothing on the subject. This suggests that insurers had no intent of attempting to change the general rule that triggered insurers are responsible for all damage flowing from the triggering event and claim. At a minimum, the CGL is ambiguous on the point—ambiguous because of the failings of the insurance industry. Under these circumstances, the correct judicial response is to require insurers to bear the cost of this failing rather than to impose the cost on policyholders through the *Domtar* methodology.

2. *Misconstruing the Nature of Liability Insurance*

The *Domtar* court's misinterpretation of the text of the CGL probably flows in significant part from an overly literal and fragmented reading of the "during the policy period" language of the CGL.²⁸³ Also at work is a fundamental misunderstanding of the nature of liability insurance and the respective equities between insurer and policyholder. An operating premise of *Domtar* is that policyholders are given an undue benefit if they are not required to absorb some pro rata share of a tort claim even though there exists sufficient insurance (purchased by the policyholder) to satisfy the claim. This premise is used, sometimes tacitly, by courts demanding allocation to the policyholder, to suggest that any absence of insurance or "gap" in a string of CGL policies somehow demonstrates irresponsibility by the policyholder—irresponsibility for which the policyholder must be punished by being forced to pay some of an insured loss out of the policyholder's own pocket.

In effect, courts mandating allocation to the policyholder on this basis are treating commercial entities like some sort of actuarial juvenile delinquent. The court attempts to punish policyholders for being "bad boys" who self-insured. Presumably, "good boys" are the policyholders who dutifully purchased seamless insurance without interruption, just as the insurance industry hoped they would. Although this may be prudent risk management, failure to consistently purchase CGL protection does not justify stripping the policyholder of the CGL coverage it did buy and rely upon.

283. See *supra* Part III.A.1.a.

In a case decided subsequent to *NSP* and *Domtar*, the California Supreme Court rejected this sort of reasoning, specifically disapproving prominent cases that had utilized it.²⁸⁴ Commenting on the “equitable” rationale invoked by insurers to reduce policyholder coverage through allocation, the court stated:

In answering the question of allocation of defense costs as it did [by requiring proration to the policyholder], the Court of Appeal erred to the extent that it strayed away from the contractual/quasi-contractual analysis set out [earlier in this opinion] in the direction of vague “fairness” and “rough justice.”²⁸⁵

The *Aerojet* court in particular criticized the arguments in favor of “fairness to insurers” found in *Owens-Illinois, Inc. v. United Insurance Co.*,²⁸⁶ stating:

It is perhaps in *Owens-Illinois* that the concern with “fairness” and “justice” instead of contract and quasi-contract is most evident. There, the New Jersey Supreme Court stated: “When periods of no insurance” along with periods of insurance “reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable.” Only if one’s expectation ignores contract in favor of “fairness” and “justice.” For if

284. See *Aerojet-General Corp. v. Transport Indem. Co.*, 948 P.2d 909, 930 (Cal. 1997).

285. *Id.* at 930 (footnote omitted). In the omitted footnote, the *Aerojet* court specifically singled out *Gulf Chemical & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, 1 F.3d 365 (5th Cir. 1993) (applying Texas law); *Insurance Co. of North America v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980) (applying Illinois and New Jersey law), *clarified on rehearing*, 657 F.2d 914 (6th Cir. 1981), *Owens-Illinois, Inc. v. United Insurance Co.*, 650 A.2d 974 (N.J. 1994), and *Sharon Steel Corp. v. Aetna Casualty & Surety Co.*, 931 P.2d 127 (Utah 1997), for this criticism. See *id.* at 930 n.22. Not coincidentally, these cases, particularly *Forty-Eight Insulations*, are the mainstay of many insurer arguments for allocation to the policyholder. *Forty-Eight Insulations* was invoked and quoted by *Domtar*’s insurers and the insurer amici in *Domtar*. See Brief of Amicus Curiae Insurance Environmental Litigation Association (“IELA”) at 16-18, *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724 (Minn. 1997) (Nos. C9-95-2673, C0-95-2626, and C7-95-2638).

286. 650 A.2d 974 (N.J. 1994). Cf. *Stonewall Ins. Co. v. Asbestos Claims Management Corp.*, 73 F.3d 1178, 1203 (2d Cir. 1995) (viewing *Owens-Illinois* as one of the “best” reasoned decisions on coverage and apportionment). See *supra* quoted text accompanying note 187.

an actor shifts a risk in some periods and not in others, so far as contract is concerned its omission should generally have the same effect whether it finds its genesis in choice or in compulsion.²⁸⁷

As the California decision emphasizes, *Domtar's* allocation doctrine is something of an “unreasonable expectations” doctrine operating in favor of insurers.²⁸⁸ Contract language favoring the policyholder is subordinated to reduce insurer liability for no basis other than that it seems somehow “unfair” that so many insurers should be responsible for years of liability claims. What the *Domtar* court ignored was that its decision worked greater unfairness upon the policyholder in addition to failing to give the policyholder the full benefit of its contract rights.

Even where the policyholder had seamless coverage, some allocation decisions have enforced an allocation regime that required the policyholder to absorb the financial consequences when some of that insurance is exhausted or uncollectible even though the policyholder has other triggered CGL coverage that has not been fully used. In these cases, the premise appears to be a judicial view that the policyholder deserves to be punished for purchasing “inadequate” insurance or foolishly having bought insurance from a now-insolvent company.²⁸⁹ However, with nothing in the CGL mandating allocation across the years or allocation of costs to the policyholder, the policyholder can hardly be held culpable for underinsurance—the insured thought it had purchased adequate coverage because it expected to collect on any triggered policy if triggering damages required full use of any unexhausted policies. Similarly, the consequences of insurer insolvency hardly justify reducing the policyholder’s solvent triggered insurance coverage.

While most commercial policyholders have a risk management program in place and maintain it over the years, it is not necessarily the case that the responsible policyholders uniformly purchase liability insurance for every year of operation. For example, a policyholder may self-insure for several years, then purchase CGL coverage if it has reason to worry about dangerously low assets or

287. See *Aerojet*, 948 P.2d at 930 n.22.

288. See *id.* at 930-31.

289. See *supra* Part II.D.1.a (discussing the *Stonewall* opinion of the Second Circuit, which implicitly criticizes policyholders for purchasing insufficient insurance if after allocation by time there is not enough coverage to satisfy claims).

heightened liability risk.²⁹⁰ Subsequently, the policyholder may return to self-insurance or move to a higher deductible or SIR as conditions improve. The periods of self-insurance mixed with insurance do not in any way suggest that the policyholder is “unfairly” seeking to obtain insurance on the cheap or to fob off on the occasional insurer the consequences of the policyholder’s years of tort-feasing. The commercial policyholder is entitled to make prudent commercial risk management decisions and enjoy the benefits of the insurance coverage it did purchase during certain years when that coverage is triggered.

In addition, of course, policyholders such as those in *NSP* and *Domtar* may acquire property or subsidiary operations. They cannot retroactively purchase insurance for years or decades gone by. But they can buy occurrence-basis liability insurance that will provide coverage should any of these land or business acquisitions prove to be time bombs that cause coverage triggering injury during the years in which the acquiring policyholder has liability insurance. This type of CGL purchase is simple business prudence. It does not suggest any attempt to retroactively insure against a known loss. If this were the case, insurers could defend completely on known loss, loss-in-progress, expected or intended, or lack of fortuity grounds. There would be no need to discuss allocation.

In addition, the move to the claims-made form of CGL insurance, which makes the coverage trigger turn on the assertion of a claim against the insurer during the policy period, and use of a retroactive date designed to avoid coverage for claims with roots in the distant past, shows that insurers can draft policies preventing coverage for such multiyear events decades after the injury first took place.²⁹¹ But prior to the wider use of the claims-made form, the insurance industry itself chose the occurrence basis form of CGL and used it as the primary form of CGL for twenty years. The industry can hardly say that it was victimized by policyholders who simply want to collect on these policies when claims for bodily injury are made under the policy. Prior to the advent of the claims-made policy, insurers saw nothing wrong with policyholders protecting themselves through occurrence coverage for the potential

290. I am here referring to society-wide liability risk (e.g., a litigation explosion, an upward trend in jury awards, etc.) rather than a higher risk peculiar to the policyholder, which may suggest adverse selection by the policyholder.

291. See *Aerojet*, 948 P.2d at 930-31 (noting the distinction between claims-made and occurrence policies on the allocation issue).

liability consequences of their operations or acquisitions.

Most important, when the policyholder purchases liability insurance, it expects to enjoy the benefits of this purchase should a triggering event take place. The insurance policy states that it provides coverage for such claims and there is no mention in the policy of adjusting policy limits if the claim or loss is part of a multiyear event. The insurer has made a contractual commitment and the policyholder has this benefit. Until all triggered insurance is exhausted, there is no logical basis for requiring the policyholder to expend its own funds simply because the loss triggering the as-yet-unexhausted policy also caused injury during other years.

Put together, these traits of liability insurance provide no basis for the *Domtar* view that equity requires allocation of coverage responsibility to the policyholder when the claims span multiple policy periods. On the contrary, equity and fairness would seem to require that the party purchasing liability insurance receive the full benefit of that purchase when it faces third party claims clearly triggering the policy or policies in question.

Rather than recognize this simple and inarguable aspect of equity and fairness, the *Domtar* court suggests that failure to allocate somehow gives the policyholder an undue benefit even though the policyholder has yet to realize the full benefit of the triggered insurance it has purchased.²⁹² Only if one finds a rule of law requiring annual and uninterrupted insurance coverage as a prerequisite to receiving the full policy proceeds of a given year can such a result be justified. Of course, there is no such rule. To the contrary, insurance purchased in Year 1 does not become invalid or uncollectible because the policyholder has no insurance in Year 2. By the same token, the policyholder who purchased applicable insurance in Year 5 should not be stripped of the benefits of this coverage simply because it had no such insurance during Years 1 through 4 and the claims against it implicate those years as well. The Year 5 insurance policy is still a contract obligating the Year 5 insurer to provide coverage to the policyholder for claims against the policyholder claiming damage from injury taking place in Year 5.

292. See *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 733 (Minn. 1997).

3. *The Domtar Allocation Operates as a Hidden Exclusion at Odds with the Reasonable Expectations of the Parties, Particularly the Policyholder*

Policyholders expect to receive the defense and indemnity they purchased when they bought a CGL policy. This is both an actual and an objectively reasonable expectation of the policyholder. Minnesota, like many states, has adopted in modified form the "reasonable expectations" approach initially outlined by Robert Keeton, then a law professor and now a federal district judge, in an important 1970 law review article.²⁹³

In its "pure" form, the Keeton statement of the reasonable expectations principle or doctrine provides that "objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations."²⁹⁴ In other words, even clear policy language that thwarted the policyholder's objectively reasonable expectations of coverage would not be enforced. Although the Keeton version of the concept has enjoyed favor in a number of courts, Minnesota, like most jurisdictions, has adopted a modified or middle-level of the reasonable expectations approach.²⁹⁵

Minnesota, like all jurisdictions, construes ambiguous language in light of the reasonable expectations of the policyholder

293. See Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (1970). For more recent general commentary regarding the application of the reasonable expectations principle and debate over the approach, see Symposium, *Reasonable Expectations in the Third Decade*, 5 CONN. INS. L.J. 1 (1998) (collection of several articles addressing the topic) and Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823 (1990).

294. Keeton, *supra* note 293, at 967.

295. Whether the reasonable expectations factor is a "principle," a "doctrine," an "approach," a "methodology," or something else is a matter of some disagreement. For example, Judge Keeton has stated that the concept began as a principle and became a doctrine during the 1970s. See Robert E. Keeton, *Reasonable Expectations in the Second Decade*, 12 FORUM 275 (1976). My own view is that "principle" or "approach" remains a more apt term for describing the workings of the reasonable expectations factor. See Stempel, *supra* note 7, at 186-87. Although I am hardly in a position to second-guess Keeton, the characterization of the concept may not matter to the correct resolution of insurance coverage cases through apt utilization of reasonable expectations thinking.

(and, for that matter, the insurer).²⁹⁶ This sort of “reasonable expectations” factor predated Keeton’s article, which distilled the reasonable expectations principle from its unspoken application in caselaw. In addition, where an insurance policy provision, even one that is textually clear, operates as a hidden exclusion, results in illusory coverage, or makes for unfair surprise or an unconscionable situation, that policy provision will not be literally applied but coverage will instead be determined by the policyholder’s reasonable expectations.²⁹⁷

Application of even the mildest notions of the reasonable expectations principle augers in favor of the policyholder and against the *Domtar* decision on matters of allocation. The standard CGL is at best silent on the subject. Even if one rejects my view that the only appropriate interpretation of policy purpose, structure, and language forbids general allocation to the policyholder, the CGL is at least ambiguous on the point. In Minnesota and every U.S. jurisdiction, an insurance policy provision is considered ambiguous if it is subject to more than one reasonable interpretation.²⁹⁸ Under the longstanding rule that ambiguous language, even if not automatically construed against the drafter, is interpreted consistently with policyholder expectations, the better view is that policyholders are entitled to triggered coverage without reduction due to proration.

If an insurance policy is otherwise silent on the issue of allocation due to consecutively triggered policies, this does not mandate a particular focus on other policy language not designed to address this issue. Where a court faced with no specific policy language on

296. See *Minnesota Mining & Mfg. Co. v. Travelers Indem. Co.*, 457 N.W.2d 175, 180-81 (Minn. 1990); *Columbia Heights Motors, Inc. v. Allstate Ins. Co.*, 275 N.W.2d 32, 36 (Minn. 1979); *Brault v. Acceptance Indem. Ins. Co.*, 538 N.W.2d 144, 148 (Minn. Ct. App. 1995).

297. See *Board of Regents v. Royal Ins. Co.*, 517 N.W.2d 888, 892 (Minn. 1994). Minnesota recognizes the reasonable expectations doctrine but only to the extent of permitting policyholder expectations doctrine to countermand policy language that operates in the nature of a hidden exclusion. See *Atwater Creamery Co. v. Western Nat’l Mut. Ins. Co.*, 366 N.W.2d 271, 278 (Minn. 1985) (suggesting wider applicability of reasonable expectations principle); Laurie Kindel Fett, *The Reasonable Expectations Doctrine: An Alternative to Bending and Stretching Traditional Tools of Contract Interpretation*, 18 WM. MITCHELL L. REV. 1113, 1124-32 (1992) (summarizing pre-*Regents v. Royal* Minnesota law on reasonable expectations and suggesting that Minnesota courts are too resistant to full and apt use of the doctrine).

298. See *Columbia Heights Motors*, 275 N.W.2d at 36; BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE DISPUTES* § 1.02 (9th ed. 1998); STEMPER, *supra* note 18, § 4.08.

the point requires allocation to the policyholder merely because of the “during the policy period” language of the CGL, this language interpreted in such a manner operates in the nature of a hidden exclusion making for illusory coverage. Even if the court’s reading of the “during the policy period” language were correct (which it is not),²⁹⁹ enforcing this reading of the CGL runs counter to Minnesota’s version of the reasonable expectations approach, a middle-of-the-road application of the concept that is not nearly as pro-policyholder as the pure version of the Keeton doctrine often attacked by insurers. Although *NSP* and *Domtar* err on this point, *SCSC* is correctly decided according to the reasonable expectations dimension because the result (continued coverage for the injury flowing from the covered tort until exhaustion of benefits) is the result expected by normal lay purchasers of insurance.

Under Minnesota insurance law, at least as it stood prior to *NSP* and *Domtar*, CGL coverage could not be denied or reduced for a covered event unless there was at least some text in the policy providing for this exclusion. Only if one accepts the strained premise that the “during the policy period” language is that type of clear exclusionary language, even the mildest of versions of the reasonable expectations approach forbid reduction or elimination of CGL coverage through allocation. Forcing the policyholder to pay a higher percentage of tort claims in the absence of a policy provision to that effect is even more unreasonable.

4. *Domtar Effects an Inequitable Reduction in Coverage*

As discussed above, the *Domtar* approach flies in the face of objectively reasonable policyholder expectations of coverage.³⁰⁰ In addition, it is dramatically unfair to allocate coverage responsibility to the policyholder across years during which the policyholder had no control over the instrumentality giving rise to the claim or was unaware of the events giving rise to the claim or knew nothing of the insidious damage being wrought. In effect, the policyholder is penalized because too many policies were triggered and the claim resulted from too many instances of alleged damage to third party claimants over too many years. Normally, one would expect a rational insurance coverage regime to give policyholders facing such daunting claims more coverage rather than less, assuming that the

299. See *supra* Part III.A.1.a.

300. See *supra* notes 297-98 and accompanying discussion.

other prerequisites of coverage are satisfied. However, because of *Domtar*, Minnesota now gives the policyholder facing such serious, and potentially bankrupting liability, less than that for which it bargained.

In addition to being generally unfair, *Domtar* has substantial potential to impose severe inequities upon the policyholder. Allocation per se, although not a correct reading of the CGL in these instances, is nonetheless not harmful if the policyholder has a significant amount of insurance so that allocation among insurers does not leave the policyholder bereft of coverage. This was apparently the situation in *NSP*.³⁰¹ But where the insurance is exhausted in some years, uncollectible due to insolvency in other years, or where the allocation reaches back to years of policy limits now seen as ridiculously low, allocation can result in a substantial reduction of coverage.

Where the allocation reaches across years during which the policyholder has no coverage, the result is particularly inequitable. Recall that *Domtar, Inc.* did indeed have insurance for the post-1970 period but that the qualified pollution exclusion barred coverage under Minnesota law (a result that would not have obtained under the law of many states, which treat the qualified exclusion as blocking coverage only for subjectively expected or intended pollution damage).³⁰² It cannot be said that *Domtar, Inc.* “went bare” after 1970. *Domtar* had fifteen years of insurance that was sufficient to pay the claims.³⁰³ *Domtar* bought this insurance and relied on its availability. Nothing in the policies suggested that policy benefits would be reduced if the triggering claims alleged injury in periods outside the policy period.

This is reasonable expectations in reverse. *Domtar, Inc.* was a “good boy”³⁰⁴ during the 1970-1987 time period and purchased the CGL coverage that was available to it at that time. Even though *Domtar* was unable to produce older insurance policies, there was evidence indicating that *Domtar* purchased liability insurance during the 1930s and 1940s as well as from 1956 on.³⁰⁵ As a reward for

301. See *supra* Part II.B.

302. See *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 729 (Minn. 1995).

303. See *id.* at 729 n.2.

304. See *supra* Part III.A.2 (describing the unspoken parental morality play utilized by some courts requiring allocation to the policyholder).

305. See Appellant’s Brief at 7-8, *Domtar* (Nos. C0-95-2626, C7-95-2638 and C9-95-2673).

its boy scout-like risk management, Domtar found itself with reduced insurance coverage from its 1956-1970 insurance policies, which provided for pollution coverage. Thus, even without reaching back into the first half of the century, Domtar had its 1956-1970 policies reduced in value by operation of law, a judicially imposed inequity.

5. *Refusal to Allocate to the Policyholder Does Not Render a Windfall to the Policyholder or an Unfair Detriment to Insurers*

Underlying the *Domtar* opinion is the notion that failure to allocate by time on the risk and to the policyholder for periods of no insurance would give policyholders an unfair windfall of coverage. But Domtar and other policyholders do not obtain a windfall if they are merely permitted to collect insurance benefits for which they paid and which are promised them pursuant to contract. This is not "gouging" the insurer or overindemnification. This is merely giving the policyholder the benefit of the bargain it made when it purchased CGL coverage.

The notion that proration is required to prevent injustice to the insurer has its roots in *Forty-Eight Insulations*.³⁰⁶ There, in a multi-decade asbestos claim coverage dispute, the Sixth Circuit addressed the duty to defend, as well as liability coverage, and dealt with policies that for the most part appear to have had no aggregate limits on coverage and no per occurrence limit on the expense of the duty to defend.³⁰⁷ Writing against this backdrop, the *Forty-Eight Insulations* court stated:

Were we to adopt [the policyholder's] position on defense costs a manufacturer which had insurance coverage for only one year out of 20 would be entitled to a complete defense of all asbestos actions the same as a manufacturer which had coverage for 20 years out of 20. Neither logic nor precedent support such a result.³⁰⁸

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

307. *See id.* at 1224.

308. *Id.* at 1225. *Forty-Eight Insulations* and its rationale on this point figured prominently in insurer efforts to obtain a rule of allocation to the policyholder in *Domtar*. For example, the quoted language was cited in the Brief of Amicus Curiae Insurance Environmental Litigation Association ("IELA") at 17, *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724 (Minn. 1997) (Nos. C9-95-2673, C0-95-2626, and C7-95-2638).

This sentiment is understandable but misplaced in the context of insurance coverage. First, of course, it was the insurer that wrote policies providing a duty to defend against claims of actual injury but included no provision for proration and no requirement that the policyholder keep insurance in force for other years. It may sound unfair if this hypothetical insurer now must pay for cases arising out of injury in its year, but courts frequently enforce contracts that may in retrospect seem harsh. How many courts think it is “illogical” to enforce liquidated damages, acceleration clauses, confessions of judgment, and similar contract provisions even though the liability created by such provisions (and usually imposed on the weaker, less sophisticated contracting party) may bear little relation to the damage incurred by the party seeking to collect?

Second, it is simply not the case in real life (at least not very often) that one insurer on the risk for five percent of a multiyear tort would shoulder defense of the entire mass tort. For example, if the court were applying the actual injury trigger, it is likely that certain substantial parts of the mass tort simply did not involve injury during the one year of coverage. In asbestos, for example, some plaintiffs did not have any contact with the policyholder’s product during the one year of insurance. Even under the exposure trigger (really an injurious exposure) used by *Forty-Eight Insulations*, the poor isolated insurer hypothesized by the courts probably does not exist anywhere in real life. More common are cases like *Domtar*, where the policyholder may not be able to prove up “portal-to-portal” CGL coverage (sometimes because of the insurance industry’s refusal to write coverage in certain years) but does have years of insurance and policy limits exceeding the cost of the claims and defense.

Third, in the future, the now-common use of aggregate policy limits, the claims-made CGL form, and “burning limits” (where defense costs are counted against the total policy limit and act to exhaust coverage) make it essentially impossible that an isolated insurer will ever be required to pick up the metaphorical tab because it was unfortunate enough to write coverage for a single year in the life of a customer that essentially was self-insured in all other years.

Even if the insurer’s only protection is the existence of an aggregate limit on liability payments, the typical policy of this type, like the standard CGL, provides that the insurer’s obligation is ex-

tinguished when the limits of liability are paid in judgment or settlement. Even without a cap on defense costs, a prudent insurer acting in good faith can quickly settle claims at a reasonable rate, which will consume the policy limits relatively quickly. The insurer will not be defending the policyholder on twenty years' worth of asbestos claims forever. Although there may be some difficult issues of good and bad faith, and the policyholder has a right to expect the insurer to do more than interplead the policy limits, no court would prevent the insurer from settling valid claims at reasonable rates. Although this requires the insurer to pay the policy limits, that result only mandates enforcement of the contract. Outside the multiyear mass tort context, insurers pay the policy limits on claims every day in this country.

Thus, despite the seductive tone of the *Forty-Eight Insulations* lament and its unrealistic hypothetical, the "windfall" argument against coverage is not supported by either contract law or equitable principles any more than it is a realistic portrayal of reality. Rather, in *Domtar*, we see the policyholder victimized and unable to receive policy proceeds for which it paid. Unlike the Minnesota Supreme Court in *Domtar*, the California Supreme Court recognized the illogic of the insurers' "windfall" argument:

Beneath the Court of Appeal's concern about "fairness" and "justice" is, apparently, a belief that, without an approach like the one it adopted [allocation by time on the risk to policyholder and insurer alike], Aerojet might get a windfall from the insurers. That is not the case. We shall assume for argument's sake that Aerojet has enjoyed great good luck over against [sic] the insurers. But the pertinent policies provide what they provide. Aerojet and the insurers were generally free to contract as they pleased. They evidently did so. They thereby established what was "fair" and "just" inter se. We may not rewrite what they themselves wrote. We must certainly resist the temptation to do so here simply in order to adjust for chance—for the benefits it has bestowed on one party without merit and for the burdens it has laid on others without desert. As a general matter at least, we do not add to, take away from, or otherwise modify a contract for "public policy considerations."³⁰⁹

309. *Aerojet-General Corp. v. Transport Indem. Co.*, 948 P.2d 909, 932 (Cal.

Although the California Supreme Court's analysis is perhaps a bit too facile,³¹⁰ it keeps sight of the jurisprudential "ball" of which the *Domtar* court lost sight. The task of courts is to properly interpret contracts, not to announce broad-reaching formulaic rules to change the impact of contract where the court finds the result unduly favorable (but not unconscionable) to one side.³¹¹ Although there are apt instances for judicial modification of contracts, such action is normally reserved for situations of real unconscionability of the contract or to rectify pronounced unfairness, particularly unfairness falling upon a weak, needy, or unsophisticated party. *Domtar* and similar allocation decisions may be the first line of cases whose *raison d'être* of public policy is the notion that we should all buy more insurance. The insurance industry devotes ample resources to marketing its products. It hardly needs a judicial adjunct to its marketing operation.

Furthermore, the impact of the resolution of the case sought by Domtar, Inc. is hardly excessively greedy or the equivalent of an undeserved "windfall." Domtar sought merely to realize the benefits of purchased insurance notwithstanding the long-term nature of the underlying tort and the presence of other applicable insurance. This is hardly the stuff of which windfalls and unfairness are made, particularly in light of the CGL language at issue. To quote the California Supreme Court again:

We observe that Aerojet may indeed have gotten from the insurers more in defense costs than it could have gotten

1997) (citations and footnotes omitted).

310. Notwithstanding the "contracts say what they say" rhetoric of the *Aerojet* court, the complex nature of insurance policy language applied to complex matters makes it appropriate for courts to consider extra-textual factors, including public policy, in resolving coverage disputes. But a comprehensive consideration of contracting factors indicates that the CGL policies were triggered and do provide coverage for the damages flowing from a triggering injury. By reducing the policyholder's triggered coverage through allocation, cases such as *Domtar* do not invoke misguided notions of fairness, equity, or public policy as mere tiebreakers or means of deciding the unguided case: *Domtar* invoked its peculiar notions of equity to trump the proper interpretation of the insurance policies in question.

311. Although notions of unconscionability and adhesion are often commingled by courts, the best definition of an "unconscionable" contract is that it is one that is so unreasonably favorable to one side (usually the drafting party) that the law will not enforce the agreement as written. See STEMPER, *supra* note 18, § 4.10[b]; E. ALLAN FARNSWORTH, CONTRACTS §§ 4.27-4.28 (2d ed. 1990).

in indemnification costs. But it got no more than it had a right to: Although indemnification costs were limited by the pertinent policies, defense costs were not. The insurers might perhaps have avoided such a pass, as through the issuance of "self-consuming" or "burning limits" policies, under which the indemnification limit is reduced dollar for dollar by defense costs until zero is reached and the duty to indemnify and the duty to defend are then terminated. They apparently did not attempt to do so.³¹²

6. *A Balancing of Policyholder and Insurer Interests Reveals the NSP/Domtar Allocation Approach to be a Clear Change in the Law Advantaging Insurers*

The general system of contract and insurance law is designed, at a minimum, to be fair to insurer and policyholder. In several areas, legal doctrine leans toward the side of the policyholder to prevent unfairness because of the insurer's comparative advantages in the transaction, the policyholder's greater vulnerability, or both. The ambiguity principle and the reasonable expectations approach are perhaps the best examples of this. So, too, are maxims of insurance policy construction such as the rule that exclusions are construed narrowly and that the insurer has the burden to demonstrate the applicability of an exclusion.³¹³ The canon of construction that forfeitures are not favored and that the insurer shall not be accorded unconscionable advantage, and the ground rule that the insurer must show good faith and fair dealing, are all part of this milieu of insurance contract law.³¹⁴

312. *Aerojet*, 948 P.2d at 932 n.29 (citation omitted).

313. See *Henning Nelson Const. Co. v. Fireman's Fund Am. Life Ins. Co.*, 383 N.W.2d 645, 652 (Minn. 1986); ANDERSON ET AL., *supra* note 53, § 1.17, at 40 ("The insurance company has the burden of proving that an exclusion applies."); ALLAN D. WINDT, *INSURANCE CLAIMS & DISPUTES* § 9.01, at 29-30 n.3 (3d ed. 1995) (noting that exclusions in insurance policies are given narrow construction favoring policyholder and insurer bears burden to show applicability of exclusion once policyholder shows that claim comes within coverage).

314. See, e.g., *Westfield Ins. Co. v. Farm Bureau Mut. Ins. Co.*, 515 F. Supp. 38, 41 (D. Minn. 1981) (holding that in cases of uncertainty, insurer should provide coverage purchased by policyholder); *Minnesota Mining & Mfg. Co. v. Travelers Indem. Co.*, 457 N.W.2d 175, 181 (Minn. 1990) (noting that dominant purpose of insurance is indemnity). See also *Monsanto Co. v. C.E. Heath Compensation & Liab. Ins. Co.*, 652 A.2d 30, 33-34 (Del. 1994) (stating that absent inevitable clarity, insurance policy provisions should not be construed in a manner that defeats or reduces coverage). Regarding pro-policyholder canons of construction found in the law of insurance coverage generally, see ANDERSON ET AL., *supra* note 53, ch. 2,

Against this backdrop, when courts face the most significant and complex coverage matters of pollution and product liability spanning years or decades, one would expect courts to respond with a body of law that accords the same protection to policyholders they obtain in garden variety coverage claims. Instead, however, *Domtar* (and to some extent *NSP*) rendered a rule of allocation that dramatically shifts state insurance law from the policyholder's slight advantage to law that clearly favors the insurer. In *Domtar*, the court acts as if the insurer rather than the policyholder is the one to whom must be given the benefits of ambiguity analysis, reasonable expectations thinking, and the like. Such a drastic shift in the legal landscape should be supported by something more than the vague pronouncements of the *Domtar* court.

7. *The NSP/Domtar Allocation Formula Fosters Inequity Among Insurers*

Because *NSP* and *Domtar* allocate only by time on the risk rather than according to premiums paid or policy limits purchased, the consequences of the allocation imposed may vary quite dramatically from the relative risks taken and rewards obtained by insurers or policyholders. For that reason, even commentators generally favoring allocation in some cases, advocate an allocation formula that considers both time on the risk and the respective policy limits of the triggered insurers.³¹⁵ Some courts favoring allocation have also insisted that respective insurer responsibility be apportioned by policy limits alone or policy limits and time on the risk.³¹⁶

In adopting the temporal allocation formula, the *NSP* court stated, without support, that proration by policy limits was inconsistent with the actual injury trigger. The *NSP* court stated that:

The essence of the actual injury trigger theory is that each insurer is held liable for only those damages which occurred during its policy period; no insurer is held liable for damages outside its policy period. Where the policy periods do not overlap, therefore, the insurers are consecutively, not concurrently liable. A "pro rata by limits" allocation method effectively makes those insurers with

and WINDT, *supra* note 313, chs. 9, 11.

315. See, e.g., Yin, *supra* note 109, at 1274-78.

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

higher limits liable for damages incurred outside their policy periods and is therefore inconsistent with the actual injury trigger theory.³¹⁷

A major factor in the *NSP* court's rejection of use of policy limits as a tool for apportionment again flows from the court's misunderstanding of the meaning of the "during the policy period" language of the CGL.³¹⁸ The *NSP* court incorrectly treated this language as limiting insurer responsibility only to the "damages" taking place prior to the expiration of the policy's term when in fact, the CGL language merely requires that the "injury" take place during the policy period. Damages flowing from the injury remain subject to the coverage of the triggered policy.

This error was then magnified by a seeming desire to reject anything associated with "concurrent" insurer responsibility since the *NSP* court viewed the pollution matter as one involving only "consecutive" insurance coverage. Because proration by policy limits is the majority rule for apportioning *concurrent* insurer responsibility, the *NSP* court appears to have rejected it outright, without stopping to think whether proration by limits, or at least some use of policy limits in the allocation formula, might be apt for cases of consecutively triggered coverage as well.

NSP's suggestion that proration by limits somehow violates the principle of the actual injury trigger does not seem to follow, as a simple illustration suggests. Under the actual injury trigger, assume that the insurer in Year 1 is triggered because of a third-party claim alleging injury that year from one of its products. Assume further that the product is an artificial kidney the claimant alleges was defective because its exterior casing released contaminants into the claimant's body at various junctures during the ten years it was inside the patient. Because the claimed injury was not readily visible at the outset, it is not surprising that the claimant is suing in Year 10.

In this multiyear product liability coverage matter, it would appear that the actual injury trigger is satisfied during Years 1 through 10—the claim alleges that continuous release of contaminants from the artificial kidney caused not only continuing damage from the first of year of its implantation but also caused new and

317. *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 662 (Minn. 1994).

318. *See id.* at 663.

continuing injuries during Years 2 through 10. Consequently, all ten policy years are triggered. In this case, there is nothing inconsistent with the actual injury trigger if the Year 1 insurer is required to pay until its policy limits are exhausted. This is so even if there is no insurance during Years 2 through 10. The Year 1 carrier is triggered and is liable for the continuing damage wrought by the Year 1 injury. Applying the Year 1 policy limits to pay damages flowing from the injury years later is not inconsistent with the actual injury trigger: it is the essence of the actual injury trigger.

The presence of additional injury and additional insurance coverage during Years 2 through 10 does not change, expand, or reduce the responsibility of the Year 1 insurer—it is triggered and responsible until its policy limits are exhausted paying triggered claims. However, the presence of multiple insurers may require apportionment of coverage responsibility to prevent overindemnification of the policyholder or to provide for a fair sharing of responsibilities among triggered insurers. Use of the Year 1 policy limits as part of the apportionment formula cannot be inconsistent with the actual injury trigger when use of the Year 1 policy limits as the sole delimitation on coverage responsibility was not inconsistent with the injury trigger.

NSP further erred in its assumption that prorating by policy limits somehow creates an unfair subsidy of the low limit insurers by high limit insurers in cases of multiple insurance policies. Although this is a possibility, it is equally possible that the *NSP* temporal allocation formula could result in long-term but low-limits insurers subsidizing the coverage responsibility of high-limit insurers that were not on the risk as long. For example, assume that the Year 1 insurer in the above hypothetical provided \$1 million in policy limits, with the Year 2 through Year 10 insurers each providing policy limits of only \$111,111. Assume also \$1 million in covered claims. Allocation by time on the risk makes the Year 1 insurer responsible for only ten percent of the coverage (\$100,000—ten percent of \$1 million) even though it provided fifty percent of the total coverage (\$1 million—fifty percent of \$2 million) and presumably received considerably more than ten percent of the total premium dollars paid. Even though insurance is generally less expensive per thousand when higher amounts are purchased, the effect of the *NSP/Domtar* proration formula in a case like this is to provide a huge windfall to the insurer with the high policy limits. The Year 1 insurer in this hypothetical receives \$1 million worth of

premiums but pays only \$100,000 in benefits.³¹⁹ Ironically, this occurs because the court is unwilling to consider the policy limits in apportioning responsibility.

8. *The Domtar Allocation Method Creates Unwise Behavior in the Insurance Markets*

If insurance markets are to work well, insurers are in theory taking on only good risks and eliminating or minimizing the moral hazard and adverse selection that corrupts the insurance market if policyholders with problems can easily obtain ample insurance at standard rates. Policyholders making profitable but potentially defectively dangerous products or holding property that is steadily polluting neighboring lands or groundwater would presumably be unable to obtain CGL coverage at standard rates—at least if the insurer knows that the applicant poses inordinate risks of such liability exposure. To minimize the possibility of unwittingly providing such coverage, insurers would presumably engage in close underwriting scrutiny prior to issuing or renewing such policies. CGL carriers would have this incentive because they would be liable up to applicable policy limits for claims against such policyholders. Rigid pro rata allocation by time on the risk undermines this incentive to some degree. The insurer who recklessly writes coverage has the consequences of its mistakes reduced even in the absence of contract language to that effect if it has the good fortune to be part of years of coverage and liability problems. The court's apportionment of a large amount of the coverage consequences to other years and other carriers, or to the policyholder, effectively gives the

319. Of course, the Year 1 insurer may not be able to keep all of this windfall, depending on the rest of the policyholder's loss experience. For example, the Year 1 insurer may end up paying the remaining \$900,000 in policy limits on other claims arising from injuries taking place during Year 1. However, if the total claims on the Year 1 policy fail to exhaust the policy limit, the Year 1 insurer receives some significant, unbargained-for benefit from allocation by time alone—a windfall for the Year 1 insurer vis-a-vis both other insurers and, potentially, its own policyholder.

Also, for simplicity, the hypothetical has assumed that the \$1 million Year 1 policy limits are both a per occurrence limit and an aggregate limit. However, if the Year 1 policy has no aggregate limit, as was the case for many if not most CGLs prior to the 1980s, the Year 1 insurer absolutely receives a windfall from time-on-the-risk allocation that is complete at the time of allocation. Instead of paying the policyholder with the \$1 million policy the full policy limits (or at least some figure between \$100,000 and \$1 million), the Year 1 insurer effectively is granted a judicially created \$100,000 policy limit.

CGL insurers re-insurance they did not in fact purchase. This hypothetically careless-underwriting-single-year-CGL insurer is paid back, or made to pay less, because other insurers are required to pay even where the insurer in question has the policy that is the largest, least exhausted, and first tapped by the policyholder.

The net effect of this sort of incentive system is to make insurers less likely to underwrite and supervise policies and policyholders with care. The CGL insurer selling policies to petroleum factories or medical device makers in cases such as *NSP* or *Domtar* is not really on the risk for the amount of policy limits stated in the declarations page of the policy unless the claims are so large that they completely exhaust all triggered coverage. Even then, enough years of no insurance, lost insurance policies (not hard to imagine when roots of the claimed injury are in the early 20th Century), or insurance policies containing injury-wide exclusions work to lower each triggered insurer's responsibility for coverage. This type of allocation regime creates incentives for the insurer to act with less care in writing policies with higher limits, for which the policyholder is charged higher premiums, but for which each triggered insurer ultimately will pay less than stated in the declarations page in many if not most of the multi-year tort claims against the policyholder. The incentive, even if not drastic in most cases, remains perverse.

9. *The NSP/Domtar Allocation Rule and the SCSC Exception Fosters Inefficiency and Excessive Litigation*

Under *NSP* and *Domtar*, the policyholder is likely to receive reduced insurance coverage, even though it paid for the coverage, if it is sued for claims of injury taking place over an extended time period. But under *SCSC*, the policyholder may enjoy full coverage if the coverage-triggering injury is found to have taken place in only one policy period.³²⁰ In cases like *SCSC*, where the claim-causing injury takes place through a discrete, identifiable event during only one policy year, the coverage provided by the triggered policy is not reduced by the applicability of other insurance poli-

320. See *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 318 (Minn. 1995); *supra* notes 122-36 and accompanying discussion (discussing the *SCSC* case, in which a jury's finding that the cause of pollution injury was an abrupt discharge served both to make the qualified pollution exclusion inapplicable and to permit the policyholder to fully receive available policy benefits from the CGL insurer on the risk at the discharge time).

cies.

The impact of these cases and approaches is to make insurance coverage hinge dramatically and unnecessarily on particular court or jury findings as to how an injury took place and when it took place. If the injury is gradual, continuous, repeated, or episodic, and took place in multiple policy periods, each triggered insurer's coverage responsibility is reduced pro rata. Under this regime, insurers will routinely attempt to prove the injury took place during several policy periods in order to reduce their respective shares. Conversely, the policyholder's incentive is to have the factfinder conclude that there was only one injurious event or that such events were confined to one policy period.

In addition, if the case is one like *SCSC*, that involves CGL policies containing the qualified "sudden and accidental" pollution exclusion, both parties have strong incentives to "prove" that the pollution discharge took place in a manner favorable to their coverage prospects. Because the pollution exclusion issue in insurance coverage is a zero-sum game (either the pollution exclusion applies completely or it has no application), the parties in these disputes have more than the usual litigant's incentive to pull out all the stops in spinning the facts. But even without the zero-sum aspect of the pollution exclusion, insurer and policyholder operating a rigid allocation regime, such as that of *NSP* and *Domtar*, have a similar incentive to resort to extremes in trying to prove that the injury was either limited in time (the policyholder's preferred result) or extended across many years (the insurer's preferred result).

All this jockeying for position does not come cheaply. Counsel fees increase as lawyers concentrate legal resources toward influencing the court to find in the client's preferred way. The costs of expert witnesses become particularly pronounced as expert engineers, chemists, physicians, biologists, environmentalists and the like are retained to investigate the facts of the case and render detailed, persuasive, and expensive expert reports and testimony on the topic. Because the consequences of the factfinding on the manner and temporal span of injury are so important, the parties are encouraged to pour more resources into the determination. This is due to the high stakes of an adverse factual finding.

To some extent, expending legal resources in proportion to the stakes of the case is merely rational litigation behavior. It is

probably not wise to spend 75 cents to collect a dollar³²¹ but it probably is prudent to spend \$75 million to collect \$100 million, assuming the high expenditures will increase the odds of recovering the \$100 million to nearly 100 percent. However, it is one thing for the courts to watch litigants overspend because they find it rational to do so in light of the stakes of the case and its factual uncertainty. It is quite another matter when the court itself heightens the stakes and the uncertainty. In such instances, the judicial doctrine has become part of the problem rather than part of the solution.³²² In effect, *NSP* and *Domtar* encourage the parties in multiyear tort claims to pursue a scorched earth policy of litigation. In addition to being unfortunate, it is ironic one of the *NSP* court's principal rationales for allocation-by-time was the furthering of convenience

321. There are usually difficulties in calculating the costs in addition to the out of pocket costs of the 75 cents: lost time; distracted concentration from the litigant's main activity; emotional upset; frayed relations with the opponent; and so on.

322. In addition, extensive litigation over the issue of the number of years during which an injury took place may be cost-ineffective because there is often relatively little guarantee that additional marshalling of proof will significantly increase the odds of a favorable factfinding. The ultimate decision in that regard remains with the judge or jury and neither's assessment can be predicted with anything near 100 percent accuracy.

For example, in *SCSC*, the matter devolved into a battle of experts as to the cause of the pollution. See *SCSC*, 536 N.W.2d at 310-11. The jury was free to believe either side's preferred explanation. *SCSC* Corporation could in theory have retained 100 experts (assuming the court would not bar some of the testimony as cumulative). But, of course, *SCSC* Corp.'s proffering of 100 experts would probably engender a 100-expert witness list by its insurers. The net effect would be something of a "Bleak House" effect, in which the transaction costs of litigation approach or exceed the stakes of the case. See generally CHARLES DICKENS, *BLEAK HOUSE* (1853) (describing the fictional estate litigation of *Jarmdyce v. Jarmdyce* in Nineteenth Century England that consumed more than 20 years and the corpus of the estate).

Attorneys and clients are normally too rational to reach this point of overlitigation, but the "escalation of hostilities" effect frequently takes them too far down the road toward the Bleak House effect. For example, studies of the operation of the federal Superfund law suggest that well over half the funds spent in Superfund matters are devoted to litigation rather than to actual environmental cleanup. In addition, this sort of overadversarialness seems particularly misplaced for insurance coverage disputes. Insurers are said to have a relationship to policyholders that, while not completely fiduciary, are fiduciary in nature. See *Corrado Bros. v. Twin City Fire Ins. Co.*, 562 A.2d 1188, 1192 (Del. 1989); *Gibson v. Western Fire Ins. Co.*, 682 P.2d 725, 730 (Mont. 1984); ANDERSON ET AL., *supra* note 53, § 11.6, at 16-18; see also STEMPER, *supra* note 18, § 31.11, at 820 (noting that the insurer has quasi-fiduciary or semi-fiduciary relationship with policyholder). In a more rational world, one would expect insurance coverage disputes to have lower rather than higher litigation costs.

of the parties, the reduction of workload, and the overall efficiency of the judicial system.

10. *The Draconian Allocation of Domtar is Not Justified by the Continuous Actual Injury Trigger of NSP and Domtar*

There is allocation—and then there is allocation. It is one thing to apportion coverage responsibility for a claim reasonably limited in time and impact. Even where there is consecutive rather than concurrent coverage responsibility, proration seems a particularly cruel consequence when the time over which coverage responsibility numbers more than sixty years. The *Domtar* policyholder was not asked to shoulder a minor share of the coverage burden akin to a deductible, SIR, or copayment.³²³ Rather, the *Domtar* policyholder was required to pick up three-fourths of the tab simply because of the vagaries of chance.³²⁴ But the conventional view is that insurance exists to protect the policyholder from the vagaries of chance. Domtar, Inc., thought it had accomplished this through the purchase of rather extensive insurance protection. However, the court introduced new risk into the equation by a court-created rule of allocation to the policyholder by time on the risk alone.

The potential inequities of strict temporal allocation become especially apparent when applied to the multi-decade torts and injuries in cases such as *Domtar*. A hornbook rule of insurance coverage litigation is that the policyholder must prove that it had insurance.³²⁵ The rule is of course, logical, defensible, and perhaps inevitable. But in claims reaching back to the early twentieth century, it is not surprising that even conscientious businesses failed to retain ancient insurance policies. But without copies of the policies, or a remaining live witness who can prove the existence of

323. See *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 732 (Minn. 1997).

324. See *id.*

325. See 7 LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INSURANCE* § 107:41 (3d ed. 1997) ("In harmony with general principles of proof, the burden of proof is on the injured party to establish all facts essential to the existence of liability to him or her of the insurer."); see also *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 311 (Minn. 1995) ("The initial burden of proof is on the insured to establish a prima facie case of coverage.") (citing *Boedigheimer v. Taylor*, 287 Minn. 323, 178 N.W.2d 610, 614 (1970)); Mark S. Dennison, *What Constitutes 'Suit' Triggering Insurer's Duty to Defend Environmental Claims – State Cases*, 48 A.L.R.5th 355, 368 (1997) (stating that an insured must prove the existence of a potential for coverage).

coverage, the policyholder is unable to claim the benefit of these ancient policies that it probably purchased (most businesses probably purchased at least some liability coverage during the first half of the century).

Under *Domtar*, the policyholder is twice damaged. First, it is unable collect insurance benefits for which it in many cases paid but can no longer document because of the passage of time. Second, the long time frame during which injury took place is utilized to reduce the insurance coverage that the policyholder is able to prove up. There simply is no legal or equitable justification for this type of court-imposed punishment of a policyholder.

11. Strict Allocation by Time is Not Justified by the "Liberality" of the Minnesota Courts' Application of the Actual Injury Trigger

One might defend *NSP* and *Domtar* as cases balancing benefits and burdens judicially imposed upon insurers and policyholders. Many insurers, in coverage disputes implicating multiple years, argued that the CGL was not triggered unless a claimant's injury was "manifested" during the coverage period or unless the injury in question was palpable, tangible, or medically diagnosable.³²⁶ Although the manifestation trigger had some initial judicial support, it has become a clear minority in CGL trigger jurisprudence. So, too, insurer arguments that injury has not taken place unless it is detectable have generally been rebuffed by courts. The bulk of courts interpreting the CGL apply an injury trigger (usually referred to as an "actual injury" trigger or an "injury-in-fact" trigger) but do not require that the injury be particularly demonstrable. It is usually sufficient (at least regarding the duty to defend) if the third-party claimant alleges injury during the coverage period or if expert witnesses can establish the existence of injury during the policy period.

Even though such determinations may be the product of 20-20 hindsight (we now know that asbestos fibers in the lungs do damage), this does not make the injury any less real or any less triggering of coverage. Insurers sometimes bemoan this dominant jurisprudence of the injury trigger as too favorable to policyholders

326. See, e.g., *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins.*, 682 F.2d 12, 19 (1st Cir. 1982); *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034, 1043 (D.C. Cir. 1981) (arguing coverage is triggered only by manifestation of either asbestosis or lung cancer); *Insurance Co. of N. Am. v. Forty-Eight Insulations Inc.*, 633 F.2d 1212, 1218-19 (6th Cir. 1980).

since it makes the CGL applicable for even the initial stages of injury, still relatively minor, that took place long ago. Although one can understand the financial concerns of CGL insurers required to defend and cover lawsuits with roots sometimes far in the past because of the subtle onset of insidious injury undetected for years. Yet the courts have nonetheless correctly concluded that even slight, undetected injury far in the past triggers insurance coverage.

First and foremost, the CGL policies themselves were written to cover claims arising from such initially slight purported injury. There is nothing unfair about utilizing an injury trigger—insurers wrote the policies with injury triggers. Second, requiring some minimum quantum of injury would convert the injury trigger to a manifestation trigger, something not set forth in the CGL and problematic in other respects. Third, the application of the injury trigger based on allegations of even undetected and initially slight injury is fully consistent with the purpose of the CGL and the intent of the parties underlying the CGL.

Liability insurance containing “duty to defend” coverage is “litigation insurance”—it is designed to protect the policyholder by providing a defense to claims of policyholder-caused injury. If the claimant alleges injury during the policy period, courts have correctly concluded the insurer should not be permitted to avoid its contractually established duty to defend. Courts argue that the claimant is mistaken or that the claimed injury was too trivial until a later juncture. Such arguments are inconsistent with the CGL’s structure and purpose: claims alleging covered injury trigger the duty to defend even if the claim is “groundless, false, or fraudulent.” The insurer cannot second-guess the bona fides of the claim in order to deprive its policyholder of coverage. The insurer must defend. If it obtains information permitting it to avoid coverage, it may take action (e.g., a summary judgment motion seeking elimination of a covered claim) to minimize its liability coverage. But in the meantime it must defend.

In actual cases, investigating and defending insurers have normally been unable to avoid coverage based on the claim’s “real facts.” For example, in the asbestos cases, medical evidence supports the assertion that asbestos does both immediate and continuing damage and that the introduction of new asbestos particles into the body causes new, additional, and continuing damage. In the pollution cases, the facts of the claims frequently show that injury to land, water, or people took place on a continuing basis well be-

fore it was detected by the claimant or others. In short, judicial application of the actual injury trigger as something of a “hair trigger” or “claimant allegation trigger,” is perfectly proper. Indeed, it is compelled by the CGL policy language and the nature of CGL insurance.

A number of courts have used an “exposure” trigger of coverage in the multiyear asbestos and pollution cases. For example, the leading exposure case, *Forty-Eight Insulations*,³²⁷ held that CGL coverage was triggered for asbestos claims whenever the claimants were allegedly exposed to asbestos fibers.³²⁸ Because it viewed itself as having granted the policyholder something of a gift through the seemingly easily satisfied exposure trigger (a super-sensitive hair trigger), it was required that the responsibility of triggered insurers be allocated by time, including allocation to the policyholder.³²⁹ *Forty-Eight Insulations* has been very influential both in prompting other courts to adopt an “exposure” trigger and in prompting allocation by time on the risk.³³⁰

However, on closer examination, the *Forty-Eight Insulations* “exposure” trigger appears to have been an actual injury trigger misnamed by the court. The court spoke of exposure as automatically bringing injury,³³¹ which implies that the exposure to the asbestos was not benign but began hurting the claimant on contact. Subsequent medical evidence presented in the asbestos cases has been consistent with the medical evidence before the *Forty-Eight Insulations* court.³³² *Forty-Eight Insulations* noted, with apparent approval, medical evidence that exposure to asbestos fibers begins to cause at least some injury immediately and that asbestos-related diseases are

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

328. *See id.* at 1224.

329. *See id.* at 1225.

330. *See, e.g., Ducre v. Executive Officers of Halter Marine Inc.*, 752 F.2d 976, 993-94 (5th Cir. 1985) (applying Louisiana law); *Porter v. American Optical Corp.*, 641 F.2d 1128, 1145 (5th Cir. 1981) (applying Louisiana law); *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1391 (E.D.N.Y. 1988). *NSP* and *Domtar*, of course, are part of this strand of post-*Forty-Eight Insulations* insurance law doctrine.

331. *See Forty-Eight Insulations*, 633 F.2d at 1222 (“The medical evidence is uncontroverted that ‘bodily injury’ in the form of tissue damage takes place at or shortly after the initial inhalation of asbestos fibers.”).

332. *See Stonewall Ins. Co. v. Asbestos Claims Management Corp.*, 73 F.3d 1178, 1197-98 (2d Cir. 1995) (applying New York law); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 983-85 (N.J. 1994) (describing etiology of asbestos-related injuries before making legal determinations regarding trigger and allocation).

progressive, continuing, and triggered anew as additional bodily contact with asbestos takes place.³³³ In light of these statements in the opinion, the *Forty-Eight Insulations* decision might be more accurately described as an actual injury case, and as one that properly rejected insurer efforts to require a minimum quantum of tangible injury or manifestation as a prerequisite to coverage. For example, the court stated:

[M]edical testimony establishes that tissue damage starts to occur shortly after the initial inhalation of asbestos fibers and that the tissue damage worsens as the victim breathes in more and more asbestos fibers. The advocates of the exposure theory characterize asbestosis as a series of continuing injuries to the body which accumulate to cause death or disability. . . .

The district court adopted the exposure theory. . . .

The principal basis for the district court's position, however, was the medical evidence. The medical testimony established that "each tiny deposit of scar-like tissue causes injury to a lung." From this, the court reasoned that "each such insult-causing injury is an 'occurrence' for the purpose of determining which coverage applies."³³⁴

The circuit court in *Forty-Eight Insulations* affirmed this aspect of the district court's findings and conclusions, in effect finding that inhaled asbestosis caused coverage-triggering injury at the time of inhalation and that new intake of asbestos fiber caused new injury as well as further deterioration of old injuries.³³⁵ Nonetheless, *Forty-Eight Insulations* regrettably used the "exposure" terminology unfortunately used by the district court and policyholder counsel.³³⁶ In retrospect, the terminology has suggested to courts and commentators that policyholders can gain coverage without being required to demonstrate the requisite claims of injury.³³⁷

During the intervening eighteen years, insurers have continued to argue that the injury trigger requires something more like manifestation to obtain coverage but courts have largely rejected

333. See *Forty-Eight Insulations*, 633 F.2d at 1217.

334. *Id.* at 1217 (citations and footnote omitted).

335. See *id.* at 1219.

336. See *id.* at 1221.

337. See *id.*

these arguments. For the most part, courts have applied the actual injury trigger with common sense and sensitivity and refused to take on the burden of gauging the amount or severity of injury during any particular policy period in order to evaluate whether there has been "enough" injury to trigger coverage.³³⁸ But most of this CGL construction has been accomplished through an appropriate application of an actual injury trigger. The exposure trigger has been spurned because its nomenclature appears inconsistent with the CGL language³³⁹ even though its use in *Forty-Eight Insulations* was perfectly consistent with the CGL text.³⁴⁰

To a large degree, the *NSP* court operated within this larger judicial school of thought when it refused to require the policyholder to demonstrate precisely how much damage took place during particular policy periods.³⁴¹ However, like a number of other courts, including the *Forty-Eight Insulations* court, the *NSP* court appears to have viewed itself as having favored the policyholder with its choice of a relatively easily satisfied trigger (although a self-

338. The leading case on this point is probably *American Home Products Corp. v. Liberty Mutual Insurance Co.*, 748 F.2d 760 (2d Cir. 1984). In *American Home Products*, the Second Circuit generally affirmed a well-crafted district court opinion that correctly adopted the actual injury trigger for the CGL but incorrectly required that an asbestos-related injury be medically diagnosable before the CGL trigger was "pulled." See *American Home Products*, 748 F.2d at 765, *aff'd* 565 F. Supp. 1485 (S.D.N.Y. 1983). The Second Circuit correctly reasoned that injuries in their infancy might elude diagnosis but nonetheless were injuries within the meaning of the CGL. See *id.* Consequently, coverage attached without any requirement of diagnosability. See *id.* The appellate court might also have added that a diagnosability requirement or other insistence upon a minimum amount of injury would in effect erroneously convert the CGL, which was written with an "injury" trigger, to policies with a "manifestation" trigger.

Since *American Home Products*, the injury trigger has been widely accepted in the form of the Second Circuit opinion rather than in its trial court form. See, e.g., *Stonewall Ins. Co. v. Asbestos Claims Management Corp.*, 73 F.3d 1178, 1194 (2d Cir. 1995) (applying New York and Texas law); *Detrex Chem. Indus., Inc. v. Employers Ins.*, 746 F. Supp. 1310, 1325 (N.D. Ohio 1990); *Triangle Publications Inc. v. Liberty Mut. Ins. Co.*, 703 F. Supp. 367, 370-71 (E.D. Pa. 1989); *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1388 (E.D.N.Y. 1988). See ANDERSON ET AL., *supra* note 53, §§ 4.9-4.11.

339. See *American Home Products Corp.*, 748 F.2d at 764-65.

340. The manifestation trigger has been rejected on the ground that it runs contrary to the language of CGL policies and that it provides insurers an opportunity to unfairly cancel coverage. This after years of receiving premiums when the first manifested claims are made against the policyholder even though the source of the claims stems from years of accumulated injury. See, e.g., *Forty-Eight Insulations*, 633 F.2d at 1220; Yin, *supra* note 109, at 1262-65.

341. See *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 663 (Minn. 1994).

identified injury trigger in *NSP*) and then utilized a temporal allocation scheme as a counterweight favoring insurers by limiting their responsibility for coverage notwithstanding a finding that the insurance was triggered.³⁴² In a case of full coverage such as *NSP*, the negative consequences of this approach are not readily apparent. However, the ravages of rigid temporal allocation become all too apparent in a case like *Domtar*, where the policyholder is clearly not given advantage from triggering of coverage but in fact has its coverage reduced in the same breath due to allocation across the bulk of the twentieth century.

Although one can debate the correctness of the relatively hair trigger version of the actual injury trigger, it is a debate insurers have consistently lost during the last twenty years. Beginning with key 1980s cases such as *Keene*³⁴³ and *American Home Products Corp. v. Liberty Mutual Insurance Co.*³⁴⁴ and extending through cases such as *Owens-Illinois*,³⁴⁵ *NSP*, and *Domtar*, courts have correctly found that insurance is triggered by allegations of even slight and hidden injury. This is what the CGL says and this is what the CGL promises policyholders as well as the measuring stick by which insurers calculate risk. Unfortunately, many judicial discussions have clothed this inarguable concept in language like the "exposure" trigger, the "continuous" trigger, or the "triple" trigger.³⁴⁶ In fact, there is no

342. See *id.*

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

344. 748 F.2d 760 (2d Cir. 1984).

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

346. See STEMPER, *supra* note 18, § 14.09 (describing principal court decisions on trigger of CGL coverage according to terminology used in cases themselves or commonly used by commentators). *Forty-Eight Insulations* adopted the term "exposure" trigger but appeared in fact to regard exposure to asbestos as being tantamount to injury. See *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1222-23 (6th Cir. 1980); *supra* Part II.D.1.

Cases using hybrid triggers (triggers that combine elements of exposure, injury, or manifestation), particularly the continuous trigger, obscure with their nomenclature the essence of the courts' determinations: at least some injury has taken place during a policy period. *Keene Corp. v. Insurance Co. of North America*, 667 F.2d 1034 (D.C. Cir. 1981), is the motherlode of all continuous trigger cases. But *Keene* involved asbestos injuries just as did *Forty-Eight Insulations* and for asbestos and similar chemicals, harmful products, and pollutants, injury is inflicted (or is at least alleged to have been inflicted) on the claimant from mere exposure and continued, at least through any times of manifestation, and usually beyond. See *id.* at 1045.

In effect, the properly applied actual injury trigger in cases like asbestos becomes a continuous trigger because of the proper application of the injury trigger, not because the court has benefited the policyholder by formulating a "con-

inconsistency between the two trigger formulations for many product or pollution claims. “[I]n the asbestos context, the injury-in-fact trigger of the CGL policies becomes a continuous trigger.”³⁴⁷

In the vast majority of decisions, the courts have in fact merely been applying an actual injury trigger that is activated by the assertions and medical or environmental facts of the cases before the court. For asbestos, exposure itself causes injury. For pollution, the contamination was long unseen from the surface but was causing injury for years. Coverage should have been described in cases such as *Keene* based on an injury analysis without the additional baggage of a purported “continuous” trigger that opened the decision to criticism as one unduly favorable to policyholders.

Minnesota law clearly recognized this, at least prior to *NSP* and *Domtar*.

We view this “actual injury” rule to be sufficiently broad to recognize that in cases involving long exposure to a toxic substance there can be damage with more than one manifestation and more than one insurance policy can afford coverage. We reject the argument that there can be only one occurrence in a case where property damage results from continuous or repeated conditions of exposure.³⁴⁸

Regarding trigger jurisprudence, *NSP* is not directly contrary to this sensible view, although *NSP* does read as though it is based

tinuous” trigger out of whole cloth. In addition (although courts and commentators seem to lose sight of this fact), for purposes of determining a CGL insurer’s duty to defend, it is the allegations of the third-party claim that are key. Thus, regardless of the “real” science or etiology of asbestos, pollution, or medical devices, duty to defend coverage of the CGL is triggered under an injury approach when the claimants allege actual injury beginning during a policy period. Where cases settle reasonably, the same rule should apply to determining the trigger of liability coverage unless the insurer can prove that no damage took place during the policy period at issue, a point recognized by the *NSP* court despite its misfiring on the matter of apportionment. See *Northern States Power v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 662-63 (Minn. 1994).

347. *Flintkote Co. v. American Mut. Liab. Ins. Co.*, No. 808-594 (Cal. Super. Ct. Aug. 17, 1993), reported in 7 Mealey’s Litig. Reps.—Ins. No. 45, at A-56, A-57 (Oct. 5, 1993) quoted in *ANDERSON ET AL.*, *supra* note 53, § 4.10, at 224. Accord *Sentinel Ins. Co. v. First Ins. Co.*, 875 P.2d 894, 917 (Haw. 1994); *Armstrong World Indus. Inc. v. Aetna Cas. & Sur. Co.*, No. A049419 (Cal. Ct. App. Apr. 30, 1996), reported in 10 Mealey’s Litig. Reps.—Ins. No. 25, at A-1 (May 7, 1996) (stating actual injury trigger not inconsistent with continuous trigger in asbestos or similar cases).

348. *Industrial Steel Container Co. v. Fireman’s Fund Ins. Co.*, 399 N.W.2d 156, 159 (Minn. Ct. App. 1987).

substantially on efficiency concerns that can be interpreted as permitting the policyholder to trigger coverage with a lower showing of injury than might otherwise be required.³⁴⁹ Thus, it is possible that the *NSP* court viewed itself as conferring a benefit on the policyholder that needed to be matched with the burden of proration by time on the risk.

Reflection on the trigger issue, however, reveals that use of the so-called continuous trigger was not an unwarranted judicial gift to the policyholder. Rather, *NSP* correctly (if perhaps unwittingly) applied the standard actual injury trigger, which in cases such as insidious harm from products or pollution becomes something of a rolling actual injury trigger. Application of the injury trigger results in continuous trigger of the CGL not because policyholders are benefiting from some newfangled or extra-textual trigger but because the third-party claims and actual facts of the underlying lawsuits activate the injury trigger during multiple policy periods.

Once it is realized that courts finding multiple policies triggered in cases such as asbestos and pollution have merely correctly applied the injury trigger and done nothing extraordinary to favor the policyholder, the case for allocation that goes beyond the insurers or that operates to deprive the policyholder of coverage collapses. The policyholder has not been "given" anything by the courts regarding trigger and the jurisprudence of the dominant actual injury trigger does not "take away" any benefits owed the insurer. Consequently, there is no need to adopt as a counterweight an allocation regime that advantages insurers or deprives policyholders of some coverage benefits.

Consequently, the aversion of some courts to permitting poli-

349. See *NSP*, 523 N.W.2d at 663. The court stated:

Where it is scientifically possible to prove the amount of harm occurring during each policy period, it may be nonetheless too expensive to do so in cases involving relatively small total damages. At the same time, the extremely fact-dependent nature of such an allocation scheme may reduce the likelihood of settlement. Finally, as a public policy matter, this court cannot ignore the enormous difficulty insureds would face if, as is generally the case, they had the burden of proving the amount of damages for each policy at issue.

Id. (footnotes omitted). What the *NSP* court overlooked, however, was that the text of the CGL imposes no such requirement on the policyholder. The policyholder has coverage if it can show that damages flowed from an injury beginning during the policy period. There is no requirement that the policyholder show exactly how much of this damage from covered injury took place at given time periods.

cyholders to select the order in which they will call upon insurers to defend or pay claims is unwarranted. If several CGL policies are triggered, a policyholder should be permitted to select the order in which triggered insurers are approached for defense and payment. There is nothing unfair about this. The insurer required to defend or pay may seek apportionment of coverage responsibilities vis-a-vis other insurers and thus can avoid paying anything above its fair share. There is no need to reduce the policyholder's benefits, force the policyholder to contribute to the insurance fund, or require the policyholder to defer receiving insurance coverage while apportionment among insurers takes place.

Unfortunately, however, the impression persists in some quarters that permitting the policyholder to select its order of requesting the benefits of triggered coverage somehow imposes "joint-and-several" liability upon insurers or constitutes an improper policyholder license to "pick-and-choose" among insurers. Both views are wrong.

Allowing policyholders to enjoy the full benefit of multiple triggered insurance coverage is not imposition of joint-and-several liability upon insurers. In a case of true joint-and-several liability, each of several defendant tortfeasors are all potentially required to pay all of the plaintiff's claim even if the most easily tapped defendant is only one percent at fault (although the paying defendant is entitled to contribution in proportion to fault from the other defendants). Under a *Keene* regime where the policyholder selects the year when coverage is first sought,³⁵⁰ the targeted insurer is in a

350. See *Keene*, 667 F.2d at 1049-50 (permitting the policyholder to select the applicable policy for a particular claim but also stating that the policyholder's right to recovery was limited to the amount of the selected policy). This limitation is unnecessary. If actual injury/continuous injury triggers the coverage of several policies and policy years, there is no reason why the policyholder should not be permitted to tap a second insurer for coverage if the policy limits of the first insurer selected are exhausted. In subsequent administration of the case, the trial court permitted the policyholder to draw benefits for covered claims from more than one triggered policy, suggesting that it was eventually recognized that the "one policy" restriction of *Keene* was something of a slip of the pen. See *Keene Corp. v. Insurance Co. of N. Am.*, 1985 U.S. Dist. LEXIS 17282 (D.D.C. July 31, 1985) (other insurers required to assume defense when Liberty Mutual, policyholder's designated carrier, exhausted; carriers informally agree among themselves to prorate by risk). Accord *Keene Corp. v. Insurance Co. of N. Am.*, 597 F. Supp. 946 (D.D.C. 1984); *Keene Corp. v. Insurance Co. of N. Am.*, 1983 U.S. Dist. LEXIS 16944 (D.D.C. 1985). Although the one policy limit or one policy period restriction might work fine for isolated claims falling within the ambit of one policy's coverage, it would work to reduce coverage in mass claims situations by limit-

far different position. Absent bad faith, this insurer will never be required to pay more than its remaining unexhausted policy limits for the year in question. In other words, an insurer first tapped by the policyholder in cases of multiple triggered policy years never pays more than its fair share. When a CGL carrier writes coverage, it knows it is at risk of paying the full policy limits for a triggered claim. Under a *Keene* system, the insurer first approached by the policyholder continues to have this risk and only this risk. The insurer is never required to pay for the fault of others or the liability of others. The CGL contract itself previously obligated the insurer to potentially pay the entire policy limits if triggering injury takes place during the policy period.

Because the *NSP* and *Domtar* courts incorrectly read the CGL as entitling the insurer to further reduce its policy limits if all injury was not complete at the close of the policy period, the supreme court also erroneously viewed NSP Company's desire to first tap the 1957 St. Paul Companies CGL as an effort to obtain unfair advantage.³⁵¹ In reality, all NSP Company wanted was to receive the benefits to which it was rightly entitled under a contract that had more value than other applicable contracts. There is nothing unfair to the insurer if the policyholder draws down triggered benefits so as to maximize coverage. The insurance policy promised the policyholder coverage for triggered claims without any limitation based on other loss experience or insolvency of other carriers. Thus, if the 1957 St. Paul policy was the one with the most benefits readily available to NSP Company, NSP should have been permitted to receive these benefits without reduction and without the prerequisite of simultaneously approaching other triggered insurers for a pro rata share of coverage. What was inconvenient in *NSP* became intolerable in *Domtar*: the policyholder was not only prevented from enjoying the fruits of purchased insurance in the most expeditious manner but was denied some of the contractual benefit merely because of the timespan over which injury took place.

ing the policyholder's right to recover for claims that straddle different policy periods.

351. See *Northern States Power v. Fidelity & Cas. Co.*, 523 N.W.2d 657, 660 n.4 (Minn. 1994) (criticizing the NSP position as greedy). The *NSP* court is correct, however, in suggesting that it would be unfair to permit a policyholder to tap multiple triggered policies but to pay only one policy year's deductible.

B. Although Ironclad Allocation Schemes Generally Hold Potential for Mischief, Allocation to the Policyholder is Particularly Problematic

Even if allocation is restricted to insurers, the policyholder may be deprived of the benefit of the bargain when the insurer is permitted to reduce coverage responsibility. Where some of the time periods involve insurance that is uncollectible because of insolvency or because the policyholder has already properly called upon this insurance for covered claims, inter-insurer allocation works an injustice. Even if allocation among insurers by time on the risk is the general rule, it should not be an inflexible rule and should be subject to adjustment in cases of uncollectability or exhaustion. Many commentators favoring allocation largely recognize and admit this need to fine-tune an allocation formula so that the policyholder is not denied coverage in such situations.³⁵² But no amount of fine-tuning can justify imposing coverage costs on the policyholder when the policyholder is simultaneously prevented from receiving available triggered insurance coverage.

Several reasons make imposition of coverage burdens on the policyholder especially unjustified. Although some of these reasons apply to rigid allocation schemes generally, they take on particular force where the policyholder is included in the allocation mix. In addition, allocation to the policyholder raises additional problems not found if allocation is restricted to insurers.

1. Allocation to the Policyholder Undervalues CGL Policy Language and the Insurers' Role in Crafting the Terms of the Policy

Perhaps the most succinct assessment is provided in the recent *Armstrong World Industries Inc. v. Aetna Casualty & Surety Co.* case:

The insurers [attempting to limit their payments through proration] have confused the trigger of coverage and the scope of coverage. . . . [T]he event which triggers an insurance policy's coverage does not define the extent of the coverage. . . . [O]nce a[n all sums] policy is triggered, the policy obligates the insurers to pay "all sums" which the insured shall become liable to pay. . . . The insurer is responsible for the full extent of the insured's liability (up to the policy limits), not just for the part of the damage

352. See, e.g., Yin, *supra* note 109, at 1290; Gillespie, *supra* note 198, at 534-35.

that occurred during the policy period.³⁵³

The Minnesota Supreme Court put the matter succinctly nearly thirty years ago:

If the underwriters intended that the policy not include the use [of the automobile resulting in the loss at issue], they could have easily said so. Under the most favorable aspect of construction, it may be said that at the very most the language chosen by [the insurer] is ambiguous and must be construed in favor of [the policyholder], thereby yielding the same result.³⁵⁴

2. *The Policyholder-Insurer Relationship is Dramatically Different Than the Relationship of Overlapping or Serially Triggered Insurers*

As the *Armstrong World* court noted:

A distinction must be drawn between apportionment among multiple insurers and apportionment between an insurer and its insured

[In an all-sums policy] once coverage is triggered, the insurer's obligation to the policyholder is to cover the policyholder's liability "in full" up to the policy limits The logical consequence of this ruling is that the policyholder is covered (up to the policy limits) for the full ex-

353. 52 Cal. Rptr. 2d 690, 742 (Cal. Ct. App. 1996) (citations omitted).

354. Federal Ins. Co. v. Prestemon, 278 Minn. 218, 227, 153 N.W.2d 429, 435 (1967) (citing Quaderer v. Integrity Mut. Ins. Co., 263 N.W.2d 383, 116 N.W.2d 605 (1962)). Accord Pan-American World Airlines v. Aetna Cas. & Sur. Co., 505 F.2d 989 (2d Cir. 1974) (applying New York law and finding rationale of construing ambiguous provision against insurer buttressed by more exclusionary language used by insurance industry in other policies but not present in policy at issue in coverage litigation; thus holding that policy's exclusion for war, riot and insurrection did not preclude coverage for loss of airplane to skyjacking, which can be characterized as mere crime rather than act of war or civil insurrection); Kief Farmers Coop. Elevator Co. v. Farmland Mut. Ins. Co., 534 N.W.2d 28, 35-36 (N.D. 1995) (holding that the insurer precluded from arguing that property insurance coverage was triggered only upon "discovery" of loss when the insuring agreement spoke of damage caused rather than discovered, and criminal loss provisions of same policy demonstrated the insurer's ability to require discovery as a trigger in the policy text if it so desired).

tent of its liability and need not pay a pro rata share.³⁵⁵

The key point, obviously related to the contract point made previously, is that the policyholder is entitled to certain benefits from its insurance policies, irrespective of whether other policies are involved in the underlying matter (absent express “other insurance” provisions that reduce or void coverage where overlapping insurance exists).

3. *The Illogical Prejudice Against the Self-Insuring Policyholder*

Cases allocating coverage burdens upon the policyholder, even largely sound cases like *Stonewall*³⁵⁶ appear beguiled by an apparent siren song of proration that obscures a court’s ability to realize that it has engaged in the judicial rewriting of contracts judges so often deplore.

First, the assumption in *Stonewall*, *Owens-Illinois*,³⁵⁷ and similar cases is that a policyholder who “goes bare” is to some extent undeserving of full insurance coverage even if policies purchased by the policyholder would otherwise allow for full indemnity. This sentiment is reflected in Judge Weinstein’s wiseacre aphorism in *Uniroyal* that “[s]elf-insurance is called “going bare” for a reason.”³⁵⁸ This same unduly dismissive characterization of the policyholder’s conduct is of course found in the *Stonewall* trial court’s assessment (rejected by the Second Circuit) that the insured had “bargained away” asbestos coverage.³⁵⁹ As the Second Circuit in *Stonewall* noted, anyone familiar with the insurance market of the mid-1980s could not seriously describe the unavailability of asbestos or other product liability coverage as the result of manufacturers’ risk acceptance or wheeling-and-dealing over coverage terms.³⁶⁰ The forced

355. *Armstrong World*, 52 Cal. Rptr. 2d at 710-11.

356. *Stonewall Insurance Co. v. Asbestos Claims Management Corp.*, 73 F.3d 1178 (2d Cir. 1995); see *supra* Part II.D.1.a (noting that *Stonewall* made a welcome modification of the trial court’s onerous position that the policyholder was responsible for post-1985 losses even though the insurance industry united in refusing to sell asbestos coverage).

357. *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994) (using continuous injury trigger, requiring factual examination of timing of damage from triggering injury, but adopting default formula of allocation according to time on the risk and respective policy limits of triggered insurers).

358. *Uniroyal Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1392 (E.D.N.Y. 1988).

359. See *Stonewall*, 73 F.3d at 1203-04.

360. See *id.* at 1204.

shift from the occurrence to the claims-made policy, one chronicled in the Insurance Antitrust Litigation brought by state attorneys general against insurers for alleged collusion in forcing industry-wide adoption of the claims-made CGL form,³⁶¹ further evidences the degree to which insurers rather than policyholders were calling the shots regarding liability coverage during most of the time periods at issue in mass tort insurance coverage cases.³⁶²

But on closer analysis, this judicial assessment that the policyholder without ample annual insurance has somehow done something wrong and punishable is erroneous and unfairly critical of the policyholder. The courts prorating to the policyholder overlook:

- (1) the terms of the occurrence CGL itself, which provides for all sums coverage without restriction related to uninsured periods;
- (2) the insurers' own role in underwriting these policies to customers it knew (at least constructively) had self-insured or purchased small policies in the past; and
- (3) prorating to the policyholder for the multiyear tort provides reduced coverage for this type of claim as compared to the "typical" episodic tort claim that arises from an occurrence taking place in only one policy period.

Although there is perhaps some room for debate, the logically stronger public policy is to provide for broader coverage of the multiyear mass tort than the "single shot" or "garden variety" tort so long as this is done without doing violence to contract language, party intent, the purpose and function of the CGL, reasonable expectations, insurance principles or other important public policy factors. Applied to cases like asbestos, medical products and pollution, it appears that no other factors of significance auger in favor of providing policyholders with less mass tort coverage than would exist from a barrage of "plebeian" torts.

361. See, e.g., *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 770 (1993).

362. The tightness of the insurance market was so pronounced in the mid-1980s that *Time* magazine ran a cover story describing the ironclad tightness of the liability insurance market and a situation where coverage was simply unavailable from conventional insurers, even for policyholders willing to pay premium prices. See *Sorry: Your Policy is Canceled*, *TIME*, Mar. 24, 1986, at 20.

4. *Prorating Coverage to the Policyholder Vitiates the Very Function of Liability Insurance*

The CGL policy language—which was drafted by the insurance industry³⁶³—weighs against proration. The policyholder could reasonably expect not to absorb losses for which it had purchased insurance and may have had an actual expectation to this effect. A substantial amount of evidence of the drafting history of the CGL suggests that individual insurers and perhaps the entire industry knew that multiyear torts would trigger several policy periods but the CGL drafters specifically declined to seek an express proration provision in the policies.³⁶⁴

Proration to the policyholder also violates the function and purpose of CGL. The very theory of insurance is that the policyholder accepts and shoulders a certain but manageable expense (premium payment) in return for obtaining protection against a larger but contingent loss (the tort claim).³⁶⁵ The insurer obtains some upside certainty through the policy limits. When the policyholder pays the premium it should therefore be accorded the full benefit of the CGL. Although the policyholder may need to shoulder deductibles or retentions or co-payments if expressly written into the policy, the insured normally has an ironclad right to coverage should a qualifying tort claim be made against it. Thus, if a manufacturer's improperly made widget explodes and kills someone, the insurance in place at the time of the explosion provides coverage. But under the rationale of *Domtar* and similar cases, the policyholder does not obtain full coverage when the widget silently injures a large group over several years if the policyholder was uninsured for so much as a single year. But the CGL in each case is the same in language and structure. Thus, proration to the policy-

363. This authorship holds true even in most cases involving large commercial or "sophisticated" policyholders. See, e.g., *Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467, 469 (Ind. 1985) (finding insurer's "manuscript" policies written for larger commercial insured to be considered as authored by the insurer and construed against insurer in cases of ambiguity where policy language "identical in all material respects to the coverage provision in the insurance industry's Comprehensive General Liability Policy (CGL)").

364. See generally Eugene R. Anderson et al., *Environmental Insurance Coverage in New Jersey: A Tale of Two Stories*, 24 RUTGERS L.J. 83, 202-04 (1992) (discussing that the drafters clearly understood that the CGL does not limit the insurance company's obligation to a "portion" of the policyholder's liability); EUGENE R. ANDERSON ET AL., *supra* note 53, §§ 4.1-4.2 (discussing the drafter's understanding of the triggering of several policy periods for consecutive torts).

365. See ABRAHAM, *supra* note 2, at 1-5.

holder gives the policyholder less coverage under the same CGL form than would be provided by that CGL form under ordinary circumstances.

This aspect of *Domtar*—judicial activism to reduce purchased policy benefits—is particularly pronounced and pernicious when the proration occurs because other liability insurance in other policy periods has been exhausted by other claims. In these cases, the policyholder is not some careless lout “going bare” but instead is a victim of the mass tort phenomenon and the growth of liability claims during the twentieth century. The policyholder buys insurance every year. When the policyholder is hit with claims—the very reason it purchases insurance—some policies become exhausted as expected. However, the unexhausted policies continue to purport to provide “all sums” coverage. Under these circumstances, the policyholder is even more obviously deprived of purchased CGL coverage simply because the very events insured against have come to pass.

In view of the public policy benefits of maximizing funds for tort injury compensation when this can be done without violating contract norms, the clear weight of considerations suggests that manufacturers facing a mass tort should at least do no worse in seeking insurance coverage than do manufacturers facing ordinary and episodic tort claims. However, proration to the policyholder provides just this perverse result: policyholders who have purchased the “all sums” occurrence coverage once trumpeted by the insurance industry find their insurance protection reduced by judicial fiat simply because of the configuration of the underlying tort, which took place over several years rather than in one big bang of injury.

5. *Proration to the Policyholder is Unjustified for Even Pronounced Instances of Self-Insurance*

These basic and unassailable arguments against proration to the policyholder hold true irrespective of the type of tort claims, the number of years when insurance is lacking, the market for insurance, and the policyholder's irresponsibility in not purchasing insurance. Consider the “horrible hypothetical” invoked by the *Forty-Eight Insulations* court in support of proration to the policyholder.³⁶⁶ A manufacturer goes bare for nineteen years and pur-

366. *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212,

chases one year of CGL coverage with a policy limit of \$1 billion. During this twenty year period the asbestos or similar injury occurs. The *Forty-Eight Insulations* court asked in almost rhetorical fashion whether it could be fair to require the insurer to pay when the manufacturer has gone so long without coverage, and quickly concluded that this was sufficiently unfair to require proration to the policyholder.³⁶⁷

But a more sustained analysis reveals no unfairness, no wind-fall and certainly no legal basis for denying the policyholder the benefits of the coverage purchased through a (95 percent!) pro rata reduction. Examining the single CGL in isolation shows that the insurer promised to pay, without reduction, as much as \$1 billion in settlement or judgment of claims without any reduction because of any absence of insurance in other years. The insurer could have included such provisions in its policy but did not. Consequently, the Year 20 insurer is obligated to pay (and to defend under this variation of the *Forty-Eight Insulations* hypothetical, which is remarkably similar in impact to *Domtar*) without regard to whether the insurers for Years 1 through 19 were exhausted, insolvent or unwilling to pay. By implication, the complete absence of any insurance in Years 1 through 19 should not have any impact on the contractual duties of the Year 20 insurer vis-a-vis the policyholder.

As a matter of contract law, then, the Year 20 insurer's obligations can not be reduced by the status of Year 1 through Year 19 insurance or its absence. When the *Forty-Eight Insulations/Domtar* hypothetical is examined more closely, it also becomes apparent that there is nothing unfair about holding the Year 20 insurer to its contractual arrangement and nothing improper about permitting the policyholder to enjoy the full "fruits" (bitter though they may be in the mass tort context) of the Year 20 policy. The policyholder paid for the Year 20 policy. The insurer took the application, engaged in underwriting and issued the policy. The policyholder's activities in other years implicated by the tort claims are irrelevant to the duties owed the policyholder by the Year 20 insurer.

1219 (6th Cir. 1980).

367. See *id.* at 1225.

6. *Where the Policyholder is in Some Way Undeserving of Coverage, One or More Traditional Defenses to Coverage Will Be Applicable, Making Proration to the Insured Unjustified or Superfluous*

It should also be emphasized that the Year 20 insurer, lest courts continue to have some inclination of pity, has a variety of grounds for contesting coverage if there really is anything improper or unjustified about the policyholder's request for coverage. With or without foundation, experienced insurer counsel can often suggest as many as two dozen possible defenses to coverage for the average claim, and often do so in their first response to a policyholder's claim. Without slicing the subject as finely as do many insurer counsel, it is safe to say that at least half a dozen and probably a dozen defenses are available should the coverage claim stem from any legitimate possibility of serious wrongdoing or overreaching or unfair conduct by the policyholder. For example, the insurer may contest coverage on the basis of:

- late notice
- inadequate documentation of the loss
- failure to cooperate
- unauthorized claims resolution
- the claim stemming from injury expected or intended from the standpoint of the policyholder
- the claim lying outside the scope of coverage
- the claim falling within an exclusion from coverage
- the claim stemming from negligence during the policy period but not actually resulting in injury during the policy period
- the exhaustion of the policy's limits from other claims
- lapse of coverage due to premium nonpayment
- rescission of the CGL due to misrepresentation in the application process
- rescission of the policy on mutual mistake or any other grounds available under contract law.

Although this list undoubtedly is overdone for even the average mass tort matter, it serves to illustrate the point. If there is any

serious problem with the claim, the insurer has a wealth of widely recognized defenses to coverage. The insurer hardly needs the benefits of a partial or hidden defense to coverage in the form of proration to the policyholder.

This raises a further jurisprudential problem with proration to the policyholder. It provides an additional, unwritten, unexpected tactical defense and substantive benefit to the insurer. This is problematic for several reasons.

First, recognition of such “implied” defenses to coverage or grounds for reducing coverage run counter to contract law norms, which generally do not recognize refusals to honor a contract based solely on nontextual arguments. The insurers may characterize their proration position as a “prudential” argument that attempts to prevent windfalls and to spread the imposition of loss, but as the analysis earlier in this article underscores, the policyholder obtains no windfall and the insurer is not entitled to spread back to the policyholder the loss that the insurer previously accepted without reservation.

Second, adoption of this sort of defense runs counter to the maxim of insurance contract interpretation that exclusions should be narrowly construed in favor of the policyholder and that the insurer bears the burden of proving the applicability of the exclusion. Although the policyholder has the initial burden to show that a third-party claim comes within coverage, this burden has been easily satisfied by the manufacturer defendants in mass tort product liability claims such as asbestos or silicon implants. Consequently, an attempt to reduce the scope of coverage operates in the nature of an exclusion and the insurer bears the burden to persuade courts by a preponderance of the evidence that something about the mass tort coverage situation justifies a *de facto* diminution in coverage simply because the injury resulted over several years, including some time periods for which insurance is not available. As delineated above, the insurers simply cannot make a sufficient showing to justify coverage reduction, even for the manufacturer who buys insurance only in the last year of a twenty year period. The policyholder remains entitled to the insurance it bought for Year 20.

Third, acceptance of proration to the policyholder—or for that matter, any allocation among insurers that fails to account for

insolvency, exhaustion or collectability³⁶⁸—provides insurers with yet one more bite at the metaphorical apple of claims denial. Insurers ordinarily have many potential opportunities to avoid or reduce coverage. Under these circumstances, it seems odd for courts to stretch to create another ground for diminishing coverage absent a compelling command from the contract language, the nature of the insurance business, tort law or statute. Applied to mass product liability claims to date, no such compelling need appears to exist for creating from relatively whole cloth yet another insurer defense to coverage.

Fourth, the availability of proration or allocation defenses by insurers provides not simply another defense but a defense largely repetitive of other existing defenses. A defendant can by definition prevail by playing defense and engaging in a war of attrition in which the claimant must again and again move forward to prove its entitlement by a preponderance of the evidence. In addition to often wearing the claimant down for settlement, this tactic can permit winning by attrition in litigation, even where the defendant as a technical matter bears the burden of persuasion and the detriment of rules of construction.

Applied to the insurance coverage context, the defense advantage works something like this. The policyholder makes a claim. The insurer denies and cites the laundry list of defenses noted above, including intentional act, misrepresentation and the like. To the extent some defenses involve the language of the insuring agreement clause, the policyholder bears the burden of persuasion. Even if the defense is in the nature of an exclusion on which the insurer bears the burden of proof, the policyholder is nonetheless forced to put on a case, often at substantial expense (including inputs of cost in kind such as employee time and distraction from the company's main business) and delay.

Assume the policyholder surmounts these defenses. Having proven that it did not expect or intend the loss, that the loss was fortuitous and not known, that adequate notice was provided to the insurer, that damages were mitigated, that it was sufficiently cooperative, and that it did not engage in *ex gratia* settlements, the policyholder faces yet another hurdle, one that is essentially insur-

368. In addition to concerns over insolvency, there may be an issue as to collectability of some insurance policy proceeds. For example, a foreign insurer may not be insolvent but its assets may be difficult (or perhaps impossible) to reach if it refuses to honor a judgment against it in a coverage action.

mountable under the essentially rigid allocation formula used by *Domtar*. Despite having shown its entitlement to defense and indemnity, the policyholder now has its indemnity reduced, often dramatically, through an apportionment not provided by contract or insurance essentials. Only if the policyholder can, per *SCSC*, show that the pollution came from a discrete, identifiable, temporally cabined cause, can the policyholder obtain coverage.

But the great and unspoken irony in this sudden emergence of allocation as a *de facto* coverage defense is that allocation to the policyholder (or allocation that fails to account for insolvency and exhaustion of other policies) can be justified only on equity grounds. Therefore, to be permitted, allocation must be necessary to prevent unfairness or in some other way “do equity” among the disputants.

But, as detailed above, a failure to allocate is anything but unfair to the insurer. The insurer accepted the risk of nonallocation by issuing a contract that committed it to providing defense and indemnity without allocation. Enforcement of this term of the insuring agreement is far less onerous to the insurer than enforcement of deadlines, default provisions, and penalties frequently enforced in contract litigation. Thus, allocation is not necessary to give equity to the insurer.

Allocation could perhaps be justified on equitable grounds if it is used to prevent unjust enrichment to the policyholder. But as long as the policyholder does not get overpaid, there is no unjust enrichment—unless the apportionment is intended to serve as a proxy for denying or diminishing coverage because of other misconduct or undeservingness on the part of the policyholder. But the policyholder has already proven itself to be deserving and not possessed of unclean hands by virtue of triumphing over the insurer’s defenses of intentional harm, known loss, misrepresentation and the like. Thus, when the arguments for allocation are pursued full circle, the inevitable conclusion—the point where argument can go no further—is that there is no equitable justification for apportioning coverage responsibility to the policyholder.

Even without allocation, the policyholder will bear substantial coverage responsibility in many ways in a typical complex products liability mass tort. The policyholder must often:

- shoulder a deductible or retention;
- suffer the costs of insurer insolvency when no overlapping

- coverage exists;
- suffer insolvency costs because excess insurers will seldom be required to drop down;
- incur the transaction costs of pursuing through litigation coverage it should have received without dispute;
- perhaps absorb additional costs if after providing a defense the court finds them to have paid counsel too well;
- pay the liability costs after policy limits are exhausted;
- pay for judgments and settlements for which no insurance policy is triggered.

Consequently, the policyholder often pays, at least initially, vast sums from its own treasury even where it was prudent and pure of heart regarding insurance. Imposing further costs on the policyholder through allocation can be justified only if the insurer was not pure of heart—but the policyholder's successful parrying of other "bad policyholder" defenses of the insurer precludes such an assessment. In the end, proration to the policyholder merely punishes the deserving insured based on an unspoken and inaccurate perception that the policyholder is in some way an undeserving insured merely because it was self-insured or ran out of insurance during some years.

7. *Prorating Coverage to the Policyholder Defeats the Purpose of Liability Insurance by Effectively Punishing the Policyholder for Negligence or Miscalculation*

Related to this is yet another argument against allocation to the insured: it essentially punishes the policyholder for perceived negligence in failing to purchase insurance or buying too little insurance. However, the very purpose of insurance is to protect the policyholder from the consequences of negligence. Consequently, even if one accepts for purposes of argument that the policyholder was negligent, this should not strip the policyholder of the insurance it did purchase, just as a policyholder's negligence giving rise to tort claims does not negate insurance coverage. Rather, the essence of insurance is to provide coverage to the negligent policyholder, regardless of the form of that negligence.

8. *Proration to the Policyholder Violates Reasonable Expectations and Substitutes Ex Post Analysis for the Ex Ante Analysis that Normally Governs Contract and Commercial Law Policy*

Allocation to the policyholder is wrong in large part because the courts, seemingly without appreciating the consequences of their actions, have changed the rules of insurance coverage in the proverbial middle of the game and have done so at the expense of the policyholder, the entity that under traditional insurance jurisprudence is supposed to receive the benefit of any close legal questions.

In addition, the court's implicit determination that the policyholder was negligent in failing to buy insurance is of course a post hoc evaluation. In effect, the courts allocating to the policyholder employ 20-20 hindsight to find fault with risk management strategies of decades previous on the basis of 1990s knowledge of the potential ravages of mass tort claims. Under traditional insurance doctrine, difficult issues related to risk bearing under conditions of uncertainty are resolved against insurers and in favor of policyholders—not the other way around. Apportionment against the policyholder thus in another manner turns the principles of insurance law inside out in the cause of inequity rather than fairness.

IV. THE IMPOVERISHED AND UNREALISTIC ARGUMENTS OF THE INSURANCE INDUSTRY: ADVOCATES OF ALLOCATION TO THE POLICYHOLDER EMPLOY UNREALISTIC ASSUMPTIONS AND ERRONEOUS CONCEPTS OF THE INSURING ARRANGEMENT IN ARGUING FOR ALLOCATION TO THE POLICYHOLDER

Courts and commentators favoring allocation to the policyholder make a superficially persuasive case that tends to implode upon examination. Several of these infirmities—ignoring the insuring agreement and the function of insurance and mischaracterizing issues of fairness and desert—are detailed above. In addition, those favoring proration to the policyholder have, at least implicitly, rested support for imposing costs upon the insured on an essentially strained or inaccurate portrayal of liability insurance arrangements. Recent scholarly commentary has delineated these fallacious assumptions and arguments in greater detail than one finds in the case law and permits closer examination of this aspect of the error of allocation to the policyholder.

Of particular interest is the recent article by Professors J. David

Cummins and Neil A. Doherty, *Allocating Continuous Occurrence Liability Losses Across Multiple Insurance Policies*.³⁶⁹ Cummins & Doherty advance a sophisticated rationale for allocation to the policyholder that when applied to multiyear mass tort claims may deprive the policyholder of even more coverage than would be lost under the *Domtar* regime.³⁷⁰ The Cummins & Doherty thesis sufficiently outraged some policyholder counsel to engender a swift response.³⁷¹ The policyholder response is quite persuasive and deserves more credence than the theoretical case for allocation. Although there have been other thoughtful commentaries on the allocation issue,³⁷² I will focus on the Cummins & Doherty piece because it pre-

369. J. David Cummins & Neil A. Doherty, *Allocating Continuous Occurrence Liability Losses Across Multiple Insurance Policies*, 8 ENVTL. CLAIMS J., Spring 1996, at 5. Although the *Environmental Claims Journal* is a proprietary publication rather than an established law review, it is widely read by insurance coverage attorneys, who will undoubtedly marshal favorable commentary in case briefs and argument. In addition, Cummins and Doherty, both professors at the Wharton School of Business at the University of Pennsylvania, have substantial academic reputations that may make invocation of their allocation writings persuasive to courts.

370. See *id.* at 22-23.

371. See John E. Heintz et al., *Allocation of Indemnity among Multiple Insurance Policies*, 9 ENVTL. CLAIMS J., Autumn 1996, at 5.

372. See Michael G. Doherty, Comment, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. 257 (1997) (arguing allocation among policies where proportions of damage cannot be determined due to extended periods of time over which the damage occurred); Gillespie, *supra* note 198; Hickman & DeYoung, *supra* note 98; Yin, *supra* note 109; see also James M. Fischer, *Insurance Coverage for Mass Exposure Tort Claims: The Debate Over the Appropriate Trigger Rule*, 45 DRAKE L. REV. 625 (1997) (arguing not so much for allocation as that continuous version of actual injury trigger is inapt for product liability injuries where damage in later years is merely profession of disease or deterioration of claimant's condition set in motion by original injury rather than result of years of separate, coverage-triggering injuries). In general, there has been relatively little academic commentary on the issue. There have been some well done articles that are too partisan for my taste, particularly in their suggestion that policyholders are to blame for multiyear torts or are insurance delinquents who failed to buy enough insurance and thus somehow forfeit the insurance actually purchased. See Laura A. Foggan & John C. Yang, *Tortfeasors' Responsibility for Uninsured Periods: Allocation, Economics, and Market Demand*, 8 ENVTL. CLAIMS J., Summer 1996, at 3 (contributing article by lawyers representing IELA); Hickman & DeYoung, *supra* note 98, at 290-91 (implying that policyholders' just dessert is to shoulder portion of coverage where insurance is not seamless). Although arguments based on wrongdoing would be persuasive if the policyholder's role in the underlying tort met the expected or intended defense, the known loss defense, or the loss in progress defense, it really becomes only an exercise in rhetorical posturing when trotted out to justify imposition of coverage responsibility upon the policyholder. To date, most courts, like *NSP* and *Domtar*, have rejected the insurance industry argument that the asbestos and pollution defendants should be denied coverage because of their conduct in the underlying tort actions.

sents the full array of the mainstream insurer arguments for allocation, it takes the most extreme position for allocation—and because it is one of the most sophisticated presentations.³⁷³

Cummins & Doherty take the basic position that policyholders should bear some of the coverage responsibility for multiyear occurrences for any periods of self-insurance.³⁷⁴ Beyond this, however, Cummins & Doherty also take the position that the maximum insurance coverage available to the policyholder in a multiyear occurrence situation is the insurance coverage it possesses in a typical year or year of greatest coverage.³⁷⁵ They take this position out of a belief that policyholders engage in risk management in which they attempt to purchase and keep in force a certain amount of insurance in case faced with an occurrence—any occurrence, even a multiyear mass tort with massive liability. Based on this assumption, Cummins & Doherty take the position that any apportionment that gives the policyholder (even the policyholder who never self-insured) more coverage for a series of related claims than this maximum one-year coverage package in effect “stacks” different liability policies and thus violates basic insurance principles.³⁷⁶

Cummins & Doherty calculate and defend the calculation of their aggregate insurance coverage in a series of illustrations which posit that the policyholder has a package of insurance for each year that includes: \$10 million deductible, primary coverage of \$40 million, excess coverage of \$50 million on top of the primary level, and policyholder self-insurance (an “upper SIR”) for amounts in

373. The sources cited in the previous note, particularly *Nailing Jello to a Wall* (Yin, *supra* note 109), are also sophisticated in approach, particularly as to the economics and mathematics of allocation. But the Cummins & Doherty piece is the most pro-insurer academic contribution to the debate (they would allocate more coverage responsibility to the policyholder even though Yin advocates some allocation to policyholders). Consequently, the Cummins & Doherty article is my principal target for criticism.

374. See Cummins & Doherty, *supra* note 369, at 19-20.

375. See *id.* According to Cummins & Doherty, “a sensible approach” is to first “establish the aggregate liability of all insurers and self-insurers (i.e., the policyholder) and then to find a heuristic for allocating this total across all insurers and self-insurers.” *Id.* at 7. But according to Cummins & Doherty, the policyholder is not permitted to aggregate years of occurrence coverage to determine the scope of the insurers’ liability. See *id.* at 18-19.

376. See *id.* at 7 (“Stacking of limits per event or occurrence (or of the per event or per occurrence deductibles) over the years is incompatible with the reasonable expectations of the parties and will have damaging consequences for insurance markets.”).

excess of \$100 million.³⁷⁷ Thus, for a \$200 million, one-year claim, the policyholder would obtain \$90 million in insurance coverage (the \$40 million primary limit and the \$50 million excess limit) but would pay \$110 million of its own money (the \$10 million deductible and the \$100 million “upper SIR” above the excess policy limit). In all of the Cummins & Doherty scenarios, this basic package of insurance is the same in each year, obviating any need to calculate the apt amount when the policyholder’s coverage package varies from year to year.³⁷⁸

The rationale for this assumption is the idea that when the policyholder purchases coverage for a particular policy period, the amount of insurance purchased is the maximum that the policyholder wished to purchase for application to any one occurrence. Cummins & Doherty posit that this is the policyholder’s objective no matter how extraordinary the occurrence, how large the liability flowing from the occurrence, how many years are spanned by the occurrence, and whether other insurance policies are involved.³⁷⁹ Hence, where a multiyear mass tort arises from one cause and is deemed one occurrence under the policy, the policyholder is limited to one year’s worth of insurance for that entire occurrence—no matter how multiyear or mass the occurrence. In other words, the policyholder gets the same aggregate coverage for asbestos, Dalkon Shield, Times Beach, Agent Orange, and breast implants as the policyholder would possess for a fatal auto accident, defaming a competitor, or tortious interference liability.

Cummins & Doherty justify this result under a self-styled “principle of symmetry” that suggests treating the multiyear mass tort occurrence as the risk management equivalent of the episodic tort liability that happens crisply in one policy year.³⁸⁰ They also offer a “rational risk manager” model of behavior to reconstruct the intent

377. *See id.* at 14-18.

378. *See id.* at 15-18. Although Cummins & Doherty are not clear on what happens then, it appears they endorse using the coverage package of the year closest to the occurrence’s initiation as the benchmark for each year of the multiyear occurrence. *See id.* at 21-23. Where this cannot be done, they would apparently average coverage packages to calculate the deductible, the primary policy, the excess coverages, and the maximum aggregate limit or “upper SIR” or permit use of the year with the highest coverage package as the benchmark. *See id.* But even under the most favorable application of the Cummins & Doherty approach, the policyholder is essentially limited to one year’s worth of insurance even though it faces a crippling multiyear tort claim.

379. *See id.* at 15.

380. *See id.* at 13-15.

of the policyholder in purchasing insurance *prior* to the multiyear tort claims:³⁸¹

[W]e believe the clear and consistent intention of the parties is that the policyholder is protected by a single deductible of \$10 million per occurrence consistent with its calculated capacity to bear and absorb smaller losses. The primary insurer, having assessed its financial capacity, has agreed that it can bear \$40 million per event and has been paid for coverage at that level; similarly with the excess carrier. Thus, if it was financially appropriate to have a \$10 million deductible and \$90 million of coverage for Cases 1 and 2 [single-year occurrences], given the financial capacities of the policyholder and insurers, then it was sensible to have \$10 million deductible and \$90 million coverage in Case 3 [for a multiyear occurrence].³⁸²

By characterizing the single year's insurance package as the outer limit of intended coverage, Cummins & Doherty then make a gigantic inferential leap, suggesting that collection under more than one triggered policy amounts to impermissible "stacking" of policy limits:

We do agree that policies in separate years can be triggered by an event that results in bodily injury or property damage in those years. What we disagree with is that such triggering implies stacking of either deductibles or per occurrence limits. This implication is inconsistent with the functioning of insurance markets.³⁸³

Cummins & Doherty also state:

[T]he idea of stacking violates any reasonable interpretation of the risk-bearing capacities of the parties, their plausible risk management strategies, or the pricing of the contracts. . . . Occurrences that just happen to span two policy years would (retroactively) be determined to have twice as much coverage as occurrences within a single pol-

381. *See id.* at 18.

382. *Id.* at 17.

383. *Id.* at 19.

icy year. Occurrences that spanned five years would have five times the coverage as occurrences happening in an instant, and so on. This random approach fits no sensible model of risk management that we have ever encountered.

. . . Stacking would expose the insurer that continued coverage in any layer to paying many times over for the same event, despite the fact that the annually renewed policies limit coverage per occurrence. In this way, stacking may force the insurer to pay beyond its declared prudent capacity to absorb the loss. Stacking violates the principles of diversification on which insurance rests, and for this reason, it would be uninsurable prospectively.³⁸⁴

As part of this calculation of a single-shot amount of coverage, Cummins & Doherty characterize any liability rising above their calculated one-year maximum policy limits as an “upper self-insured retention,” theorizing that the rational policyholder acting prior to the onset of the occurrence “chose” to self-insure for losses above the policy limits—even where these losses stem from long tail occurrences triggering several policies.³⁸⁵

As discussed in greater detail below, Cummins & Doherty’s feigned shock comprises the insurance scholar’s equivalent of protesting too much. The expectation of coverage from several policies because of a multiyear occurrence is hardly shocking, irrational, or unfair. For example, assume the policyholder made a batch of defective widgets in Year 1 and this manufacture was one occurrence. Assume the widgets are pulled from inventory in Years 1 through 5, causing horrendous injury that equals or exceeds policy limits in all years. A policyholder would presumably expect coverage under all of these policies, which were all triggered by damage caused by an occurrence during each year. Although the five

384. *Id.* at 18.

385. *See id.* at 19-20. Cummins & Doherty do treat their “one-occurrence/one policy period coverage package” model logically regarding deductibles and therefore would impose only one deductible on the policyholder. *See id.* at 27. The amount of the deductible would be calculated in the manner in which the policy limit is calculated. They acknowledge that this approach would benefit policyholders with relatively small multiyear losses because multiple deductibles would erode significant amounts of coverage. *See id.* at 35-36. They also appreciate that the effect is exactly the opposite for the policyholder who has large multiyear losses in which the insurance received after multiple deductibles provides significant coverage near or at the policy limits. *See id.* at 36.

triggered policies may each have a “per occurrence” limitation, the per occurrence limit applies separately to each insurer—this is what the CGL provides. Had insurers wished to further limit their own policy’s exposure where the occurrence also caused injury during other policy periods, the CGL could have been so drafted.

Cummins & Doherty describe a multiyear tort as some sort of odd coincidence with little meaning for liability or insurance. They conjure a misleading example (damage that begins late in Year X and continues to the beginning of Year Y) in an attempt to argue that policy periods and amounts are essentially arbitrary conveniences of accounting that should not distract judicial focus from a single occurrence. But in reality, most multiyear torts are something more than a tort that straddles calendar years. On the contrary, the famous multiyear torts of the reported cases are insidious or hidden injury that takes place gradually over an extended period of time. For these types of claims, policyholders undoubtedly expect triggered policies to respond and it is not in any way unfair to the insurer or overcompensating to the policyholder for all triggered policies to be responsible as promised in the policy limits for which premiums (separate premiums each year) were charged.

To the extent that Cummins & Doherty’s arguments are accepted, the consequences would be to strip the policyholder of a substantial amount of coverage for which it paid. The only means of avoiding this result, under this theory of limits, is to readjust the strict cause analysis that dominates judicial determinations of what constitutes an “occurrence.” Instead of seeing the manufacture of asbestos or widgets as the “cause” of loss, courts could characterize each installation of product or each shipment of product as the cause. Although this approach runs somewhat against the text of the typical CGL’s unifying directive attempting to link as one all loss stemming from substantially the same underlying conditions, the suggested expansion is not precluded by policy text (a court could interpret the “substantially the same conditions” language to apply to the injury to claimants rather than the cause of the injury).

Cause analysis has been popular with the courts in recent years in part because it limits the number of deductibles or self-insured retentions that must be satisfied by the policyholder.³⁸⁶ At the same

386. See STEMPEL, *supra* note 18, § 2.06[h] (discussing modern comparative popularity of “cause” analysis, which measure number of “occurrences” according to cause of loss rather than “effects” analysis, which determines number of occurrences according to number of affected claimants).

time, cause analysis limits the insurer's exposure by making it far less likely that the insurer will be required to pay the policy limits in numerous instances arising from related circumstances. In essence, cause analysis is popular not so much because it is invariably decreed by clear policy language but because it results in most cases in evenhanded interpretation consistent with the parties' expectations and does not unduly favor either insurer or policyholder.

But if the Cummins & Doherty approach is adopted, the balance of fairness tips strongly toward the insurer and creates unfairness. Under their scheme, the insurer still retains the advantage of a narrow definition of occurrence that limits the number of occurrences. In addition, even where the loss spans many years, the insurer's policy limits are not threatened more than once. Furthermore, the many insurers triggered by the multiyear occurrence, despite having faced no greater risk, are permitted (even compelled) to share in the multiyear loss. In other words, the Cummins & Doherty approach turns insurance into a means of spreading risk among insurers for benefit of the insurers when insurance is supposed to spread risk among policyholders for the benefit of policyholders. Insurers have ample means to share risk through obtaining reinsurance or diversifying their risk portfolios and do not need to obtain relief from policyholders. The Cummins & Doherty approach both turns risk distribution inside out and gives insurers a judicially created benefit at odds with their contractual commitment to policyholders.

The Cummins & Doherty thesis is riddled with other problems as well, many of which are addressed at some length in the policyholder counsel article written directly in response.³⁸⁷ In addition, it bears emphasis that Cummins & Doherty have mischaracterized the notion of "stacking" policy limits, a term unfortunately borrowed from automobile insurance. This is common misunderstanding made even by commentators favoring the application of multiple policies and policy periods to multiyear torts.³⁸⁸

This attempted analogy suffers from a fundamental

387. See Heintz et al., *supra* note 371, at 6-8.

388. See, e.g., Thomas Baker & Eva Orlebeke, *The Application of Per-Occurrence Limits From Successive Policies*, 3 ENVTL. CLAIMS J. 411, Summer 1991, at 420-21; Gillespie, *supra* note 198, at 572-73 (comparing application of CGL policies in successive years to stacking of uninsured motorist benefits under multiple automobile coverage's in same policy period).

mischaracterization of risk. In the uninsured or underinsured motorist cases, the typical scenario has a policyholder who insures two or more cars with the insurer. Car 1 is hit by an uninsured driver, causing damage dramatically higher than the uninsured motorist benefits available in Car 1's insurance policy. The policyholder then seeks to collect Car 2's uninsured motorist benefits as well, arguing that both policies were purchased and a covered loss has occurred under one policy, activating the related policy. Many states permitted such stacking under older, more ambiguous versions of the standard auto policy. Subsequently, insurers amended auto policy forms to add anti-stacking language, and courts have routinely enforced such language to preclude stacking.³⁸⁹

The commercial liability situation is simply very different. In the auto stacking case, the insurer has issued one policy that covers a particular risk: the chance that Car 1 will be involved in an injury-producing event. The insurer also issues a policy for Car 2 that insures a different particular risk: the chance that Car 2 will be involved in an injury-producing event. Even in the absence of anti-stacking language, it would make sense for courts to prohibit stacking on the ground that the insurer has arguably made a separate valuation of the risk involved with insuring each car, attempted to limit its maximum liability for incidents involving the car, and calculated a corresponding premium specific to that car. Thus, the Car 1 policy and its risk is different than the Car 2 policy and its risk. It seems unfair then to saddle the Car 2 policy with the Car 1 risk and loss.³⁹⁰

By contrast, the typical CGL policies issued to a commercial policyholder over several years all cover the same type of risk: liability and claims against the policyholder. Only the time periods are different, and for each time period the policy in force takes on the risk of covered loss occurring during that time period. Consequently, if the event causing loss during the policy period causes loss in other policy periods, multiple policies are triggered. Cummins & Doherty concede this point.³⁹¹ When a policy is triggered

389. See *Hanson v. Prudential Property Cas. Ins. Co.*, No. 98-0692, 1999 WL 8391, at *1 (Wis. Ct. App. Jan. 12, 1999); *Magnifico v. Rutgers Cas. Ins. Co.*, 710 A.2d 412, 420 (N.J. 1998); *Willison v. Economy Fire & Cas. Co.*, 690 N.E.2d 1073, 1077 (Ill. Ct. App. 1998); *Hamic v. Doe*, 499 S.E.2d 619, 626-27 (W. Va. 1997).

390. However, the converse could be persuasively argued if auto insurers in fact tend to assess risk more by drivers or households insured rather than cars insured.

391. See Cummins & Doherty, *supra* note 369, at 18.

by a covered loss, it applies to the loss because it agreed to cover the occurrence or a portion of a large occurrence that implicates its coverage period. Once this happens, there is no unfairness in requiring each triggered insurer to pay so long as (a) it does not pay more than its policy limits; or (b) the policyholder is not over-indemnified.³⁹²

Thus, the CGL insurer in Years 1 through 8 of an eight-year tort is not being asked to do anything it did not agree to do at the outset: pay for defense and damages triggered by injury during its period of coverage. By contrast, the insurance policy of Car 2 is being asked for something it arguably did not agree to provide: insurance coverage for Car 1. Consequently, multiyear commercial liability occurrences make a far more compelling case for application of multiple policies than do auto policies.

In addition, Cummins & Doherty make a number of other arguably incorrect conceptual assumptions regarding the nature of insurance. Perhaps most egregiously, they have a narrow and inapt concept of insurance, stating that "[a]n insurance policy is an agreement between two parties to share risk."³⁹³ Although this definition is not strictly false or inaccurate, it misses the mark. All contracts allocate risk but not all contracts are insurance. Insurance, logically, must be something more than risk sharing or allocation in the broad sense. In addition, although the policyholder with deductibles, SIRs, or copayments shares risk, many policyholders think of themselves as removing risk (not sharing it) when they purchase insurance. Insurance is usually described as one party's agreement to suffer a certain but relatively small loss (i.e., the premium payment) in return for obtaining the insurer's agreement to cover the possibility of contingent but larger losses.³⁹⁴ By defining

392. This assumes that there is no showing of bad faith by the insurer. The existence of bad faith can justify requiring the insurer to pay more than the policy limits. Similarly, fraud by the policyholder can result in negation of coverage that would otherwise be available under the terms of the policy and the nature of the third-party claim.

393. Cummins & Doherty, *supra* note 369, at 19.

394. See ROBERT H. JERRY II, UNDERSTANDING INSURANCE LAW § 11, at 17 (2d ed. 1996). Professor Jerry stated:

It can be said, then, that *a contract of insurance is an agreement in which one party (the insurer), in exchange for a consideration provided by the other party (the insured) assumes the other party's risk and distributes it across a group of similarly situated persons, each of whose risk has been assumed in a similar transaction.*

insurance in this inapt manner, Cummins & Doherty move toward a biased outcome that requires policyholders to function as co-insurers even where they assumed no such role.

For example, Cummins & Doherty may be incorrect even in characterizing the deductible purely as an item of risk sharing. Although the deductible has elements of this, it also serves as a contract demand of sorts by the insurer and a means of behavior modification. For example, the insurer may be unwilling to write coverage without a deductible even where the insurer is willing to purchase a no-deductible policy, even at substantial costs. The deductible in many cases is not so much a measure of risk allocation but a means for reducing moral hazard, adverse selection, or excessive claims by the policyholder, particularly small claims that are administratively costly to the insurer.

If, instead of using the misleading Cummins & Doherty definition, insurance is more properly characterized as a means of trading the certain small loss of premium payment for protection against the contingent large loss, there is nothing wrong (in economic or ethical theory) with permitting liability policies covering multiple years to apply to a loss and pay in full up to their policy limits. The policyholder has paid the required premium, the policies have been triggered and losses have been incurred and paid for or are in the process of resolution. The large risk assumed by the insurer may turn out to be larger than the insurer would have preferred, but the insurer is still only being asked to honor its contract. There is no windfall to the policyholder, and no moral hazard in light of the inadequacy of the insurance to cover all liability claims.³⁹⁵

Id. at 17 (emphasis in original); see also ABRAHAM, *supra* note 2, at 2-3 (describing insurance as the process of risk transfer from policyholder to insurer, risk-pooling or diversification by insurers, and risk-allocation, again by insurers). Although it is true that the insurance policy operates to some extent to allocate risk among the parties (i.e., by setting forth what is or is not covered), as Professor Jerry and others have noted, all contracts allocate risk between the parties and thus this sort of risk allocation is not what makes insurance different than other contractual undertakings. See, e.g., JERRY, *supra*, § 10[d], at 16 (“[A]ll contracts either expressly or implicitly allocate risk in one way or another.”).

395. Moral hazard has been described in various ways but generally refers to a tendency to take less care when protected against financial responsibility for loss (by insurance, a benevolent parent or employer, etc.). Although the notion is today largely identified with this economic definition, the concept continues to carry some of the implications of its name: that insured parties may not only take less care but act recklessly, intentionally, or even nefariously in causing or ignoring losses. See generally, Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV.

Thus, when Cummins & Doherty state that "any allocation rule must respect the clear division between insured and self-insured risk," they are overstating the case.³⁹⁶ If the policyholder did nothing more than buy policies over several years, it has not really assumed for itself the risk that large losses will fall in years where it is not a self-insurer. Rather, the policyholder is simply buying the available coverage; it is not attempting to assume a significant personal risk. This is particularly true in the real world of 1970s and 1980s liability insurance, which had soft and hard cycles or mini-cycles. At many junctures, insurance was not available at all, available only with low limits, or available only at prices so high as to force self-insuring that the policyholder would have preferred to avoid.³⁹⁷

Similarly, when Cummins & Doherty state that "the economic function of insurance [is] to share the risk between the parties according to their respective abilities to bear that risk," they are mischaracterizing the process.³⁹⁸ Although some attempt to reach optimal allocation goes on, much insurance is purchased without a calculation of risk-bearing ability. The policyholder is more interested in obtaining coverage than finding an optimal risk-sharing arrangement. Many policyholders may see insurance as a means of jettisoning risk rather than allocating or sharing it. The policyholder may also be purchasing insurance because of a mandate imposed by the government, a lender, or a contractor. For the policyholder, the optimal arrangement is one in which the policyholder pays the required premium to be rid of the risk of a large claim, a multiyear claim, an employment claim, and the like. The policyholder wants to transfer risk, not to share it. The occurrence CGL purports to do this for each policy period. Consequently, limiting the policyholder to one year's worth of insurance in the face of a multiyear tort distorts the insuring arrangement. Prorating among insurers without adjustments for insolvency and exhaustion

237, 288-92 (1996) (concluding that the breadth and effects of the moral hazard concept are overstated and that a moral hazard has a limited impact in real world applications).

396. Cummins & Doherty, *supra* note 369, at 19.

397. Recall the asbestos coverage matter in which the court found that an industry-wide asbestos exclusion added to the CGL in the mid-1980s effectively prevented policyholders from obtaining coverage even if they so desired to pay for it. *See Stonewall Ins. Co. v. Asbestos Claims Management Corp.*, 73 F.3d 1178, 1202 (2d Cir. 1995).

398. Cummins & Doherty, *supra* note 369, at 19.

of policy limits further distorts the original insuring arrangement of the parties.

Related to this misconception is the Cummins & Doherty assumption that policyholders buy policy limits in the amount they desire and that any amount of loss above the policy limits is an upper level self-insured retention. Rejecting the findings of the *Owens-Illinois* court (and implicitly *Stonewall* as well), Cummins & Doherty suggest that “[l]ike any other economic transaction, insurance is always available at the right price.”³⁹⁹ This pronouncement flies in the face of recent history of “hard” liability markets.

In addition, Cummins & Doherty argue for something like a “sophisticated policyholder” defense without factual support. According to them:

An insurance contract is written when both parties agree on a set of mutually acceptable conditions. Usually, in the bargaining leading up to the sealing of contract, a wide range of coverage options and policy conditions are considered at different prices. Moreover, the parties to many general liability policies that incur continuous occurrence liabilities are often corporations that bargain on equal terms with insurers.⁴⁰⁰

Cummins & Doherty also appear to reject, at least for commercial policyholders, the time-honored rule of insurance policy construction: contra preferentem or construing contract ambiguities against the drafter. They theorize that “there are two blades to the pair of scissors that cuts the contract, and [therefore] the question ‘which blade did the cutting?’ is meaningless.”⁴⁰¹

399. *Id.* at 20.

400. *Id.*

401. *Id.* The footnote following the above quote provides another window on the Cummins & Doherty thought process through the non sequitur: “Within this bargaining process, it is routine for policyholders to seek deductibles. In some cases, the policyholder itself may seek to restrict coverage by means of upper limits.” *Id.* at 20 n.16.

The policyholder’s purchase of given amounts of insurance with differing requested deductibles hardly indicates a policyholder role in the design or wording of the liability policy. The policyholder, even in the pro-insurer world of Cummins & Doherty, is merely buying insurance “off the rack” and looking at price tags and attempting to select the blue suit it can afford (rather than the grey suit that costs substantially more). This hardly makes the policyholder a “co-tailor” of the insurance contract.

This view, and consequently a good deal of the argument for allocation to the policyholder, runs counter to the bulk of general contract theory, which posits that even among equal bargainers, one party is often responsible for contract language and, in close cases, this party should bear the brunt of any ambiguity in language that can not be resolved readily by resort to nontextual sources.⁴⁰²

Further, the Cummins & Doherty thesis that there is something illogical about having larger aggregate policy limits available for the multiyear occurrence also fails scrutiny. By definition, multiyear losses are usually large losses taking place over time in unusual circumstances. It stands to reason that the large losses would trigger more insurance policies and hence more coverage than smaller, more episodic torts or even large claims such as commercial liability litigation.

The degree to which Cummins & Doherty are willing to stretch in favor of insurers is revealed in their arguments in favor of proration to the policyholder. In the course of criticizing *Keene*,⁴⁰³ they inveigh against the *Keene* court's refusal to permit allocation of losses among covered and uncovered years, because the *Keene* approach:

retroactively creates insurance for the missing years (for which no premium was ever charged since no contract was ever written) and mandates that the involuntary insurer for these years is the firm which insured other years spanned by the occurrence. By symmetry, this reasoning could be reversed to suggest that the full loss should be allocated only across those years in which no insurance was purchased, leaving the insurers to escape all liability for any MYO [multiyear occurrence] in which there was a single year of self-insurance. The logic is just as tight and the equity considerations just as compelling as those used in *Keene*.⁴⁰⁴

402. See E. ALAN FARNSWORTH, *CONTRACTS* § 7.11, at 518 (2d ed. 1990); Jeffrey W. Stempel, *supra* note 266, at 846-49 (stating that courts have been reluctant to abandon the contra proferentem approach to contract interpretation even where the party that did not author unclear language, is sophisticated, or has bargaining power or wealth).

403. *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981) (applying general legal principles).

404. Cummins & Doherty, *supra* note 369, at 19.

The above-quoted argument is as outrageous as it is bizarre. Imposition of financial responsibility for insured losses solely on the policyholder merely because of some "gap" years would completely vitiate the insurance contracts concededly in place for most years of a multiyear occurrence. Each of these policies must impose at least some responsibility on the insurer when triggered. Whatever their common ambiguities, insurance policies are at least clear on this point. As even Cummins & Doherty concede, an injury that takes place across years triggers applicable policies. By definition, then, these policies must pay something. The insuring agreement does not permit the insurer to avoid all payment simply because the policyholder was without insurance in a different policy year. Only the most extreme insurer advocate would take such a position.⁴⁰⁵

Continuing to function as industry apologists, Cummins & Doherty also argue against the holdings of *Owens-Illinois* and *Stonewall* that there be no proration to the policyholder for periods when insurance was unavailable. According to them, "insurance is always available at the right price."⁴⁰⁶ This assessment is the academic equivalent of Judge Martin's trial court holding in *Stonewall* that the asbestos makers "bargained away" coverage through purchasing insurance coverage after 1985 that contained nonnegotiable asbestos exclusions. The Second Circuit reversed this assessment because of its unrealistic view, a view that becomes no more realistic when enunciated by Cummins & Doherty.

Pushing their views to an extreme, Cummins & Doherty then argue that proration to the policyholder should not be mitigated through recalibrated proration when an insurer's assigned portion of the loss is unavailable for payment because of policy exhaustion

405. This portion of the Cummins & Doherty article can be viewed as rhetorical and aimed at attacking *Keene* so as to not literally represent their views. The entire article, after all, advocates shared apportionment rather than apportionment only to the policyholder. But I am disinclined to give Cummins & Doherty this favorable a reading. Although *Keene* can be responsibly attacked as permitting the policyholder too good a deal, it is fallacious to argue that permitting all triggered insurers to escape responsibility altogether is merely a conversely similar good deal for insurers. On the contrary, total proration to the policyholder completely destroys the insurance promise that was made, while the absence of proration merely demonstrates a judicial preference for resolving a tough case on the basis of policy language, the insuring relationship, and public policy grounds rather than on the basis of concern that proration to the policyholder is necessary to combat adverse selection and moral hazard.

406. Cummins & Doherty, *supra* note 369, at 20.

or insurer insolvency. According to them:

In the case of insolvent insurers, the loss should be assigned to the insured rather than to solvent insurers covering the insured in other years of the trigger period. In a competitive insurance market, the price of insurance reflects the probability that the insurer will become insolvent, so safer insurers command higher prices and riskier insurers receive lower prices. In buying insurance, policyholders are aware of the possibility that the insurer may become bankrupt, and this possibility plays a role in the choice of insurer. It is part of the mutual understanding between the two parties that the risk reverts to the policyholder in the event of the insurer's insolvency. . . . [For the solvent insurers, t]he agreement between these insurers and the policyholder was to cover losses arising from periods when they provided coverage, not from periods when other insurers were on the risk. Likewise, the premiums paid to the solvent insurers did not contemplate their paying claims for policy years when they were not on the risk.⁴⁰⁷

This argument is refuted on the grounds previously discussed, which refute the notion of proration to the policyholder in general.⁴⁰⁸ But it is particularly galling to argue that the policyholder should pick up the tab for insolvent carriers when that same policyholder has yet to fully reap the benefits of other triggered policies which it purchased and which by definition cover the loss in question. Even if the Cummins & Doherty risk assumption argument is correct (and it is not), the policyholder has implicitly "agreed" only that it can not expect to collect from the insolvent carrier. The policyholder never imagined—let alone agreed—that it would be forced to forgo benefits from solvent insurers because the claim against the solvent insurers is related to a claim against an insolvent insurer. There is simply no connection.

Proration, therefore, completely undermines the insuring agreement and the policyholder's expectations in cases of multiyear occurrences and insurer insolvency. Even in states like Minnesota that do not embrace the classic Keeton formulation of

407. *Id.* at 37-38.

408. *See supra* Part III.B.

the reasonable expectations doctrine, expectations analysis is used to resolve ambiguous policy language and can be invoked to override even clear text where the text is deceptive or operates in the nature of a hidden exclusion.⁴⁰⁹ The entire allocation conundrum proceeds precisely because there is no on-point text in the policy. Thus, expectations analysis is particularly apt and favorable to the policyholder as the insolvent insurer situation both lacks policy language favorable to the insurer and, if applied as urged by Cummins & Doherty, operates like a hidden exclusion or limitation on coverage in that it imposes a reduction in coverage *ex post facto* on the policyholder.

In addition, the Cummins & Doherty view of the market realities of insurer insolvency seems incorrect. As noted in one policyholder counsel's rebuttal,⁴¹⁰ studies reflect no difference in premium among insurers of varying solvency or financial strength. In addition, an outsider has difficulty evaluating insurer strength notwithstanding the availability of Best's, Moody's, and Standard & Poor's. Several once highly-rated insurers have become insolvent. State regulators are supposed to police insolvency but do an inevitably imperfect job, particularly so because insufficient resources are usually committed to the task by insurance departments and state legislators. Some insurers appear falsely sound because of misrepresentations or carelessness in preparing financial statements, but this may not be noticed by regulators or raters. Under the circumstances, policyholders can hardly be blamed for assuming that any admitted insurer or carrier with decent private ratings is an insurer who will be available to pay if the policy is triggered.

In addition, the Cummins & Doherty "let them eat cake" position on insolvency is also in part the product of their failure to appreciate that large multiyear torts are in fact qualitatively different types of covered occurrences. If we were to assume an ordinary episodic liability claim arising shortly after the insurance went into effect, the Cummins/Doherty view might make sense. If the policyholder buys a policy from Company A in 1980 and the loss occurs in 1981, it might be reasonable to argue that the policyholder knew enough or should have known enough about the insurer's condition to be charged with some responsibility for the insurer's inability to pay claims in 1981. But when the policyholder buys insurance

409. See *supra* notes 293-98 and accompanying discussion.

410. See Heintz et al., *supra* note 371, at 20.

from Company A in 1957 and undetected injury during 1957 prompts a claim in 1987, the policyholder can hardly be retroactively charged with constructive knowledge and risk bearing of the insurer's financial condition 30 years in the future. Too much time has passed to seriously argue that the policyholder "had it coming" because it bought occurrence insurance from a company that was unable to pay years later.

The Cummins & Doherty thesis and the arguments of others urging proration to the policyholder also tends to muddy the distinction between occurrence and claims-made coverage. Under occurrence coverage, of course, the policyholder has purchased unlimited prospective protection regarding any injuries occurring during the policy period. The policyholder could stop buying insurance and it would forever have insurance coverage for losses caused by an occurrence during that initial policy year. Many businesses that cease operations or are sold do just that if they have solid occurrence coverage in place: they decline to purchase further insurance. There is no need to keep buying insurance to cover the potential tail claims stemming from any injuries during the policy period. This, of course, is why occurrence insurance is generally much more popular than claims-made insurance and dramatically more popular with merchants or professionals who wish to retire without continuing to buy claims-made insurance until death (or for their estates or heirs after death). The mid-1980s switch to claims-made product liability coverage was consequently opposed by most manufacturers and many state regulators. The effect of the switch, even with no or liberal retroactive dates, was not only to limit the scope of the insurer's risk, but also to require the policyholder to keep claims coverage in force forever lest claims should arise decades after an initial injury.

When courts require proration to the policyholder, particularly in the Cummins/Doherty manner that provides no escape hatch for insurer insolvency or unavailability of insurance, they in effect require the policyholder to continue to purchase insurance year after year after year even when no significant risk is apparent. Where covered losses are reallocated from insurers to a policyholder, the practical effect is to require the policyholder to keep buying insurance just as that policyholder would need to under a claims-made system.

In addition, the policyholder must continue to buy lots of insurance. If it fails to do so, it could end up woefully uninsured if

ever faced with a multiyear mass tort. As other commentators observe:

[T]he [Cummins & Doherty] model and *Owens-Illinois* create the unfair result by, in essence, requiring the policyholder to buy insurance each year to maintain the full value of earlier coverage limits. This result is not only unfair, it makes little economic sense.⁴¹¹

Judges following the Cummins & Doherty approach would limit the policyholder to the policy limits of a single year even though the policyholder had paid and paid and paid for continued coverage. Furthermore, the policyholder must invest substantial resources in hoping to purchase insurance only from carriers who will be solvent for decades to come. Thus, another oft overlooked and odious effect of proration is that it converts occurrence coverage into claims-made coverage, a move that clearly violates policyholder expectations and resolves a difficult situation in favor of insurers rather than policyholders, totally reversing standard insurance law doctrine.

In addition, courts following this approach give insurers something of a "free" victory through adjudication when insurers themselves seem not to have expected or felt entitled to this victory since they expended considerable effort in the executive and legislative arena to switch to claims-made forms in the 1980s. Because risk distribution is the primary expertise of insurers, it is the insurance industry rather than individual policyholders who should shoulder the close or debatable liabilities engendered by the multiyear occurrence. Insurers facing these responsibilities have the right of allocation against each other and are also protected by deductibles, policy limits, and reinsurance.

To be sure, other commentators have supported proration, but most have accepted that adjustments should be made according to solvency and remaining insurance available under losses subject to proration.⁴¹² To a large degree, commentary favoring alloca-

411. *Id.* at 24.

412. See, e.g., Yin, *supra* note 109, at 1276-78 (arguing for proration to policyholders for years of self-insurance, but with an adjustment for insurer insolvency; unclear about adjustment for exhaustion of some triggered policies); *Developments in the Law—Toxic Waste Litigation*, 99 HARV. L. REV. 1458, 1583-84 (1986) (advocating allocation by hybrid of time on the risk and the policy limits, with a proration

tion generally, and to policyholders in particular (save perhaps for the Cummins & Doherty article), has not advanced substantially beyond the Hickman & DeYoung article cited by the Minnesota Supreme Court in *NSP: Allocation of Environmental Cleanup Liability Between Successive Insurers*.⁴¹³ This article, despite some flaws, rendered a largely accurate picture of the judicial approaches to allocation then used. Although largely pro-insurer, Hickman & DeYoung refrain from extreme or erroneous statements in the vein of the Cummins-Doherty article. According to Hickman & DeYoung, a court allocating by time on the risk "will likely allocate liability to the insured proportionate to the period of time it was uninsured."⁴¹⁴

Hickman & DeYoung endorse a textualist approach examining the particulars of the insurance policies rather than adopting a formula on the basis of public policy. Although they imply that the contractualist approach favors insurers (largely because, in their view, it precludes cases like *Keene*, which permitted the policyholder to select and order the response of the insurers), subsequent debate suggests that, if anything, a strict textual approach to all sums policies will favor the insured more often than it favors the insurers on questions of apportionment.

Additional recent commentary has rejected proration, concluding that "the case *against* proration carries more weight."⁴¹⁵ In particular, this author finds allocation cases such as *Owens-Illinois* disturbing because of the practical impact of their rejection of the venerable ambiguity rule favoring the policyholder when disputes arise because of unclear policy language. "After all, why should drafters bother to formulate clear policy terms if courts will cast aside *contra proferentem* and come to their rescue with public policy arguments?"⁴¹⁶

As this author also notes:

The insurance industry drafted the policies over which the millions and millions of dollars have been spent to deci-

formula applying to policyholders for self-insured periods).

413. Hickman & DeYoung, *supra* note 98, at 314-15.

414. *Id.* at 313 (citing *Fireman's Fund Ins. Cos. v. Ex-Cell-O Corp.*, 662 F. Supp. 71 (E.D. Mich. 1987) and *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 451 F. Supp. 1230 (E.D. Mich. 1978)).

415. Gillespie, *supra* note 198, at 574.

416. *Id.* at 579.

pher through court battles. The simple reality is that if the policies had been clear, minimal litigation would have occurred. This fact argues for the use of *contra proferentem*. That doctrine spurs carriers to create clear policy language, because if they produce unclear terms, courts will interpret them in a pro-coverage manner.⁴¹⁷

V. A MORE REASONABLE AND RATIONAL APPROACH TO APPORTIONING COVERAGE RESPONSIBILITY

Although *Domtar* is a potentially disastrous ticket to unfairly depriving policyholders of coverage, the error of its allocation scheme stems from legitimate concerns about the efficiency and equity of insurance coverage in complex, multiyear torts involving both ongoing progressive damage and new injury occurrences over time. In these situations, *NSP* and *Domtar* are clearly correct in holding that the law does not require a baroque inquiry into the exact quantum of injury and ensuing damage taking place at particular junctures in a coverage saga such as asbestos or pollution matters. But, as demonstrated in this article, a rigid allocation formula holds similar potential for waste and inequity.

Insurers will try to make strategic use of the *NSP/Domtar* allocation formula. One tactic employed by insurers even prior to *Domtar* was an argument that *NSP* required proration of coverage responsibilities into years when the policyholder was able only to obtain claims-made coverage after a certain time. The practical effect of this insurer position would be to allocate coverage into years where the policyholder could not have purchased insurance no matter how hard it tried. To the extent that use of an *NSP/Domtar* allocation formula forces the policyholder to look only to certain insolvent insurers in particular years to which coverage responsibility has been rigidly prorated, the allocation operates to deny coverage,⁴¹⁸ a direct violation of the venerable maxim that forfeitures of insurance coverage are not favored in the law.

Even if insolvency is not a problem, a policyholder faced with judicially imposed limits on where it can look for coverage may find

417. *Id.* at 578-79.

418. See James F. Hogg, *The Tale of a Tail*, 24 WM. MITCHELL L. REV. 515, 553-58 (1998) (making the point that the effective loss of coverage by operation of law occurs due to an industry-wide switch to claims-made forms, but the point is applicable where allocation extends into time period where insurance coverage is marred by insolvency or has been previously exhausted by claims).

that the insurance in certain years of the allocation formula has been exhausted through other claims. In this instance, the policyholder is left holding the metaphorical bag, unable to collect some insurance that has already been used in some allocation years and barred by *NSP/Domtar* allocation from seeking unspent coverage from other triggered insurers in other triggered years. In addition, insurers may argue that *NSP* (and now *Domtar*) requires the court to adjudicate the issue of relative insurer coverage responsibility and applicable allocation of coverage among insurers and the policyholder. This effort can result in more than a little motion practice, delay, and expense in the case.

The ongoing continuation of triggered damage does not make the triggered insurer any less responsible for the claim. This should be the case even if the *NSP* and *Domtar* allocation doctrine remains unchanged. The pollution in those cases was found to bring new injury in different years rather than continuing injury from the events of a single year. Nonetheless, the 3M insurers' argument, based on the "during the policy period" language of *NSP* and *Domtar*, appears to have given the trial court additional pause. Four years after their insurers raced to the courthouse to attempt to avoid providing coverage, 3M's dispute with the forty-four insurers who filed the amicus brief in *Domtar* and who wrote hundreds of millions of dollars of coverage for (and collected corresponding premiums from) 3M remains pending.

Insurance coverage law should prevent delaying tactics, unreasonably protracted insurer-policyholder litigation, and unexpected coverage reductions without a clear basis in the policy as well as windfalls to either insurer or policyholder. The *NSP/Domtar* allocation scheme appears to fail these tests. A better approach would retain the relative simplicity and efficiency wrought by a formula or per se rule, prevent overindemnification, and permit the policyholder to receive the benefits of purchased insurance.

The best means of satisfying these objectives is no formula. Rather, the policyholder, once having shown that coverage is triggered, should be able to call on any triggered insurer for coverage. Each insurer would, of course, be limited in its responsibility by the policy limits (both per occurrence and aggregate limits), as well as by any applicable exclusions and reductions in coverage for amounts spent on defense, investigation, or mitigation if so provided in the policy language. In cases where several years of insurance policies are triggered, the policyholder should be allowed to

approach the insurers for coverage in any order desired by the policyholder absent specific and clear policy language revising this prerogative.

After an insurer has provided coverage (both payment for defense and payment of liability), the insurer retains a right of indemnity as against other triggered insurers. In determining the relative responsibilities of triggered insurers vis-a-vis one another, use of an allocation formula makes perfect sense. However, the apt formula is one that considers both time on the risk and the policy limits provided by the respective insurers. The apportionment of relative coverage responsibility among the insurers should not delay payment or provision of a defense to the policyholder. However, a lead insurer (e.g., the first insurer approached and required to provide a defense) should in appropriate protracted, complex, or expensive cases be permitted to seek interim payments from other triggered insurers or to obtain an award of interest on these expenditures from insurers who were able to sit on the sideline during the early stages of multiple-year tort litigation. This form of inter-insurer apportionment vindicates the judicial interest in efficiency and equity without depriving the policyholder of coverage. Because the policyholder is permitted to determine the order in which coverage is sought, no special rules of apportionment are required to account for time periods when some applicable insurance is unavailable due to insolvency or exhaustion due to other claims.

This proposal is, of course, essentially what the D.C. Circuit suggested in *Keene*⁴¹⁹ nearly two decades ago during the relative youth of today's modern mass tort insurance coverage litigation. *Keene* has been subjected to predictable criticism by insurers as too friendly to policyholders.⁴²⁰ *Keene* has also been erroneously labeled

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

420. But *Keene* did state that only one insurance policy should be applicable to a triggering claim, suggesting that a claim for serious injury might exceed applicable policy limits and that the policyholder would be unable to look to other policies for coverage even if the claim involved injury in other policy periods. *See id.* at 1049-50. In a sense, then, my proposal is more favorable to policyholders than *Keene*. However, this is justified in cases where more than one triggering injury takes place to the same claimant in more than one policy year and the total damages from the injuries exceed any one policy limit. In such cases—surely rare—the policyholder is entitled to tap the other triggered policies. This point appears to have been recognized in the subsequent history of the actual *Keene* case, where (according to my conversation with knowledgeable counsel) multiple policies were utilized to satisfy claims.

a decision providing for "joint and several" liability of insurers.⁴²¹ However, as detailed in this article, a *Keene*-like approach with allocation among triggered insurers simply permits the policyholder to receive coverage to which it is entitled by contract and for which it has paid premiums. The allocation among insurers that takes place after the policyholder has received policy benefits is not disproportionate as in the case of joint and several liability, where a one percent negligent manufacturer must pay 100 percent for what was mostly the negligence of a slipshod but impecunious small construction company or individual. Rather, the insurers pay according to time on the risk and policy limits written, both factors particular to each insurer. No insurer pays disproportionately in relation to its own stake in the case and its own agreement to bear risk.

Minnesota courts may have been irrevocably brainwashed by the "joint and several" liability criticism of *Keene* fueled by insurers and may be unwilling to permit policyholders complete discretion over the manner in which policy proceeds are collected and insurer defense obligations initiated. But one need not embrace *Keene's* approach in order to improve significantly on *NSP* and *Domtar*. All that is required is a rule providing that no amount of coverage responsibility be allocated to the policyholder unless the total amount of liability exceeds the applicable triggered insurance. When triggered insurance is exhausted, of course, there is no further need for allocation to the policyholder. By definition, payments not covered by insurance must come from the policyholder.

In determining the manner in which the policyholder is permitted to draw upon triggered insurance in cases where the total insurance exceeds the costs of the triggering claims, allocation by time on the risk and policy limits is appropriate—so long as the allocation formula is recalibrated to account for previously consumed insurance and insurance uncollectible because of carrier solvency. This permits the policyholder to enjoy more of its purchased insurance coverage but does not require any insurer to provide coverage that was not already promised in the insuring agreement, which simply states that the insurer is responsible where an injury takes place during the policy period. Insurers writing these policies knew all along that they were at risk of paying the full policy limits if triggering injury took place. Insurers were paid for as-

421. See *supra* notes 98, 194-95 and accompanying discussion.

suming this risk, sometimes quite handsomely. They should not be heard to complain if their contribution and indemnity from other insurers is reduced because of the insolvency of some insurers.

The economic and other policy arguments made by insurers in favor of allocation of coverage responsibility to the policyholder are flawed in logic or premised on doubtful or even erroneous presumptions. Despite the high profile of recent cases such as *Domtar*, the more persuasive intellectual case weighs against proration to the policyholder, except perhaps in extreme cases where the policyholder's scanty insurance can be shown to be a calculated attempt to purchase insurance for a known or highly expected loss at an advantageous premium. If a policyholder has engaged in such behavior, the "expected or intended" defense, the "known loss," or the "lack of fortuity" defense is the applicable avenue of analysis. If none of these fortuity defenses applies, the policyholder is entitled to receive the insurance benefits for which it paid.

In addition, the approach suggested in this article creates incentive for insurers to more carefully underwrite risks (to attempt to avoid signing onto the risk of a portion of a multiple-year tort) and to consider the policyholder's risk management behavior in other years (to avoid being unable to obtain indemnity from a triggered but insolvent insurer in another year when injury occurred). Insurers are in at least as good a position to assess risk exposures and the quality of other insurers as is the policyholder. Revising *NSP* and *Domtar* in the manner suggested would thus appear to foster more prudent insuring decisions at the outset. Under *Domtar*, insurers have too much incentive to write coverage, bank the premiums, and litigate excessively in an attempt to persuade courts to reduce the insurer's exposure by judicially imposed proration by time on the risk alone.

VI. CONCLUSION

Examining the recent history of allocation law in Minnesota reveals a state jurisprudence where historical concern for the underdog has somehow performed the proverbial 180 degree somersault. Driven by a misplaced and miscalibrated concern for fairness to insurers and formulaic consistency, the Minnesota Supreme Court has made a classic wrong turn and adopted a doctrine that works substantial unfairness upon policyholders and the insurance-purchasing public.

Ironically, Minnesota courts remain possessed of a strong im-

pulse to achieve fairness and equity in insurance coverage matters as in other areas of the law. But in *Domtar* that impulse is applied in the service of the insurance industry and against policyholders notwithstanding policy language and other interpretative factors to the contrary. It is as if the insurance industry has miraculously morphed into an archetypical underdog requiring the special protection of the court—a most odd result.⁴²²

There is no good reason of contract law, equity, or public policy that justifies a reduction in the policyholder's coverage simply because it is the victim of multi-year claims by third parties rather than more typical liability claims. But *Domtar* punishes the policyholder unfortunate enough to be faced with such events. Liability insurance is supposed to remove or mute the ravages of such fortuity. *Domtar* only exacerbates it.

422. A significant amount of the current coverage literature is written by policyholder counsel and insurer counsel—with the twain meeting only on occasion. Both policyholder and insurer lawyers have engaged in more than a little rhetorical posturing. From the perspective of some policyholder counsel, all insurers sometimes seem to be part of a vast Ponzi conspiracy where premiums are received but coverage is extracted only after protracted litigation against a united industry front. Many insurer counsel seem to see a world where most claimants are attempting fraud against the insurer or are using insurance as a means to reckless behavior.

Although there is of course partisanship on both sides, the stridency of the insurer rhetoric is notable. For example, policyholders seeking coverage are routinely labeled “tortfeasors” or “polluters.” See Foggan & Yang, *supra* note 372. This is hardly the portrayal of insurer advertisements or other promotional material. There, a more realistic view obtains: the policyholder is simply a customer protecting itself from the ravages of modern litigious society. Although inconsistency between a sales arm and a service arm of a company is hardly news, insurers owe something more to their clients and the public. Rather than attempting to make insurance coverage a morality play, insurers should focus on efficient resolution of cases, making appropriate compromises, revising policies and disclosures in the future to minimize coverage litigation.

In any event, the notion that insurers are the poor sheep victimized by unscrupulous policyholders absent judicial intervention to help insurers through doctrines like allocation by time on the risk is belied by common sense and everyday review of the days' news. See, e.g., John D. McKinnon, *Insurer Eyed Regulator's Love Life*, WALL ST. J., Sept. 30, 1998, at F1 (describing seeming insurer efforts to obtain embarrassing information about state employee in order to, according to a state official, “find information that would let them manipulate state decision making”).