Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute

Jeffrey W. Stempel
University of Nevada, Las Vegas – William S. Boyd School of Law
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INTRODUCTION, OVERVIEW, AND SUMMARY

Asbestos is perhaps the penultimate mass tort. It involves millions of victims and purported victims, thousands of defendants, hundreds of insurers, years of litigation, countless hours and transaction costs. As one commentator observed, the asbestos mass tort invites inevitable comparisons to the Ever-Ready Battery television commercials featuring the "Energizer Bunny," a toy that, at least when powered by the advertised battery, keeps going and going and going in seeming perpetuity.1

Although such scenes make for memorable product advertisements, there is nothing amusing about the asbestos mass tort. Almost everyone agrees that the asbestos situation has been too prolonged, too costly, too wasteful, and a not-so-great monument to the failures of the American political and legal systems. One commentator labeled asbestos the "tort that ate the Constitution" because of the pressure asbestos cases put on courts to relax traditional adjudication procedure.2 Just as it seems the asbestos mass tort had appeared to run its course, a new wave of mass litigation against previously peripheral asbestos defendants took root, placing new pressures on asbestos handlers and distributors as well as on liability insurers that wrote liability coverage for these peripheral asbestos defendants as well as major manufacturers. As Deborah Hensler puts it

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* Doris S. & Theodore B. Lee Professor of Law, William S. Boyd School of Law, University of Nevada Las Vegas. Special thanks to Symposium organizers Tom Baker, Deborah Hensler, and Adam Scales as well as to other Symposium participants and thanks also to Ann McGinley. This project was supported by a grant from the James E. Rogers Research and Scholarship Fund. Some of my views on insurance coverage issues relating to asbestos claims were formed in the course of examining these issues as an expert witness or consultant, primarily for policyholders who manufactured, sold or used asbestos in some form.


well: "People in the 1980s used to wonder what mass tort would be the
‘next asbestos’; it turns out that asbestos was the ‘next asbestos.’" 3

What the participants in this long-running asbestos drama cannot seem
to agree upon, of course, is the assignment of blame. Asbestos victims,
plaintiffs, their counsel, and consumer groups tend to blame the asbestos
industry, government, defense lawyers and insurers. Asbestos defendants
tend to blame the plaintiff’s bar, government, and insurers. Insurers tend to
blame policyholders, plaintiffs, and their respective counsel.

These issues of tort liability and civil dispute resolution have tended to
dominate discussion of the asbestos mass tort. Often overlooked are the
insurance issues related to asbestos and the degree to which the asbestos
mass tort has changed the face of liability insurance and liability insurance
law. The asbestos mass tort brought insurance coverage litigation into the
big leagues of litigation, adjudication, and scholarly examination (although
even the most rabid insurance coverage junkie would concede this is not
much silver lining to the asbestos cloud). But after 30 years of big-time
liability insurance coverage litigation involving asbestos or influenced by
asbestos, what is the outcome? My assessment is

1. Despite their protestations, insurers have not been
unfairly treated by the judiciary’s adjudication of asbestos-
related insurance matters, although their success in public
relations has left many with the impression that the insurance
industry was handed too stiff a tab due to the legal system’s
desire to maximize available compensation for the asbestos
mass tort;

2. Insurers themselves, in designing the comprehensive or
commercial general liability ("CGL") policy that has been
the focus of so much insurance coverage disputation,
willingly took on the asbestos coverage risk, even if they did
not specifically anticipate or fully appreciate the exposure
they had embraced;

3. Insurers have survived the asbestos mass tort to date and
will, when the final tally is finally tallied, have weathered
the financial aspect of the asbestos storm quite well;

3. See Deborah Hensler, Remarks at the University of Connecticut School of Law
also Deborah Hensler, Asbestos Litigation in the United States: Triumph and Failure of the
4. With all its faults, the asbestos mass tort has significant traits tending to advantage insurers. Adjudication and payment of the claims has extended over decades, postponing payment. This allows insurers to garner years of investment income and to pay claims in dollars whose real value has been substantially reduced by inflation. By contrast, other catastrophes such as Hurricane Katrina and September 11 require insurers to pay covered claims within a relatively short time frame in which the insurer gets far less benefit from either investment income or the effects of inflation;

5. In spite of the limited adverse impact of asbestos upon insurers, the insurance industry has successfully portrayed itself as a victim not only of the asbestos mass tort but also of judicial decisions favorable to policyholders. This in turn has made the judiciary more receptive to insurer arguments against coverage, in both asbestos and non-asbestos matters;⁴ and

6. The asbestos mass tort provided insurers with something of a baptism of fire for modern liability exposures and has enabled the insurance industry to structure its products and behavior in a manner reducing its future exposure. Although there may someday be a “next asbestos” for tort law, there will not likely be a next asbestos for the insurance industry.

Insurers, having already paid billions of dollars in asbestos claims and defense costs, are understandably upset about continuing to face ongoing asbestos coverage liability, as they have been from the earliest days of the asbestos coverage litigation, which began in earnest with the Insurance Company of North America v. Forty-Eight Insulations, Inc.⁵ and Keene Corporation v. Insurance Company of North America⁶ litigation. Although

⁴. See infra text and accompanying notes 180-245.
⁵. 633 F.2d 1212 (6th Cir. 1980) (applying Illinois and New Jersey law).
⁶. 667 F.2d 1034 (D.C. Cir. 1981), cert. denied, 455 U.S. 1007 (1982). Forty-Eight Insulations and Keene are generally viewed as the lead cases that ushered in the modern era of high-stakes insurance coverage litigation. They were the first major federal appeals court cases focusing on the issue of the “trigger” or inception of insurer obligation for so-called “long-tail” tort claims that do not result in tangible injury or claims until years after the
I am not suggesting that asbestos has been "good" for insurers, I am suggesting that much insurer bemoaning of the ravages of asbestos claims has a quality of crocodile tears.7

In addressing the history and implications of the asbestos mass tort, one must inevitably address insurance coverage questions surrounding asbestos and the question of whether insurers asked to respond to asbestos claims have paid more or less than their cosmically and contractually "fair share" of this oppressive social burden. Professor Adam Scales has observed that the asbestos situation is "almost perfectly-suited for disrupting liability insurance markets and the expectations of insurers."8 His view, at least as I interpret it, is that insurers have been required to pay too much for the asbestos problem and that during the course of three decades of insurance coverage litigation, insurers have found themselves faced with a body of law that is different than anticipated at the time they wrote the general liability policies implicated by the asbestos mass tort and that this factor—and insurer expectations generally—should have been given more consideration by courts adjudicating asbestos-related coverage disputes than has been the case.

The magnitude and longevity of the asbestos problem undoubtedly caught the insurance industry by surprise. To that extent, I agree with Professor Scales. But I am in disagreement to the extent that he may be

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7. One can even make quite a persuasive case that the asbestos mass tort has indeed been "good" for insurers because it prompted insurers to redesign the CGL to their advantage and to be more alert to potential mass tort liability exposures. Friedrich Nietzsche’s observation, "that which does not kill me makes me stronger," resurrected by Professor Tom Baker, makes this point well. See Tom Baker, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005). In addition, as Professor Baker and insurers have noted, the happening of a large loss tends to make policyholders more conscious of risk and more willing to buy more insurance at higher premiums. See id.; Jeffrey W. Stempel, The Insurance Impact of September 11, 37 TORT & INS. L.J. 817, 878-79 (2002) (noting comments of insurance executives and analysis that disaster tends to be good for spurring insurance sales and attracting capital, with longer term benefits even if short term effect is to increase indemnity payments and reduce profits).

8. E-mail from Adam Scales, Professor, University of Connecticut School of Law, to other participants in connection with the 2005 Program of the Insurance Section of the Association of American Law Schools (AALS) (Dec. 8, 2004) (on file with author).
suggesting that asbestos coverage outcomes have exceeded the scope of the insurance industry’s contractual commitments made in the CGL and other liability policies—or that insurers have been treated “unfairly” by courts or the American judicial system. Insurer coverage burdens in this area result not from any disregard of principles of contract or equity but instead stem from the peculiar factual and legal properties of the underlying asbestos mass tort. The asbestos-related financial obligations of insurers result from what has largely been correct judicial application of basic legal principles and not from any result-oriented radical changes in tort law or insurance coverage jurisprudence.

Regarding asbestos and insurer expectations, examination of liability insurance background materials and the development of the occurrence-based CGL policy suggests that insurers were fully cognizant of the possibility that a given third-party claim could trigger multiple consecutive policy periods. Insurers writing comprehensive or CGL coverage certainly understood that they were agreeing to insure injuries that took place gradually over time. In addition, insurers understood when providing general liability coverage that they were obligating themselves to provide both (a) general premises-operations liability coverage and (b) products/completed operations coverage in cases where there was product-related injury to third parties stemming from either ongoing policyholder operations, products sales and distribution, finished construction products, or any combination of these factors.

Unfortunately for the insurance industry, it did not foresee that a particular harmful substance such as asbestos might be able to both cause immediate actual injury upon exposure and to continue to cause new injury during subsequent years after inhalation or ingestion, and to do so on a large scale. As a result, many insurers were probably genuinely surprised to see courts so widely adopt a continuous trigger of coverage in so many cases. But insurers were generally cognizant of the possibility of long-tail, continuous trigger claims and accepted this risk in return for being able to market a broad comprehensive liability cover and capture additional premium dollars that could be profitably invested.

In addition, insurers may have been genuinely surprised that the same substance could lend itself so readily to (a) inflicting new injury during so many policy periods and triggering so many policies; (b) that the asbestos mass tort would have so many individualized injury scenarios, thus making for more “occurrences” under liability policies with per-occurrence limits; and (c) triggering general premises liability claims (e.g., from asbestos released during construction and related operations or building cleanup) as well as products/completed operations hazard claims (e.g., when third
parties sued asbestos insulation makers or builders that had improperly installed asbestos-containing products). Insurers were probably also genuinely surprised when so many of their policyholders sought bankruptcy protection, which potentially accelerates the when payment under policies is due.

When the magnitude of the asbestos problem exceeded expectations and investment income fell below expectations, insurers were left with an expensive piper to pay—but this was a risk insurers took on decades ago in what seemed to them a profitable move at the time. Although the reasonable expectations of insurers deserve consideration approaching that of policyholders, asbestos insurance coverage rulings by most courts do not violate the objectively reasonable expectations of insurers in light of the history and background of the comprehensive general liability policy and the broad insuring language selected by the industry.

Despite being required to provide considerable asbestos coverage, general liability insurance as a whole has been a profitable venture from 1943 to the present (the time of the reign of the CGL policy) at the very time that asbestos use and asbestos litigation and coverage litigation flourished. Asbestos appears not to have been an insurmountable problem for insurers, despite the failures of Congress to enact a legislative solution to the asbestos mass tort.

Section I of this article describes the background of the CGL policy. Section II addresses the question of the burden of persuasion when exclusions to the policy’s coverage are at issue. Section III focuses on the trigger of coverage and the insurance industry’s understanding that multiple CGL policies could apply to tort claims involving hazardous material and other sources of injury. Section IV explains how a standard approach to determining the number of occurrences also worked against insurer efforts to limit CGL coverage for asbestos claims. Section V focuses on the distinction between general operations liability and completed operations liability, and the lack of an aggregate policy limit for the latter during many of the years when asbestos exposure was at its height, a drafting error that in hindsight prevented insurers from obtaining maximum premiums and increased asbestos coverage to at least a significant degree. Section VI addresses the issue of policyholder identity and its potential impact on asbestos coverage. Section VII describes an additional threat to insurers, the risk that policyholder bankruptcy may accelerate the time of payment. Section VIII describes some substantial countervailing judicial victories obtained by insurers, which were arguably if not clearly undeserved and in my view resulted in part from unconscious judicial sympathy for insurers. Section IX describes the degree to which
the asbestos coverage experience has made the insurance industry better insulated from similar future coverage obligations. Section X considers whether in the balance of these events, insurers have been unfairly required to provide substantial coverage to asbestos defendant policyholders.

I. THE BACKGROUND AND DEVELOPMENT OF THE CGL POLICY

The Comprehensive General Liability policy (since renamed a "Commercial" General Liability Insurance Policy by the insurance industry in 1986 in order to avoid the broad coverage connotation of the word "comprehensive") has its roots in the 1930s and was established during the 1940s.9 The first standardized CGL form, crafted by the National Bureau of Casualty and Surety Underwriters and the Mutual Casualty Insurance Rating Bureau, was issued in 1941.10 Liability insurance itself is "a relatively new line" which began in the late 19th Century in both the United States and England.11

A revised standard form CGL issued in 1943 became widely used. The CGL policy was again revised in 1947 and significantly revised in 1955, 1966, 1973, and 1986.12 The two rating bureaus that crafted the CGL policy eventually merged into the Insurance Services Office ("ISO"). ISO of course continues in its role as drafter of subsequent revisions to the standard form CGL.13 During the first part of the 20th Century, various types of more sophisticated liability insurance products arose: Public Liability Insurance; Owners', Landlords' and Tenants' Public Liability Insurance; Manufacturers' Public Liability Insurance; Contractors' Public Liability Insurance; Contractual Liability Insurance; Owners' Protective Liability Insurance; Contractors' Protective Liability Insurance; Premises and Operations Insurance; and other separate liability insurance

9. See E.W. Sawyer, Comprehensive Liability Insurance Chs. 2, 3 (1943) (Sawyer was an attorney for the National Bureau of Casualty and Surety Underwriters, which eventually merged with the Mutual Insurance Rating Bureau to form the Insurance Services Office ("ISO"); Statement of Richard A. Schmalz on Behalf of the American Insurance Ass'n Before the U.S. Senate Committee on Environment and Public Works 3 (April 3, 1985) (Schmalz was an official of the American Insurance Association).
10. See Sawyer, supra note 9, at Ch. 2.
coverages. The CGL policy is derived in significant part from Public Liability insurance and Premises and Operations insurance, but with additional, more inclusive coverages as implied by the name “comprehensive.” At roughly the same time, insurers also began to offer defense of liability claims as part of the insuring agreement.

Prior to the advent of the CGL policy, these types of liability insurance were each sold separately. This presented difficulties for both insurers and policyholders. Insurers disliked the increased potential for adverse selection by policyholders, who might purchase only a coverage more likely to be needed while refusing to buy other coverages, thereby depriving insurers of potential premium dollars. It also raised pricing problems and issues of fairness in that some customers subsidized the coverages of others. It was also thought that presenting this much choice to some policyholders would encourage unduly risky behavior as policyholders gambled on the types of coverages they would need. Rating the multiple coverages was also difficult because of the narrow focus of risk assumed and the smaller pools of premiums for collection and investment.

In response to the problems of splintered policies and coverages, the liability insurance industry developed the CGL policy. The CGL policy, in addition to creating something closer to “one stop shopping” for businesses, risk managers, and brokers, also was designed to help insurers manage their liability exposure and to accept risk transfer profitably. Sale of the more expansive and bundled CGL policy required business policyholders in many cases to buy more insurance and pay more premiums than would otherwise have been the case. These greater

14. See Sawyer, supra note 9, at 11-17.
15. See Sawyer, supra note 9, at 12-18.
16. See id. at 11.

Whereas, in the past we have offered multiple separate liability covers, each excluding hazards within other covers and each being optional with the insured, and have insured only against hazards within the covers chosen by the insured, we now insure against all of the hazards within the scope of the insuring clause which are not specifically mentioned as excluded. Stated differently, instead of insuring against only enumerated hazards we now insure against all hazards not excluded . . . Liability insurance is now in the process of transition from the multiple separate covers to one comprehensive cover.

17. See Sawyer, supra note 9, at 135 (CGL insurance “offers opportunities for the producer to increase his own income through the placing of additional insurance”) and at 145 (“the producer should do his utmost to place comprehensive liability insurance with every risk that has a need for it. Few businesses are too small to need it or to make it unprofitable for the producer to sell it.”); Thomas M. Reiter, David J. Strasser & William J. Pohlman, The Pollution Exclusion Under Ohio Law: Staying the Course, 59 U. Cin. L. REV.
premium receipts could be used by insurers to earn more money on investment of premium dollars. In the 1940s, as today, insurers made much of their profit on the “float” of holding premium dollars as investments for many years before they were typically required to pay claims.\(^{18}\) Without doubt, the object of the insurance industry in crafting the

1165, 1223 (1991) (CGL policy was sold as comprehensive policy providing “peace of mind” for policyholders for which insurers in turn demanded and received larger premiums); John H. Egloff, Liability Insurance, The Outside, in BEST’S INSURANCE NEWS (FIRE & CAS. ED.), Vol. 42, No. 1 (1941) (arguing that bundling of liability coverage into a comprehensive policy would enable insurers to obtain greater premium volume by encouraging sale of broad coverage product rather than more selective insurance purchases by policyholders; citing example of initial liability insurance premium of $10/year that could be “built up” to annual premium of $700 for comprehensive policy) (Egloff was Supervisor of the Agency Field Service of The Travelers Insurance Company.)

It appears that Sawyer and Egloff were not only aware of the potentially greater profits to be had from CGL sales, but also genuinely saw the broad coverage product as better for policyholders and even society. In a bit of hyperbolic boosterism that now seems part of a bygone era, Sawyer stated that “[i]f every producer would make a real effort to sell [CGL coverage] to every business on his books, he would be making a contribution toward the solution of war and postwar problems of far-reaching importance.” See SAWYER, supra note 9, at 145-46. Although Sawyer’s appeal seems more than a little overwrought, his sincerity appears genuine. He consistently argued for the mutual advantage (for insurer and policyholder) of the comprehensive approach and sought to have insurance move toward a supremely comprehensive all-risk model.

There seems to be little doubt that the ultimate goal is an “all risk” liability policy. Such a policy would cover all liability hazards of the insured. It would not be limited in any way except to tort liability . . . [It] is still far in the future [and requires] a long series of intermediate steps [but is] the general direction in which we are traveling.

See SAWYER, supra note 9, at 115-16.

18. Insurers make substantial profits because of the time value of funds they hold due to premium payments. Insurers profit from this “float” and investment income for years prior to paying claims. Even where the amount of claim costs exceeds premium collections, insurers typically make money because of earnings on these collected premiums prior to payment of related claims costs. Warren Buffett, who has described his company Berkshire-Hathaway as primarily an insurance company, notes that the insurers owned by Berkshire-Hathaway earn most of their profits not from underwriting but from the float of premiums collected well before claims are paid under the policies for which those premiums were charged. See Letter from Warren Buffet to shareholders (2000), at 8-1, available at http://www.berkshirehathaway.com. See also Richard E. Stewart & Barbara D. Stewart, The Loss of Certainty Effect, 4 RISK MGMT. & INS. REV. 29, 32 (2003) (insurers have explicitly recognized that “the earnings on funds reserved for claims [are] the most significant component of earnings for a property liability insurance company” and “[i]nsurance managements are more than sufficiently intelligent to see that delaying the payment of claims increases the float period and denying claims decreases the cost”). See generally SCOTT E. HARRINGTON & GREGORY R. NIEHAUS, RISK MANAGEMENT AND
CGL was to offer for sale an attractive product providing comprehensive insurance protection in order to both reduce adverse selection and to encourage greater premium payments by policyholders.19

The CGL policy at its inception made a broad commitment to the policyholder to pay “all sums” resulting from third-party claims for bodily injury or property damage caused by an accident. The CGL policy form in use today continues to make a broad commitment to providing a wide scope of liability policy coverage to policyholders. The CGL policy is structured with a broad insuring agreement but then utilizes exclusions as necessary to protect insurers from certain risks. The exclusions of the CGL policy are provisions narrowing the scope of coverage. For example, intentionally caused injury was excluded, as was liability assumed by contract, automobile, aircraft, or watercraft liability, employee injuries, and damage to the policyholder’s own property or own products.

II. STRUCTURE AND PRESUMPTION IN THE CGL: THE QUESTION OF BURDEN

Because exclusions attempt to take away coverage provided to the policyholder, an axiom of insurance is that the insurer relying on an

19. An insurance company executive writing at the time of the promulgation of the CGL policy emphasized its breadth of coverage:

[With the CGL policy form, the] burden of determining what to insure and what not to insure is removed from the shoulders of the insured and placed squarely on the producer and the carrier. How much better it is to say – “We cover everything except this and this and this” instead of “We cover only this and this and this.” No longer will an insured with Owners’, Landlords’ and Tenants’ coverage in one company and Elevator coverage in another company take them both to court to prove where the claimant fell down...Since a risk cannot choose the kind of accident that will give rise to the need for liability insurance, it is wise to be protected against all losses under one policy – One policy – one premium and worry regarding liability insurance is off his mind.

See Eglof, supra note 17, at 19 (emphasis in original) (Eglof was a Supervisor in the Agency Field Services of the Travelers Insurance Company).
exclusion is required to shoulder the burden of persuasion as to the applicability of that exclusion if the exclusion is to defeat coverage.\textsuperscript{20}

Insurance custom and practice as well as hornbook statements of insurance law provide that ambiguous language is construed against the drafter of the insurance policy and that the insurer shoulders the burden of persuasion to establish the applicability of an exclusion or another provision of the policy that reduces or restricts coverage. The insurance industry has long accepted this axiom of construction of ambiguous language against the drafter as a pivotal principle of resolving insurance coverage disputes.\textsuperscript{21} The insurance industry, scholars, and courts have also long accepted the axiom that ambiguous language is construed against the drafter of the insurance policy.\textsuperscript{22} Even if a coverage-limiting provision in a

\textsuperscript{20} See Stempel, supra note 6, § 2.06(c); Barry R. Ostrager & Thomas R. Newman, Handbook on Insurance Coverage Disputes § 1.03[b] (11th ed 2002).

\textsuperscript{21} See Memorandum to Insurance Industry Officials attached to Letter of July 23, 1957 from Andrew G. Meyer, Esq. of Liberty Mutual Insurance to Messrs. Earle et al., at 39 (where coverage question is “shadowy”, then “insurers must either clearly exclude or clearly cover. If insurers fail to eliminate ambiguous language from policies, there is no doubt against whom the ambiguities will be resolved.”). This axiom is reflected in numerous insurance and insurance law treatises. See, e.g., Mark S. Dorman, Introduction to Risk Management and Insurance 184 (7th ed. 2001) (“If an insurer denies a claim based on an exclusion and the insured then contests the denial, the insurer has the legal burden of proving the exclusion was applied correctly.”); C.A. Kulp & John W. Hall, Casualty Insurance 322 (4th ed. 1968) (describing exclusions as limitations on otherwise existing coverage); Robert I. Mehr & Emerson Cammack, Principles of Insurance 136 (4th ed. 1966) (“the insuring agreement is the cloth from which the final coverage is cut. The exclusions are the cuttings from the coverage.”); Harrington & Niehaus, supra note 18, at 176 (describing exclusions as removing coverage for specific losses that would otherwise be covered under the insuring agreement); A.S. Arnold, General Insurance Principles, Revised Edition 96 (1983) (“any ambiguities in the language of the contract are construed against the insurer in favor of the insured. Reasonable doubt as to the meaning of the language of an insurance policy is thus resolved in favor of the insured.”); Herbert S. Denenberg et al., Risk and Insurance 219 (2d ed. 1974) (“Because the insurance contract is one of adhesion, and because it is drafted by the insurer, the contract is usually construed in favor of the insured and against the insurer, when there is any ambiguity.”). See also Ostrager & Newman, supra note 20, § 1.03[b][1] and § 10.02[a] (“It is well-settled that the burden of proving the applicability of the pollution exclusion is on the insurer.”). Accord, Stempel, supra note 6, § 2.06[c] (“An important legal aspect of exclusions is that demonstrating the applicability of an exclusion places the burden of proof on the insurer.”). Even if a coverage-limiting provision in a policy is not denominated as an “exclusion”, if an insurer is relying on language in a definition, condition, or other portion of a policy to defeat or reduce coverage, the provision is treated as an exclusion, it is narrowly construed against the insurer in favor of coverage, and the insurer must successfully shoulder the burden of persuasion on the issue.

\textsuperscript{22} See, e.g., James S. Trieschmann & Sandra G. Gustavson, Risk Management & Insurance 272 (9th ed. 1995) (describing uncertainty as to application of care, custody,
policy is not denominated as an "exclusion", if an insurer is relying on language in a definition, condition, or other portion of a policy to defeat or reduce coverage, the provision is treated as an exclusion, it is narrowly construed against the insurer in favor of coverage, and the insurer must successfully shoulder the burden of persuasion on the issue.\textsuperscript{23}

This basic structural and doctrinal framework is important in close insurance coverage questions for a reason seemingly obvious but often overlooked: in close cases turning on exclusionary provisions of a policy, the presumptive default resolution of lack of clarity is that the insurer provides coverage. Further, where the coverage turns on the meaning of non-exclusionary language such as the insuring agreements or conditions of the policy, unclear language will be resolved against the insurer as drafter of the policy, provided that other indicia of meaning (e.g., extrinsic evidence of specific intent, overall purpose of the policy, drafting history of the policy, representations, conduct, and reliance) do not resolve the ambiguity.\textsuperscript{24}

Although this framework for assessing coverage disputes does not routinely result in findings of coverage, it is a methodology favoring policyholders in the close cases, one commentators have justified due to the structural advantages held by insurers in the design, marketing, sale,
and adjustment of insurance policies. Although insurers are quick to point out that they are at significant risk from information asymmetry, adverse selection, and moral hazard in underwriting liability risks, insurers are able to control these risks through effective design of liability policies in order to limit their exposure. Except in the softest of insurance markets, insurers generally can draft policies to their liking and of course refuse to issue policies absent sufficient comfort with the risk and receipt of an adequate premium.

Most important, insurers are the classic "repeat players" of the dispute resolution game. If an insurer loses on a particular coverage point, it normally remains free to continue to litigate in other forums. Because insurers are in essence, to borrow Professor Baker's phrase, "huge accumulations of money," insurers are in a favorable position to win wars


26. For a discussion of these basic insurance concepts, see Stempel, supra note 6, Ch. 1; Emeric Fischer, Peter Nash Swisher & Jeffrey W. Stempel, Principles of Insurance Law Ch. 1 (3d ed. 2004).

27. A "soft" insurance market is one in which coverage is widely available at low prices as insurers compete aggressively to capture business and premium dollars. Conversely, a "hard" market is one in which conditions are not favorable for policyholders and coverage is restricted or available only at relatively high premium prices. See Mark S. Dortman, Introduction to Risk Management and Insurance 332 (8th ed. 2004).

28. A repeat player is one that frequently participates in the dispute resolution system while a "one shot" player is one that only occasionally is involved in litigation or alternative dispute resolution. The repeat play has significant advantages in battling one shot players, including economies of scale, acquired expertise, institutional memory, familiarity with adjudicators, knowledge of forums, and the ability to spread losses and take the long view of a dispute. See Marc Galanter, Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change, 9 L. & Soc. Rev. 95 (1974). Individual losses normally tend to be of relatively little consequence to the repeat player while they are often devastating to the one shot player.

In the insurance context, individual policyholders (e.g., homeowners, automobile owners) are classic one shot players. With commercial policyholders, the distinction is muted but still obtains for coverage matters. For example, Acme Widget Company may have substantial experience prosecuting collection actions and fending off customer complaints (particularly if it self-insures or has a liability policy with a large retention making it responsible for small claims). But such companies are seldom frequently embroiled in insurance coverage litigation while insurers are regularly engaged in such disputes.

29. See Baker, supra note 7; Tom Baker, Remarks at Insurance Law Section Program, Association of American Law Schools (January 6, 2005) (San Francisco, CA).
of attrition with both third-party claimants and policyholders simply by wearing them down to accept sub-optimal settlements (all the while continuing to earn investment income).  

But because of the pro-policyholder framework for assessing insurance coverage erected to counteract the inherent advantages held by insurers, insurers may find themselves with massive coverage obligations under certain circumstances. To take an obvious example, after a destructive hurricane, a windstorm insurer such as Citizens (Florida’s hurricane insurer of last resort) will be paying a lot of claims (and probably losing money in at least the short term) no matter how well it may have priced coverage or constructed the policy to avoid being required to also provide coverage for flooding or other destructive forces. But after large losses come large premium increases, and for many working class and middle class Americans, forgoing hurricane insurance is now not likely to be seen as an option after the disastrous hurricane seasons of 2004 and 2005.

30. See Baker, supra note 7 (noting degree to which insurers earn substantial investment income on premiums with premium receipts predating payment requirements by years or even decades); V.J. Dowling, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005).

31. See Liam Pleven, Who Should Pay? As the Number of Customers Rises For Insurers of Last Resort, Rates May Be Headed Up, Too, WALL ST. J., Feb. 1, 2006 at B1, col. 2 (noting Citizens’ losses after bad hurricane years of 2004 and 2005 but also noting that many Florida homeowners are “in no position to shop around” because the “only company offering a policy is Citizens Property Insurance Corp., Florida’s insurer-of-last-resort.”). Also, the typical Citizens policy is quite explicit in stating that it covers only wind storm damage and does not cover flood damage or even losses stemming from a “storm surge” of water (even if the water was of course propelled by a hurricane). However, even the most restrictive of draftspersons can miss things. The typical Citizens policy does not establish an aggregate limit on coverage (at least this is to me the clear wording of the policy although it is disputed by the insurer in coverage litigation in which I am an expert witness), which means that the insurer is obligated to pay covered losses stemming from multiple occurrences during an annual policy period. Although comparatively rare, separate hurricanes can ravage the same property twice in a season. For example, in 2004 some parts of Florida were hit by both Hurricane Frances and Hurricane Jean and in 2005, some parts of the Gulf Coast were hit by both Hurricane Katrina and Hurricane Rita.

32. See Susanne Scalfane, Florida Homeowners Rates Could Triple, Citizens Warns, NATIONAL UNDERWRITER, Dec. 5, 2005, at 21 (“We’re looking at a statewide average increase . . . of 60 percent, with many coastal areas receiving triple digit increases,” according to Robert Riker, “president and executive director of Citizens Property Insurance Corp. in Florida, the state’s largest insurer of last resort.”). Although general liability insurance rate increases have been more gradual in response to the more gradual onset of asbestos mass tort insurance coverage, the same economic and marketing factors are at work. See Sorry America, Your Insurance Has Been Cancelled, TIME, Mar. 24, 1986 at 20 (describing abrupt rises in select liability insurance premiums).
Consequently, insurers are in a relatively good position to recoup past losses through future price increases.

Even if this were not the case, there is nothing unfair about a legal regime structured to give policyholders the benefit of the doubt in close cases after the policyholder has established that a claim comes within coverage (or is potentially within coverage if the question centers on the duty to defend). As discussed in Section X, infra, insurance is a aleatory contract, one in which the value of the exchange may be lopsided depending on the contingencies involved. In similar fashion, liability insurers underwriting asbestos policyholders prior to the advent of the asbestos mass tort may have been in a favorable business position. From the time of the CGL policy’s introduction in the 1940s until the arrival of asbestos and pollution claims in the 1970s, the CGL appears to have been a business success and large moneymaker for the insurance industry. But when the asbestos mass tort arrived, the basic contractual and legal framework of coverage determination combined with the peculiarities of asbestos to require coverage beyond that anticipated by insurers when they first accepted the risk. This may have made the CGL less profitable, but it hardly brought the liability insurance industry to ruin.

III. THE TRIGGERING SHIFT FROM “ACCIDENT” TO “OCURRENCE”: INSURERS EMBRACE A POTENTIAL CONTINUOUS TRIGGER

The original CGL policy provided coverage where injury giving rise to a liability claim was “caused by accident.” The term “accident” was not

33. See infra text and accompanying notes 247-54.
34. See infra text and accompanying notes 247-54 (attributing demise of Providence Washington Insurance Companies, a Rhode Island insurer established in 1800, to its exposure on asbestos claims). See Special Report, Asbestos: Impact on U.S. Insurance Industry, Fitch Ratings, July 25, 2002 at 9 (“ultimately, the development of asbestos claims will have a moderately negative impact on insurer ratings during the next few years.”) and at 1 (although asbestos liabilities will produce a “slow bleed” that will depress future earnings for many years” the “historic asbestos earnings drag has average 1.7 combined ratio points for the commercial lines/reinsurance sectors over the past few years” although near-term future losses may be more significant because of surge in second generation claims in late 1990s and early 21st Century); Thinking About Asbestos, Lehman Brothers Global Equity Research, March 20, 2002 at 27 (insurer earnings drag from asbestos can reasonably be estimated at 1.5 percent); Fitch Affirms Rating for St. Paul Travelers Ratings After Asbestos Charge; Outlook is Stable, Insurance Journal, Jan. 31, 2005, http://www.insurancejournal.com/news/national/2005/01/31/50493.htm. But see, Asbestos Liability Takes an Insurer Out, RiskProf, Nov. 1, 2005, available at http://riskprof.typepad.com/tort/2004-06/asbestos_liabil.html.
defined in the original CGL policy, the 1943 CGL form, the 1947 form, or the 1955 form. Courts divided significantly on the question of whether an injury-producing event must be discrete and isolated in order to constitute an “accident”. An emerging, but not overwhelming, majority of courts concluded that an “accident” need not be confined in time and space and could be an injury-producing event taking place over a longer time span.\textsuperscript{35} Many insurers were opposed to this perceived judicial trend, arguing that an “accident” needed to be an event confined in time and space.

During the 1955-1966 period, these insurers either came to change their views or accept that this elongated judicial interpretation of the “accident” trigger of coverage was inevitable.\textsuperscript{36} In addition, some insurers were offering occurrence-basis coverage that was an attractive competing product because it clearly provided coverage for liability that resulted from ongoing conditions. In response, as part of the insurance industry’s 1966 revision to the standard CGL policy, the term “occurrence” was substituted for the term “accident,” with an “occurrence” being defined as “an accident, including injurious exposure to conditions, that results during the policy period in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”\textsuperscript{37}

The language of the 1966 Form’s definition of “occurrence” also clarified what had long been the understanding of the insurance industry and the courts; the bodily injury or property damage caused by an accident/occurrence must produce injury or damage “during the policy


\textsuperscript{36} See, e.g., John J. Tarpey, The New Comprehensive Policy: Some of the Changes, 33 INS. COUNS. J. 223, 223 (1966) (stating that “[t]he principal reason given for revision of the policies [from the 1955 form to the 1966 form] was adverse court decisions”). Mr. Tarpey was a partner in the New York-based law firm LeBoeuf, Lamb & Leiby (now LeBoeuf, Lamb, Leiby & McCrae), which then, as now, represented insurers in coverage matters, and was a member of the Federation of Insurance Counsel.

\textsuperscript{37} Compare the 1955 CGL Form, reprinted in ANDERSON ET AL., supra note 12, at A-3 to A-8, with the 1966 CGL Form, reprinted in ANDERSON ET AL., supra note 12, at A-9 to A-15.
period” in order to trigger coverage. If a policyholder was negligent (either episodically or chronically) but the negligence did not harm any third party during the policy period, there was no insured event and no trigger of coverage. If, however, this negligence produced injury in a later year, the occurrence basis CGL insurance applicable to the year of injury would be triggered and would respond to the claim. Regarding the 1966 Form, one attorney representing insurers commented:

Probably the most significant portion of the definition [of “occurrence”] is the phrase “during the policy period.” It will now be required, to bring the policy provisions into play, that the bodily injury or property damage resulted during the policy period and not that the accident [meaning the antecedent negligence] resulted during the policy period. This should remove problems of interpretation where causative factors operate over a long period of time before any harm results and also where the negligent act or the operative legal fact is far removed in time from the happening of the injury (e.g., a defect in manufacture, the sale of the product). 38

With the change from an “accident” policy to an “occurrence” policy, the focus of the trigger inquiry shifted from some uncertainty as to timing to a focus on the time at which the third party allegedly suffers injury due to actions for which the policyholder is legally liable. 39 In the 1973

38. Tarpey, supra note 36, at 224.
39. See Gilbert L. Bean, Assistant Sec’y, Liberty Mut. Co., Address at the Mutual Insurance Technical Conference on New Comprehensive General and Automobile Program: The Effect on Manufacturing Risks 6 (Nov. 15-16, 1965) (“[C]overage no longer attaches when the accident occurs but rather when the injury or damage takes place. This means that the policy in force when a particular injury or damage takes place is the one which applies, regardless of when the causing accident took place.”) Bean was one of the drafters of the 1966 CGL (on file with the author); see also id. at 7 (noting the possibility that events taking place long ago can trigger coverage in subsequent policy years if the injury from those events takes place during later policy years); Richard H. Elliott, The New Comprehensive General Liability Policy, in LIABILITY INSURANCE DISPUTES, 12-3, 12-5 (Sol Schreiber & Stuart J. Motelson eds., PLI 1968) (containing the statement of Mr. Elliott, who was an industry official, that “for the purpose of applying coverage – the injury must take place during the policy period.”) (emphasis added); Letter from E.W. Sawyer, Attorney, to Robert L. Mannon, Fireman’s Fund Indemnity Company (June 3, 1939).

Under the majority of judicial decisions and what appears to be the majority view of the application of the “accident” trigger, the result would be the same: it was the injury, not the antecedent negligence or other liability-creating conduct that triggered the CGL policy.
revisions to the CGL form, there was also a technical modification to the “occurrence” and “bodily injury” terms of the policy. 40

Accidents “in the air,” so to speak, did not trigger coverage. However, because in most instances, negligence and injury were nearly simultaneous (consider, for example, poor driving, a careless workman, an exploding appliance), insurers were undoubtedly taken aback when the asbestos tort arrived. Because inhaled asbestos continues to inflict new damage, it had greater than ordinary potential to trigger multiple policies.

40. As noted above, the 1966 CGL form stated that coverage was triggered by an “occurrence” causing bodily injury or property damage “during the policy period”. See supra note 37 and accompanying text. In 1973, this “during the policy period” language was relocated from the “occurrence” definition to the bodily injury definition. See the 1966 CGL Form, reprinted in ANDERSON ET AL., supra note 12, at A-17. Beginning with the 1973 Form, “bodily injury” was defined as injury, sickness, or disease “sustained by any person which occurs during the policy period,” including resulting death. See id. The relocation of this language was not intended to effect a substantive change in the meaning of the CGL. See Enclosure to letter from R.H. Elliott, Vice President Commercial Cas. Dept, Ins. Servs. Office, to Dwight V. Strong, Chairman, WAIB-IBAC Comm. on Revised Liab. Forms 1 (Sept. 22, 1972) (on file with author).

The revised wording represents no change in underwriting intent. The additional words “which occurs during the policy period” have been included in the definition [of “bodily injury”] and also in the definition of “property damage” because of the elimination of the phrase “during the policy period” from the definition of “occurrence”. It is suggested that this emphasizes that [for purposes of triggering coverage] “the time of occurrence [meaning the antecedent negligence] does not matter [for purposes of triggering liability], only the time of its result”. Such emphasis is desirable. In many cases, the injurious result takes place at the same time as the cause of such result. The damages that are sought by the claimant and that are to be paid by the insurer on behalf of the insured are related to the adverse effect on the claimant of the occurrence. Until this adverse effect has taken place, there would be no grounds for the claimant to recover from the insured.

Id. As this commentator also observed:

This point can be demonstrated by consideration of the typical product liability claim. A manufacturer produces a defective product. The claim does not arise then; it arises when the product caused injury to the claimant, after the manufacturer has sold the product to the claimant and [after] the latter puts it to use.

... [T]he revised definition of “bodily injury” will not result in any less coverage than is currently afforded under the 1966 policy form nor does it impose any different obligation ....

Id. (Mr. Elliott was the vice president of the ISO Commercial Casualty Department and a Secretary of the National Bureau of Casualty Underwriters); see also R.H. Elliott, Remarks to the Kansas State Agents Association on the January 1, 1973 Changes in the
Under the CGL policy's 1966 Form and 1973 Form, some damage or injury during the policy period was clearly required to trigger coverage. Mere negligence standing alone would not trigger the CGL policy unless there was also actual injury. Damage and injury were considered concepts distinct from the "accident" or "occurrence" that brought about the damage or injury. Under the 1955 Form, the situation was less certain because of perceived ambiguity in the word "accident." The insurance industry moved to correct this perceived problem in the 1960s and to focus on the time of injury to a third party. In making this change generally favorable to its interests through limiting the breadth of trigger in most instances, insurers were well aware that more than one policy could be triggered by injury to a single individual.

Because there had been cases treating antecedent negligence as the "accident" under the 1955 CGL form, the insurance industry moved from "accident" to "occurrence" language to make it clearer that injury rather than negligence alone (or "negligence in the air") triggers coverage. But although the time of injury to the third-party claimant is critical to the question of trigger, the time of injury does not have any bearing on the

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Comprehensive General Liability Policy and in the General Liability Manual 3 (Jan. 3, 1973) ("[This change is] simply editorial in nature and [does] not represent any broadening or restriction in coverage.") (on file with author).

41. See Ins. Servs. Office Inter-Office Correspondence from T.V. Bayer to B.J. Shelley 1 (July 28, 1982) ("The first point to make is that the current form says that the injury or damage, and not the occurrence [meaning the antecedent negligence], must take place during the policy term for there to be coverage.").

42. In the typical tort matter, policyholder error and injury to a third party are simultaneous or at least take place within the time frame of the policy period. Where policyholder error and injury are separated, this can as easily work against the policyholder and for the insurer as vice versa. Consider Singsaas v. Diederich, 238 N.W. 878 (Minn. 1976), in which the policyholder performed negligent welding in Year 1 but the poor welds did not give way and cause injury to a third party until Year 2. Id. at 879-80. There was no coverage under Policy 1. Id. at 880. Because the policyholder had ceased operations and failed to keep insurance in force, there was no insurance coverage at all. Id.

Insurers will undoubtedly take issue with my example, finding it small potatoes as compared to the asbestos mass tort. True enough. But my point is simply that insurers in 1966 not only had something to gain from move to an occurrence trigger (resolution of conflicting judicial rulings on the accident trigger) but probably thought that the focus on injury rather than antecedent negligence made it less likely that multiple insurers would be triggered in connection with a tort claim, even though the drafting history of the CGL policy reflects an understanding that gradual injury spanning multiple policies would be covered under multiple policies.

43. See Green, supra note 18, at 318 ("exposure to conditions over a period of time is covered" under the CGL policy).

classification of the coverage. The source of the injury determines whether the loss is within coverage, is appropriately regarded as a general premise-operations liability matter or a products/completed operations hazard matter, or is subject to an exclusion.

Discussion of the move to an occurrence trigger reflects insurer understanding that an “occurrence” under the 1966 form need not be an episodic “boom” event but could well involve gradual, ongoing or continuous injury. According to a leading insurance company representative,

The definition [of “occurrence”] embraces an injurious exposure to conditions which results in injury. Thus, it is no longer necessary that the event causing the injury be sudden in character. In most cases, the injury will be simultaneous with the exposure. However, in some other cases, injuries will take place over a long period of time before they become manifest. The slow ingestion of foreign matters and inhalation of noxious fumes are examples of injuries of this kind. The definition serves to identify the time of loss for application of coverage in these cases, viz, the injury must take place during the policy period. This means that in exposure-type cases, cases involving cumulative injuries, more than one policy contract may come into play in determining coverage and its extent under each policy.45

Insurance industry materials make reference to the ability of the occurrence-basis trigger to implicate two or more liability insurance policies in connection with claims of recurring injury from exposure to harmful conditions or circumstances. Using the examples of waste disposal and pollution, one commentator illustrated the operation of the occurrence basis trigger and its potential to result in triggering of multiple policies.

Perhaps it is in the waste disposal area that a manufacturer’s basic premises-operations coverage is liberalized most

45. See id. at 199-200 (emphasis added) (Nachman was at the time manager for non-automobile casualty insurance and multiple lines insurance at the National Bureau of Casualty Underwriters). See also Bean, supra note 39, at 1 (emphasizing that 1966 form is “considerably broader” in providing coverage for gradual injuries but emphasizing that “coverage, however, is still a casualty coverage”) (Bean was Assistant Secretary, Liberty Mutual Insurance Co.).
substantially. Smoke, fumes, or other air or streams pollution [sic] have caused an endless chain of severe claims for gradual property damage. These wastes disposal cases have been difficult ones, because when the injury or damage first starts to emerge, no corrective action is taken in many cases, because the manufacturers are reticent to admit his waste disposal is causing it. This is probably an honest doubt. When the cause is pinpointed, it may or may not be easy to make a quick elimination of the cause. The cost of an alternative method of waste disposal may be terrifically expensive or might even force the manufacturer out of business, and even if it can be made, it may take months to convert. Our new policy requires the insured to promptly take reasonable steps to correct conditions causing gradual injury or damage, once discovered. Opinions as to what is reasonable may vary widely. Meanwhile losses continue.

This brings into focus one important change in our policy – the fact that coverage no longer attaches when the accident occurs but rather when the injury or damage takes place. This means that the policy in force when a particular injury or damage takes place is the one which applies, regardless of when the causing accident took place. *So if the injury or damage from waste disposal should continue after the waste disposal ceased, as it usually does, it could produce losses on each side of a renewal date, and in fact over a period of years, with a separate policy applying each year.*

*The policy limits are renewed every year, so the underwriter of a manufacturing risk may have his limits pyramid under this new contract.*

...  

So, even for new business, the underwriter must be more alert than ever. More potential losses may be inherited from the past. A harmful waste disposal practice unknown to the underwriter because it has since been corrected, or which the applicant promises to correct, may still produce serious losses during your period of coverage. This has always been
true for products, but with gradual injury or damage being covered, the potential is a lot worse. 46

As this commentator noted, insurers still retained significant protection in that “the new policy still gives the carrier the right to cancel a policy on 10 days notice.” But although this “may free the carrier from liability for future injury or damage from an occurrence which has already taken place while he was on the risk,” this type of “cancellation would be no escape from consequences of mishaps which have already happened.” 47 “I doubt very much whether the courts would permit a cancelling company to escape the inevitable consequences of what had already happened during their period of insurance.” 48

Other insurance insiders took a similar view of the likely consequences of the move from an accident trigger to an occurrence trigger.

The new policy will afford coverage on an “occurrence” basis. “Occurrence is defined as “an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury and property damage neither expected nor intended from the standpoint of the insured.” Note that this definition includes the work “accident.” This has been done in order to clarify the intent with respect to time of coverage and application of policy limits, particularly, in situations involving a related series of events attributable to the same factor. Under such circumstances only one accident or occurrence is intended as far as the application of policy limits is concerned. For example, the liability of a contractor arising out of the derailment of ten or twelve freight cars as a result of a collision with a piece of his equipment is intended to be subject to one application of the occurrence limit of the policy. Retention of the word “accident” is limiting in this sense and in no other.

Note also the reference to injurious exposure to conditions which results in injury. This eliminates any requirement that

46. See Bean, supra note 39, at 6 (underlining in original; italics added). Bean was Assistant Secretary, Liberty Mutual Insurance Company, and was one of the principal authors of the 1966 CGL form and the occurrence trigger.

47. See id. at 7.

48. See id.
the injury result from a sudden event. Although, it is most common that the injury takes place simultaneously with the exposure, *there are many instances of injuries taking place over an extended period of time before they become evident. For example, slow ingestion of foreign substances or inhalation of noxious fumes.* In cases such as these, the definition of occurrence serves to identify the time of loss for the purpose of applying coverage – the injury must take place during the policy period.

In some exposure types of cases involving cumulative injuries, it is possible that more than one policy will afford coverage. Under these circumstances, each policy will afford coverage to the bodily injury or property damage which occurs during the policy period.49

The CGL workbook used by a major property/casualty insurer (and one that would later have one of the largest books of asbestos liability business took a similar view.

Many people consider an occurrence as a one time event with a very short, sometimes split-second duration – such as an accident. However, an occurrence may also mean exposure to conditions which may continue for a period of time.50

Because an accident [as contrasted to an occurrence] originates at a particular point in time, it’s easily identified as having, or as not having, transpired during the policy period.

... An accident occurring during the policy period is easily enough identified. But what exactly constitutes “continuous or repeated exposure to conditions”? A related series of events attributable to the same factors may cause a loss. This related series of events may be interpreted as being an accident or an occurrence. This interpretation aids in

49. *See Elliott, supra* note 39, at 12-5 (emphasis added). Elliott was Secretary of the National Bureau of Casualty Underwriters.

50. *See [ANONYMOUS INSURER] THE COMPREHENSIVE GENERAL LIABILITY POLICY WORKBOOK 11 (1973).*
determining two things: 1) When the loss occurred; and 2) How the policy limits apply. [Illustration No. 5 (all caps eliminated)] Wilson Chemical Company, the Named Insured, Occupies the Second Floor of a Commercial Building Owned by West End Cleaners. The West End Operation Occupies the Entire First Floor. Wilson Chemical used Acid as a raw material. The acid is stored in 100 gallon drums on the second floor. One storage drum developed a leak allowing acid to drip onto the floor. This eventually caused extensive damage to several structural supports of the building and caused a partial collapse which destroyed much of West End’s equipment. West End Cleaners Brought a suit against Wilson Chemical for the replacement of their equipment. Would Wilson’s CGL Policy Pay?

Yes. This situation would meet the second part of the definition of occurrence, as the slow leak of acid constitutes a continuous or repeated exposure to conditions.” As such, an occurrence of this type is a related series of events attributable to the same factors which caused the damage. Since the damage occurred during the policy period, it would be covered by the CGL Policy – the Company would assume the insured’s liability. However, if the “continuous or repeated exposure to conditions” occurred during the policy period, but the actual property damage did not occur until after the policy had expired, the insurance company would not be obligated to assume the insured’s liability.51

Without doubt, liability insurers understood that the shift from an accident trigger to an occurrence trigger constituted a “broadening of coverage”52

The new definition of “occurrence” does not represent any change in underwriting intent. It is merely a clarification that this term encompasses not only the usual “accident” but

51. See id. at 11-12.
also exposure to conditions which may continue over a period of time.\textsuperscript{53}

Even when the CGL policy employed an “accident” trigger rather than the more encompassing occurrence trigger,\textsuperscript{54} insurers realized that because of the breadth of the CGL coverage commitment, they would need control their exposure through other means such as the exclusion of specific risks\textsuperscript{55} (today referred to as “laserling out” particular risks) and the use of policy sub-limits for certain types of problematic liability.\textsuperscript{56} Regular review of policies and according adjustment of premiums or cancellation were also seen as important to controlling risk under the more comprehensive cover of the CGL form.\textsuperscript{57}

In addition, insurers were well aware that expanding the trigger of the industry’s basic liability policy could expose insurers to more uncertain risk than that presented by other lines of insurance. Writing shortly before the 1966 revisions to the standard form CGL policy, insurance authorities noted:

\begin{itemize}
\item \textsuperscript{53} See id. at 3.
\item \textsuperscript{54} But see Sawyer, supra note 9, at 120-21 (appearing to interpret accident trigger in a manner similar to interpretation of occurrence trigger in that policy would provide coverage for “continued existence of a cause of injury which results in property damage without a definite accident.”)
\item \textsuperscript{55} See id, at 70 (“[T]here are situations in which it is necessary to exclude from the application of the policy certain business locations in their entirety or certain hazards at specific locations.”)
\item \textsuperscript{56} See id, at 71 (“If higher limits of liability are required for one hazard, such as elevators, the comprehensive policy may be written for the limits common to all hazards and the higher limits may be afforded by endorsement for elevators. If lower limits are required for one hazard than for the other hazards, the limits must be reduced for the single hazard. In either case, the hazard which is to have different limits must be described in the endorsement in the same manner as it would be described in a schedule or single cover policy. If the limits for the hazard are to be reduced below the policy limits it is not necessary to bother with the exclusions, because all of the coverage for the hazard is comprehensive insurance.”). See also C.A. Kulp, Casualty Insurance: Analysis of Hazards, Policies, Companies and Rates 38 (rev. ed. 1942). Liability forms have policy limits which are based essentially not on the amount of insurance required for full protection (which is incalculable) but on what the insured wishes to pay. Soundly selected, the limits will cover all but the most unusual losses. These limits, however, apply per person and per accident, not per year.
\item \textsuperscript{57} See Sawyer, supra note 9, at 97 (“In considering surveys and audits one cannot keep too closely in mind this feature of the comprehensive liability plan. . . . The success or failure of comprehensive liability insurance rests almost entirely upon the thoroughness with which the survey and audit are made.”) and at 110 (providing example of discovery of additional hazards and risks after audit).
\end{itemize}
The possible liability loss tends to be much more fluid and
difficult to estimate than some other types of losses, such as
property losses. Changing law and social outlook
continually alter the size of judgments, mutations being
obvious in the recent trend of verdicts in personal injury
accidents. At the same time, it is virtually impossible to put
a precise ceiling on a liability loss. Property may be insured
for its value, but many forms of liability know no such easy
limitations. The risk manager of a large pharmaceutical
house admitted that its potential liability arising from
products is virtually a matter of guesswork.

Finally, the liability peril not only involves a loss but
may imply or seem to imply moral shortcoming of the party
who is liable. Consider, for example, the doctor charged
with malpractice, or the careless driver charged with liability
for the death of a pedestrian, or the defendant charged with
libel or slander or assault and battery. This aspect, too, may
have important implications for any device to treat the
liability risk.58

In essence, liability insurers “knew” that by expanding to an
occurrence trigger, they were increasing their own risk that liability losses
would span more than one policy period and correspondingly increase their
responsibility for losses such as toxic torts or pollution.59

Certainly, insurers knew that by adopting an occurrence basis trigger,
they could potentially be covering latent injury cases long after the initial
exposure to the harmful substance. In retrospect,

[t]he problems resulting form occurrence-type coverage are
thus quite obvious in latent injury cases. The rate that the
insurer charges for the coverage, and the loss reserves that
the insurer sets aside to pay future claims may prove to be

58. See Denenberg et al., supra note 21, at 350-51. Accord, Greene, supra note 18,
at 289 (“[o]ne of the most serious financial risks covered by insurance is that of loss through
legal liability for harm caused others.”); Kulp & Hall, supra note 21, at 78 (liability
insurance and legal regime closely linked).

59. See Nachman, supra note 44; Mehr & Cammack, supra note 21, at 340-41 (noting
that term “accident” was sometimes not held to apply to injuries such as those “brought on
by repeated exposures to dust from cement” but that term “occurrence” clearly applied to
this type of injury and triggered coverage under a liability policy) (note, too, the similarity
between an injury from cement dust and one resulting from asbestos dust).
grossly inadequate, depending in part on unpredictable factors such as the following:
1. Whether a substance considered to be relatively safe at the time the insurance was issued proves many years later to be hazardous.
2. The extent of economic inflation and “social” inflation (for example, the tendency of juries to award greater damages than in the past) between the time of exposure and when a claim is made; and
3. Liberalizations in the law, such as the exposure and triple-trigger theories.  

The drafters may not have anticipated the avalanche of asbestos claims, but they clearly anticipated multiple policies being triggered by a liability hazard and knew that this risk was less predictable than many of the other risks they undertook. Insurers also knew that the design of the liability insurance product could affect the tort liability regime, in particular prompting larger jury awards as the public became increasingly aware of the likely presence of at least some insurance for the defendant. Although insurers in hindsight may feel they have been subjected to “unacceptable risk,” it appears that insurers willingly embraced this risk in the pursuit of broader, more salable coverage and corresponding profit.

This injury-from-an-occurrence trigger of coverage took on particular significance with the emergence of the asbestos mass tort. Substantial medical evidence has been proffered by plaintiffs and policyholders to suggest that injury from asbestos continues for years after the initial inhalation of asbestos because of the peculiar properties of asbestos. Because injury continues to be inflicted anew by asbestos fibers in the lungs, consecutive liability policies are triggered. This is not the result of judicial fiat or undue sympathy for plaintiffs and policyholders but stems instead from the insurance industry’s intentional decision to write broad coverage coupled with an unusually dangerous material with properties that trigger more than one liability policy because it inflicts injury across time.

61. See DENEENBERG ET AL., supra note 21, at 358-59.
62. See MALECKI & FLITNER, supra note 60, at 115.
IV. COUNTING "OCCURRENCES" IN THE CONTEXT OF ASBESTOS-RELATED BODILY INJURY CLAIMS

As discussed above, the trigger of coverage for CGL insurance has been injury caused by an "occurrence." But the trigger or inception of insurance coverage is a different issue than the scope of the coverage or the amount available to pay a covered claim. Liability insurance policies, like all insurance policies (at least those sold by carriers hoping to remain solvent) are not limitless but specify a maximum benefit available for each covered occurrence. Modern liability policies also have an "aggregate limit" establishing the insurer's maximum liability no matter how many occurrences, claims, or injuries may arise from a policyholder's activity during the policy period.

However, aggregate limits were not the norm for general liability claims until the 1986 ISO revision of the standard CGL policy form. Prior to this point, many if not most insurers included an aggregate limit for claims arising from a "products" or "completed operations" hazard (discussed in more detail in Section V, infra) but had no aggregate limit for general liability claims that arose out of a policyholder's ongoing operations rather than from sale or distribution of a product or the failings of a completed project causing injury at a later date.

Without an aggregate limit, it is more than possible that an insurer may be required to pay the maximum per-occurrence limit several times as a result of multiple injury-causing occurrences during the policy period. As a result, the manner in which one defines an occurrence and the number of occurrences can become very important in determining an insurer's total liability under a particular policy. Because insurance policies have varying levels of deductibles or retentions for which the policyholder is responsible for payment, a finding of multiple occurrences by either an economic benefit maximizing coverage or an economic detriment requiring the policyholder to pay more out of pocket than it receives from insurance coverage. Consequently, common torts and mass torts may engender a good deal of litigation over the apt counting of occurrences.

Further, the practices of insurers and the jurisprudence of occurrence-counting has not been a model of consistency or coherence. Insurers have a tendency to characterize the number of occurrences in a manner that minimizes their own financial burden while courts have a tendency to do the opposite in a manner that maximizes insurance coverage. Where a policy has a low deductible or no deductible, courts tend to more readily find multiple occurrences, requiring multiple insurer payments. Where deductibles are high, the tendency is to find that even many injuries stem
from only one or a few causes, requiring fewer payments of deductibles and more net insurance to the policyholder.

Disputes over occurrence-counting have taken place with a vengeance concerning the asbestos mass tort not only because of the many asbestos claims but also because so many of the policies implicated are older policies lacking an aggregate limit or containing an aggregate limit only for asbestos claims characterized as stemming from a products/completed operations hazard. In addition, many of the older policies had low/no deductibles or policyholder retentions. Perhaps unsurprisingly, courts have tended to find that each asbestos-related injury to a distinct person is a separate occurrence entitling the policyholder to the protection of a full “per-occurrence” policy limit.\textsuperscript{64} Equally unsurprising is that insurers tend to complain about this body of precedent, viewing it as excessively result-oriented and pro-policyholder.

As with its complaints about the continuous trigger, the insurance industry is not particularly sympathetic on this point. An objective legal analysis strongly supports the judicial consensus that each asbestos victim’s injury is a separate occurrence for insurance purposes. In addition, because older liability policies often have very low per-occurrence policy limits, the absence of an aggregate limit is not nearly the financial burden to insurers that it would be in today’s world where million or multi-million dollar per-occurrence limits are common.

The CGL policy was designed to provide protection for businesses from typical general liability risks. For a manufacturer or installer of what proved to be a dangerous material (asbestos), each prospective plaintiff and each lawsuit poses a significant risk of tort liability. Many individual asbestos claims have resulted in seven-figure judgments or settlements for the claimant. Many, many more have produced six-figure settlements and judgments. An extraordinary number of asbestos-related claims have at least nontrivial value and impose nontrivial burdens and exposures upon

policyholders. In order for the CGL policy to work properly, policyholders must receive the coverage they purchased for each “occurrence” that presents significant risk. In the case of asbestos claims, this augurs in favor of not batching claims in a manner that so consolidates the concept of an occurrence that it effectively deprives policyholders of promised coverage.

Although the CGL policy defines an occurrence as an “accident, including injurious exposure to conditions” resulting in “bodily injury” (the 1966 CGL Form) or an “accident, including continuous or repeated exposure to conditions,” which results in “bodily injury” (the 1973 CGL Form), the “continuous . . . exposure to conditions” language was not intended to bundle claims together unless they could reasonably be said to stem from the same cause.

Since the inception of the CGL, insurers and courts both have applied a “cause” test to determine the number of occurrences under a CGL policy.65 Adopting a cause test does not resolve the occurrence-counting task in self-executing fashion. One must still determine how broadly or narrowly to define “cause.” As a concept, the cause of an injury and a tort liability claim cannot be “negligence in the air” or a general corporate policy. Rather, to cause injury, the negligence of a policyholder must actually impact a particular claimant. Without this, no injury takes place, no claim is made, and no policy is triggered. Not surprisingly, most courts facing the issue have therefore concluded that each plaintiff with an asbestos-related injury constitutes an occurrence for purposes of liability coverage,66 a result that squares with hard-headed logic at least as much as with any judicial sympathy for commercial policyholders facing a multitude of asbestos claims.

As a matter of policy text alone, there appear to be many claims under the CGL policy involving workers or bystanders who have inhaled asbestos that was released by asbestos products that were distributed or used during construction and insulation activities. Although the philosophical inquiry “if a tree falls in the forest and no one hears it, does it make a sound” has become the stuff of TV sitcom parody, the conundrum-cum-cliché makes a

65. See Stempel, supra note 6, § 14.02; Jerry, supra note 24, § 65[c]; Anderson et al., supra note 12, Ch. 9.

valuable point. Events tend to be defined not in the abstract, but by their perception and impact. For asbestos and insurance, where injury is the trigger, an individual claimant must be exposed to harmful asbestos and suffer some kind of injury before there can be an insured event. Furthermore, each person’s asbestos exposure and injury is a separate and distinct event that is caused by a different asbestos intake and impact occurrence. Hence, each is better viewed as a separate “occurrence” for liability insurance purposes rather than as the “effects” of a single release of asbestos by the policyholder.

This analysis seems to be the correct one, even where asbestos claims stem from the sale of a single asbestos-containing product or the use by patrons of a single asbestos-containing building. However, it is important to note that there are cases that take a contrary approach and tend to find one or only a few causes based on particular bulk shipments of a product or the manufacture of a uniform injury-causing product. Where injuries

67. See generally Michigan Chemical Corp v. Midland Ins. Co., 728 F.2d 374 (6th Cir. 1984) (applying Illinois law); see generally Maurice Pincoffs Co. v. St. Paul Fire & Marine Ins. Co., 447 F.2d 204 (5th Cir. 1971) (applying Texas law). Pincoffs and Michigan Chemical are two particularly well-known cases taking what might be termed the “compromise” position that found each shipment of injury-causing contaminated product (bird feed and cattle feed, respectively) to constitute an occurrence. These cases rejected both the view that the contamination was but a single occurrence and the view that each injury to a bird or cow was an occurrence. Applying the rationale of Pincoffs and Michigan Chemical to asbestos claims, one could take the position that each wholesale shipment of asbestos product or each insulation job site was an occurrence for purposes of CGL coverage.

Although this would not be an absurd analysis, neither is it persuasive. Pincoffs and Michigan Chemical can be distinguished from asbestos claims brought by workers exposed to asbestos from working with asbestos-containing materials not only because humans are different than animals but because the nature of the injury is different. In Michigan Chemical, the distributor of the contaminated feed faced claims from farmers whose herds had been decimated by the poisonous feed. Each cow (or the cow’s estate or spouse) was not suing in its own right for bodily injury. The commercial nature of the claim made some degree of aggregation logical in light of the loss claimed. Outside of Charlotte’s Web, farmers tend not to worry about a single livestock animal but instead see the herd as a single economic asset. By contrast, each human injured by asbestos make his or her own distinct claim. If a company were suing for lost productivity due to asbestos-related injury to its workforce, the case might be apt for a Michigan Chemical approach finding some interim degree of aggregation based on something other than each individual worker’s injurious exposure.

Pincoffs fits the model less well since it involved claims by individual pet owners from the deaths caused by contaminated feed. However, the policyholder was a pet store that needed to resolve the claims as a whole to maintain its business. The perhaps results-oriented view that treating each dead parakeet as a separate occurrence and imposing more deductible payments on the policyholder, a small business, makes analytic sense in that it is
arise from exposure to asbestos during construction, insulation, or other
general ongoing operations of a policyholder, the “one victim-one
occurrence” analysis seems particularly powerful. The nature of asbestos
installation activities makes the policyholder’s asbestos installation liability
the result of many occurrences. A policyholder installing asbestos engages
in this activity over many years, in many different locations, over different
time periods at each location. During different times and locations,
numerous people were exposed in a variety of ways to different amounts
and types of asbestos and suffered immediate injuries that continued for
years as a result of that exposure. The only reasonable conclusion is that
each of these injuries results from a different cause and constitutes a
different occurrence under the CGL policy.

Although it is not an asbestos case, Koikos v. Travelers Insurance Co. provides a good illustration of the prevailing judicial approach to
occurrence counting and the view that each claimant’s injury is a separate
occurrence under the CGL policy. In Koikos, the policyholder was the
owner of a restaurant in Tallahassee, Florida. He rented the premises to a
Florida A & M University fraternity for a party. When two undesirables
attempted to crash the party, an altercation ensued. One of the party
crashers fired “two separate – but nearly concurrent – rounds,” hitting two
different partygoers and causing serious injury to each. Each victim filed a
separate lawsuit against Koikos as owner of the restaurant alleging
inadequate security. Koikos sought coverage for two separate occurrences.
Travelers disagreed, arguing that only a single occurrence—inadequate
restaurant security—caused the shootings. The Florida Supreme Court,
interpreting a policy that defined an occurrence as including “continuous or
repeated exposure to substantially the same general harmful conditions,”
rejected Travelers’ position on number of occurrences and embraced
Koikos’s view that each shooting was a separate occurrence to which full
policy limits applied. The Koikos Court said:

We conclude that the inclusion of the “continuous or repeated exposure” language does not restrict the definition
of “occurrence” but rather expands it by including ongoing
and slowly developing injuries, such as those in the field of
toxic torts. Therefore, we reject Travelers’ reliance on the
“continuous or repeated exposure” language as a basis for

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more consistent with the purposes of the CGL than a definition of occurrence that leaves the
policyholder essentially without coverage when it needs it most.

68. See generally Koikos v. Traveler's Ins. C., 849 So.2d 263 (Fla. 2003).
concluding that Koikos's negligent failure to provide security constitutes a single occurrence under the terms of the policy. The victims were not "exposed" to the negligent failure to provide security. If the victims were "exposed" to anything, it was the bullets fired from the intruder's gun.\textsuperscript{69}

V. THE ABSENCE OF AN AGGREGATE LIMIT FOR GENERAL OPERATIONS COVERAGE UNDER THE CGL: ANOTHER FACTOR EXPANDING INSURANCE COVERAGE FOR ASBESTOS CLAIMS

A. THE DISTINCTION BETWEEN GENERAL OPERATIONS HAZARDS AND THE PRODUCTS/COMPLETED OPERATIONS HAZARD

The trigger of coverage issue is conceptually distinct from the issues of the scope of coverage and amount of coverage afforded. Resolving the issue of trigger, therefore, does not determine the characterization of a liability claim. Rather, the claim must be based on the event or hazard that produced the injury, irrespective of the time that injury takes place. Trigger involves merely the question of when actual injury takes place. Actual injury may take place in one or more policy years. Actual injury may be \textit{sui generis}, or may be continuous and indivisible. In contrast to trigger, which depends on the date of injury, the question of the appropriate classification of a CGL claim as covered, uncovered, general liability, products, or completed operations depends upon the nature of the event or activity giving rise to the triggering injury.

As its name implies, the CGL policy was designed and intended to afford general liability coverage for business entities. Business policyholders who purchased CGL coverage sought protection from the common types of claims that arose from the business's regular operations. This was the type of liability coverage policyholders formerly acquired (before 1941 and the introduction of the CGL policy) through the purchase of separate polices providing premises and operations coverage, owner, landlord, and tenant coverage, public liability insurance, contractor's insurance, and the like.

\textsuperscript{69} \textit{Id.} at 268 (emphasis in original; citations omitted); \textit{accord} New Hampshire Ins. Co. v. RLI Ins. Co., 807 So.2d 171, 171 (Fla. App. 2002) (three shots fired over course of several minutes from three different locations within apartment complex constitutes three separate occurrences; "[t]he act which causes the damage constitutes the occurrence") (internal citations omitted).
At the time of the original CGL, the primary concern of both insurers and policyholders was general premises-operations liability from ongoing operations. This type of liability was the most significant threat to most policyholders. However, insurers were also aware of the risks posed by product liability claims, even for non-manufacturers, in light of *MacPherson v. Buick Motor Co.*, 70 which was decided more than 20 years before the standard CGL policy came into existence. Insurers knew that privity of contract was unlikely to be a successful defense to product liability claims, even those against policyholders with no "fault" other than the misfortune of selling a defective product at retail. As a result, insurers were aware of the need for product liability coverage and were willing to provide it to policyholders.

Insurers were also aware that products claims posed different, troublesome risks as compared to general premises-operations liability claims. The sources of liability for claims that fall within the products/completed operations hazard of CGL policies—the "hazards" for which the products/completed operations hazard was designed—may give rise to liability that may be beyond the control of policyholder and insurer by the time the claims are made. The policyholder's ability to manage the product or construction risk after the fact is quite limited or very expensive (e.g., product recall, retrofitting of a building). By contrast, a policyholder may often correct a general liability exposure quite efficiently after a single injury, removing the risk or reducing it drastically, even if the general premises-operations liability exposure involves use of hazardous material (e.g., adopting new procedures for safer handling of toxic substances). But with products/completed operations hazard claims, the "genie" has escaped the bottle and policyholder and insurer have comparatively less control over the matter. Insurers historically have been more worried about accepting products/completed operations hazard risks than general premises-operations liability risks due to fears that "problems with defective products and construction cannot be reined in once claims arise."71

As a result, insurers historically protected themselves with aggregate limits for products/completed operations hazard claims. Insurers knew that when a products/completed operations hazard did materialize and produce injury, the resulting cascade of claims could elude both prediction and control. As one commentator noted:


71. *See Stempel*, supra note 6, at 14-32.
[T]he per accident limit is a toothless tiger when it comes to controlling the cumulative impact of several hundred claims from the products of one manufacturer in one year. Therefore, the reinsurer and the insurer have fallen back on some of their old friends – the maximum dollar amount of liability and the specified period of time. This time, though, these concepts are used directly in policies issued by the primary insurer to cover products liability. In addition to the usual “per person” and “per occurrence” bodily injury limits stated in such policies, the manufacturer will find that its general liability policy which covers its products will contain another limit of liability called “aggregate.” This limit is normally written as a very low multiple of the per occurrence limit. For example, if the company is carrying $500,000 per person and a million dollars per occurrence or accident, its aggregate limit will probably be one million, or perhaps two million dollars at the most, for all claims in certain categories, and one of the particular categories is products.72

Tort law and liability insurance are of course related and overlap to a degree. CGL insurance and its liability insurance predecessors were designed as a business response to the tort system. However the tort law concept of “product liability,” in which the term is loosely used to refer to nearly any claim involving the presence of a purportedly dangerous product, is quite distinct from the more targeted CGL insurance terms “products hazard” and “completed operations hazard.” The products/completed operations hazard category of liability insurance is considerably narrower. Although a third party’s lawsuit against a policyholder may be a “product liability” action for purposes of its tort law description, for insurance purposes it is not a “products hazard” claim unless it arises from use of a product for which the policyholder has previously relinquished control. Similarly, for insurance purposes, a lawsuit is not a “completed operations hazard” claim if the injury to the

72. Products Liability Forum, 20 Fed’N. Ins. Couns. QTRLY 73, 82-83 (Fall 1969); see also Nachman, supra note 44, at 204; Roger C. Henderson, Insurance Protection for Products Liability and Completed Operations – What Every Lawyer Should Know, 50 Neb. L. Rev. 415, 426 (1971) (noting 1966 changes separated products and completed operations coverage in order to make it clear that service business not involving goods or products could nonetheless be subject to completed operations provisions of 1966 CGL Form).
third party arises prior to the completion of the construction project or insulation contracting activity.

The natural reading of the words of the CGL policy suggests that tort claims arising from a policyholder’s regular, ongoing operations are general premises-operations liability claims and do not evolve or transform into “completed operations” hazard claims merely because the construction activity comes to a conclusion sometime after the events that give rise to tort liability irrespective of the claimants’ relation to those later activities. Statements by persons associated with the insurance industry also suggest that insurers did not intend to transform general premises-operations liability claims into products/completed operations hazard claims merely because products eventually are no longer in the possession of the policyholder and construction projects eventually are finished. Thus, the text of the CGL policies and the drafting history concerning products/completed operations hazard coverage establish that claims arising out of insulation contracting are general premises-operations liability claims under the CGL policy.

ISO personnel recognize that the correct analysis to determine whether a claim is a products/completed operations hazard claim or a general liability premises/operations claim examines the source of the exposure:

Products are made to be used in the premises or operations of others . . . . Thus, for every product or completed operations exposure of the supplier, there is a corresponding premises or operations exposure for the user.73

This view is consistent with the typical general descriptions of products/completed operations coverage in the scholarly literature.

Bodily injury and property damage liability insurance is provided under the products-completed operations division of the scheduled policies, to cover the liability imposed upon the insured by law for damages sustained by any person caused by accident during the policy period arising out of the handling or use of or the existence of any condition in goods

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73. See Howard J. Walker, Jr., Memorandum of Law Addressing the Issue of Limiting the Availability of ISO’s “Claims-Made” Policy to Specific Classes of Insureds, Insurance Services Office, Inc. at 5; see also Testimony of M. Walters at 46:10-12 (“But I would suggest to you for every product liability exposure you have a corresponding premises operation exposure . . . .”) (Ms. Walters, a Senior Vice President of ISO, was representing ISO at a hearing regarding approval of a new claims-made general liability policy).
or products manufactured, sold, handled, or distributed by the insured, if the accident occurs away from premises owned, rented, or controlled by the insured and after the insured has relinquished possessions to others. Coverage is also provided for injury caused by accident arising out of operations if the accident occurs after such operations have been completed or abandoned at the place of occurrence away from premises owned, rented, or controlled by the insured. (Liability resulting from accidents involving pickup, delivery, and the existence of tools, uninstalled equipment, and abandoned or unused materials is not a part of the completed operations hazard and is covered under the premises and operations insurance [provided by the CGL policy].)\textsuperscript{74}

B. INSURANCE INDUSTRY INTENT AND THE POLICYHOLDER UNDERSTANDING OF COMPLETED OPERATIONS COVERAGE

The natural reading of the words of the CGL policy suggests that tort claims arising from a policyholder's installation and construction activity are general liability claims and do not become "completed operations" claims merely because the construction activity comes to a conclusion sometime after the events that give rise to tort liability. Statements by persons associated with the insurance industry also suggest that insurers did not intend to transform general liability claims into products or completed operations claims merely because product manufacture and construction projects eventually are finished. Thus, the text of the CGL policies and the drafting history concerning products/completed operations coverage establish that installation-related liability claims are general liability claims under the CGL.

The CGL form has deployed a number of slightly different formulations of the term "completed operations" during various iterations of the CGL. As noted above, the original CGL form provided coverage for "products hazard," which as defined in the policy not only covered product-caused injury but also injury caused by what we now term completed operations. In this very first definition of the type of liability claims that would be classified as a products/completed operations claim, the 1943 CGL Form made it clear that a claim was a "products hazard" claim as opposed to a general liability claim only if "the accident occurs

\textsuperscript{74} See, e.g., MEHR & CAMMACK, supra note 21, at 353.
after such operations have been completed" (emphasis added). Thus, where the accident takes place prior to the cessation of construction or other operations, any claim resulting from this accident (or "occurrence" in today's parlance) is classified as a general liability claim.

The 1947 CGL Form contained the same "products hazard" definition that classified completed operations as a products hazard. The 1955 Form retained this basic definition but excepted vehicles used by the insured from the definition. The 1955 Form continued to treat the time of the accident causing injury and the time of the cessation of project construction as the key junctures of classification. If an accident took place before completion of the operation, it was a general liability matter. If the accident took place after completion, it was a products hazard matter. The 1966 Form separated the products hazard and completed operations coverages, defining the "completed operations hazard" as:

[including] bodily injury and property damage arising out of operations or reliance upon a representation or warrant made at any time with respect thereto, but only if the bodily injury or property damage occurs after such operations have been completed or abandoned and occurs away from the premises owned by or rented to the named insured. "Operations" includes materials, parts, or equipment furnished in connection therewith. Operations shall be deemed completed at the earliest of the following times:

(1) when all operations to be performed by or on behalf of the named insured under the contract have been completed.
(2) when all operations to be performed by or on behalf of the named insured at the site of the operations have been completed, or
(3) when the portion of the work out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

Operations which may require further service or maintenance work or correction, repair or replacement because of any defect or deficiency, but which are otherwise complete, shall be deemed completed.

The 1966 Form continued the longstanding exception to this classification for abandoned materials (the "abandoned materials"
exception to the definition of products/completed operations is discussed infra).

The 1966 Form was not intended to alter the long-standing notion that injury arising from construction activity was general liability injury while injury arising from the finished construction itself was loss from a completed operations hazard. The significance of the 1966 changes was in: (a) clarifying that the applicability of the products/completed operations hazard turned on when the bodily injury first occurred rather than when the antecedent negligence took place; (b) separating “products” coverage from “completed operations” coverage; and (c) clarifying that pure services could be the subject of completed operations liability, with warranty or misrepresentation claims included as well. These changes were carried through in the 1973 CGL Form. As previously discussed, there were also editorial changes to the 1973 Form concerning the placement of the “during the policy period” language. These changes did not alter the basic understanding of this language.\(^75\)

The concept of what constitutes a “completed operation” and the verbiage used to describe and define it has been generally consistent throughout the history of the CGL policy. The CGL policy language itself states the perhaps self-evident proposition that when a policyholder has finished a building or project and moved on to other activities, the building or project then becomes a “completed operation” much like a product that has been placed in the stream of commerce. For injuries that begin after that time, the aggregate limits of the CGL policy applicable to products or completed operations claims set forth the insurer’s maximum liability for third-party claims that arise because of failings of the building or project that cause injury. By contrast, injuries that begin during operations are properly classified as general liability injuries. Case law concerning the products/completed operations characterization reflects this common sense approach to the language of the CGL policy.\(^76\)

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75. See supra text and accompanying notes 39-56 (noting insurance industry comments to this effect).

Authoritative insurance texts used for decades in teaching insurance principles and operations also suggest that the “completed operations” hazard (or exclusion) was intended to apply only where the injury at issue resulted from the thing constructed rather than from ongoing construction.

**Completed operations insurance.** This type of policy covers claims from *injuries arising after a service is rendered* and the property’s control is returned to the owner. This coverage would help Leaky Louis, the plumber, whose negligence caused a water heater to explode.\(^7\)

The completed operations exposure is similar to the products exposure and consists of the possibility of liability *arising out of work that has been performed*. Such work is, in a sense, the product of the firm, and any damage arising out of it may result in liability if it is defective. The legal liability arising out of products or out of work performed is covered under a form of insurance called *products and completed operations* coverage.\(^8\)

[Under completed operations coverage] the damage must occur after the contractor has completed the work and the work has been accepted by the owner or abandoned by the contractor. Examples of completed operations liability include the following cases. A contractor was held liable for extensive property damage when a rubber hose connection broke in an air-conditioning system several months after the installation and admitted many gallons of water into the attic of a building. In another case, a contractor was involved in litigation 17 years after he repaired an iron railing; it was alleged that faulty repair work caused injury to a person leaning on the railing. An electrical contractor paid $12,000

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77. See DORFMAN, supra note 21, at 397 (boldface in original; italics added).

78. EMMETT J. VAUGHAN & THERES VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 613 (8th ed. 1999) (italics in original; boldface added). See also id. at 674 (defining “completed operations” in glossary as “a commercial liability insurance coverage applicable to liability arising out of work performed by the insured after such work has been finished.”).
for the death of a three-year-old child electrocuted by an improperly installed outlet on which the work had been completed 15 months prior to the accident. 79

These insurance textbooks reflect the clear general understanding of the term “completed operations” held by policyholders, risk managers, brokers, agents, and insurers over the decades. Insurance law treatises reflect a similar understanding. As described by one authority,

The “completed operations hazard” provision limits an insurer’s liability for bodily injury or property damage to losses that occur away from the insured’s premises and that arise from the insured’s operations after those operations have been completed. 80

Regarding the temporal determination of when ordinary operations (potentially leading to general liability claims) become “completed,” Professor Roger Henderson’s 1971 article, which is perhaps the authoritative assessment regarding the classification of claims as general liability or products/completed operations matters, observed that “[w]here an insured begins an operation and the evidence shows that it is still in progress . . . the answer is self-evident”—liability arising from such a scenario was general operations liability and not completed operations liability. 81 In a more recent assessment making specific reference to Professor Henderson’s important article, a prominent attorney representing insurers echoed this analysis.

Given these seemingly clear [CGL] provisions [regarding competed operations] it should not be surprising that despite efforts by some parties (mostly insurers) to argue for a very broad interpretation of the completed operations hazard, “commentators are in complete agreement that this


81. See Henderson, supra, note 73, at 434-37
[coverage] refers to accidents caused by defective workmanship which arise after completion of work by the insured on construction or services contracts."^{82}

This view of the appropriate dividing line separating products/completed operations claims from general liability claims according to the source of the liability-causing event appears to have been shared by ISO personnel as well.

Products are made to be used in the premises or operations of others . . . . Thus, for every product or completed operations exposure of the supplier, there is a corresponding premises or operations exposure for the user.^{83}

This comports with an example of a general premise-operations liability claim used in an ISO general liability policy training manual:

Would the following situation be included in the definition [of products-completed operations hazard]? The Shadrock Vacuum Cleaning Company sells its vacuum cleaners by door-to-door sales. While a Shadrock salesperson is demonstrating a vacuum in the home of a prospective customer, the vacuum shreds the carpet. Evidence shows the vacuum was incorrectly assembled when manufactured. (Yes/No)

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83. See Howard J. Walker, Jr., Memorandum of Law Addressing the Issue of Limiting the Availability of ISO's "Claims-Made" Policy to Specific Classes of Insureds, Insurance Services Office, Inc. at 5. Accord, Testimony of M. Walters at 46:10-12 ("But I would suggest to you for every product liability exposure you have a corresponding premises operation exposure . . . .") (Ms. Walters, a Senior Vice President of ISO, was representing ISO at a hearing regarding approval of a new claims-made general liability policy).
[Answer] No. Because the product was still in the insured’s physical possession.\textsuperscript{84}

These ISO training and explanatory materials also point to the initial exposure to the injury-causing conditions as the basis on which to decide whether a claim is a general premises-operations liability claim or a completed operations hazard claim. An ISO general liability policy workbook explains that the completed operations hazard “definition clarifies when an exposure changes from operations in progress to completed operations.” The training manual defines “Completed Operations Insurance” as being for “accidents” that happen after a contractor finishes a project.

**Completed Operations Insurance.** A form of insurance issued particularly to various types of contractors. It covers a contractor’s liability for accidents arising out of jobs or operations that he has completed.\textsuperscript{85}

**C. THE ABANDONED MATERIALS EXCEPTION TO THE COMPLETED OPERATIONS DEFINITION FURTHER EXPANDS INSURER COVERAGE RESPONSIBILITY FOR ASBESTOS CLAIMS**

Even if insurers attempting to classify construction and installation-related asbestos liability as products/completed operations coverage in order to obtain the protection of the aggregate sublimit for such claims were correct in their view that the ability of asbestos to generate continuing triggering injury converts on-the-job asbestos exposure to completed

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\textsuperscript{84} See Insurance Services Office, General Liability Coverage ’86 27 (1985). This assessment is also reflected in the internal proprietary claims materials of individual insurers. For example, one manual subject to a confidentiality order reviewed in connection with litigation states that a liability claim should be classified as a products hazard claim if it is caused “as a result of ‘the claimant’s exposure to the insured’s product’ (not as a result of exposure to a product handled by the policyholder).” Further, according to the insurer, a claim should be classified as a completed operations hazard claim where the claimant’s alleged injurious “exposure [was] received as a result of some work that the insured performed, but only if the exposure occurs after the project is completed.” See [insurer identity withheld], Products/Non-Products Definitions and Examples, Nov. 17, 2000 (emphasis added). This document further provided an example in which “[t]he insured, PQR Corporation, improperly repairs a chemical tank on the premises of STU Corporation. A few days after PQR finishes their work, an employee of STU suffers chemical burns when the tank leaks. He sues PQR. This is a completed operations claim.” See id. (emphasis added).

\textsuperscript{85} See Insurance Services Office, supra note 84, at 106 (boldface in original).
operations asbestos exposure, there is an exception to the CGL policy definition of completed operations hazard which provides that liability stemming from abandoned materials will not be considered a completed operations risk. Specifically, the standard CGL policy language states that the completed operations hazard "(b) [d]oes not include 'bodily injury' or 'property damage' arising out of . . . (1) the existence of tools, uninstalled equipment or abandoned or unused materials . . . ."  

Many the third-party claims in the asbestos mass tort allege that these third parties inhaled asbestos fibers as a result of insulation contracting or other construction activities conducted by policyholders. In fact, these types of claims formed the genesis of the asbestos mass tort in the late 1960s and 1970s. These policyholder activities caused the creation of asbestos dust at these sites due to cutting and fitting of asbestos. This material is "abandoned material" within the meaning of the CGL policy since it was not intended for use by the policyholder, its customers, or others. Thus, liability from insulation contracting debris or collaterally released asbestos logically must be classified as general premises-operations liability rather than products/completed operations hazard liability.  

ISO training materials also suggest that materials that were not used in the final construction product, but are the source of injury to a claimant, are not within the scope of the completed operations hazard. An ISO general liability workbook states that, based on "what is excluded from the definition of 'products/completed operations hazards,'" the following hypothetical presents a situation that would not be subject to the completed operations hazard: "During construction of the hotels for National Inns,
Caleb Construction Company piles a supply of lumber at one of the sites. A guest is injured on a rusty nail while rummaging through the pile.\textsuperscript{89}

D. Differing Views of the General Operations/Completed Operations Divide

As the foregoing analysis demonstrates, the background, structure, language, and historical understanding of the dividing line between general operations and products/completed operations coverage matters suggests that many asbestos claims are best classified as tort claims stemming from ongoing operations for which there were no aggregate limits in most liability policies issued to asbestos defendants. This is another factor tending to increase insurer coverage responsibilities for the asbestos mass tort and has had, at the margin, an expansive effect on the insurance industry’s coverage obligations related to asbestos.

But the flip side of this coin is that insurers have had some significant success in convincing some courts or arbitrators that continuous asbestos injury that began during regular ongoing operations by the policyholder (and therefore was not subject to an aggregate limit) converts into completed operations or product hazard liability where there is some triggering injury that post-dates the initial operations that begat the claim, thereby bringing the products/completed operations aggregate into play and limiting the insurer’s asbestos coverage responsibility.

The judicial and arbitral track record in this area remains mixed and continues to be hotly disputed because of the ongoing presence of asbestos coverage disputes related to insulation, installation, and construction activities by asbestos policyholders who continue to face claims from third parties. Although this part of the asbestos mass tort has moved into the recesses of public consciousness, it remains an area with hundreds of millions or even billions of dollars yet at stake as such coverage disputes continue to move through the judicial system or alternative forums such as arbitration.\textsuperscript{90}

\textsuperscript{89} See Insurance Services Office, \textit{supra} note 84, at 28.

\textsuperscript{90} A fair number of such disputes are subject to the 1984 “Wellington Agreement” (so named for former Yale Law School Dean Harry Wellington, who helped broker it), in which major asbestos producers and their liability insurers agreed to certain ground rules for resolving their coverage disputes, including and arbitration mechanism subject to limited judicial review for purposes of resolving particular controversies.
A significant victory for insurers was *In Re Wallace & Gale Co.* In *Wallace & Gale*, the court adopted the view that general liability claims change into completed operations claims where there is continuing injury post-dating completion of the installation. *Wallace & Gale* was an important victory for insurers, a precedent issued by a federal appeals court after heavy litigation. But *Wallace & Gale*, and the entire notion that what clearly begin as general operations claims transform into completed operations claims merely because there is continuing injury, seems clearly incorrect in light of the history, intent, structure, and operation of the CGL.

In addition, the *Wallace & Gale* decision did not consider the "abandoned materials" exception to the definition of the completed operations hazard on the ground that the issue had not been raised at trial and was therefore waived on appeal. Although this may be correct as a matter of the court's procedural law, it casts a considerable shadow on the persuasiveness of the *Wallace & Gale* decision. *Wallace & Gale* was a contractor that installed asbestos-containing insulation. As part of the process, asbestos fibers were undoubtedly released due to the cutting, sawing, fitting, handling, and discarding of unused insulation. In short, *Wallace & Gale*, the defendant policyholder, was subject to suit and liability in large part because of the abandoned materials it left at its job sites, a common practice in the days before the dangers of asbestos were fully appreciated. To the extent that asbestos plaintiffs were exposed to asbestos from this type of source, it would seem to fall squarely within the abandoned materials exception to any completed operations limits on coverage and hence be regarded as a general operations claim to which the policies of the day usually contained no aggregate limit. Consequently, the precedential value of the *Wallace & Gale* decision is significantly limited as applied to asbestos contractor defendants and policyholders.

92. See 385 F.3d at 833-34.
94. See 385 F.3d at 835.
95. See 385 F.3d at 823-24. Although *Wallace & Gale* stopped using asbestos in the 1970s, it nonetheless became a sufficient target of asbestos claims that it filed for bankruptcy in 1984.
96. See supra text and accompanying notes at 87-89 (analyzing the abandoned materials exception to the completed operations definition).
In counterbalance to *Wallace & Gale*, policyholders can point to *Frontier Insulations Contractors, Inc. v. Merchants Mutual Ins. Co.*\(^{97}\) as substantial support for the policyholders’ view that asbestos injuries resulting from the general business operations of the policyholder remain general operations claims for purposes of determining insurer coverage responsibilities, thus avoiding exclusions or aggregate limits for products or completed operations liability. In *Frontier Insulation Contractors*, the New York Court of Appeals unanimously reversed an Appellate Division decision in which the majority had erroneously regarded the claims against the policyholder as products/completed operations hazard claims merely because the underlying tort claim involved a dangerous product (asbestos). The Appellate Division majority had failed to appreciate that the category of “products hazard” claims under a CGL policy is only a “subset of product liability claims” found in the tort system.\(^{98}\) The Appellate Division majority had also failed to appreciate that the classification of a claim as a general premises-operations liability matter or a products/completed operations hazard matter “depends on the location of the accident and possession of the product” rather than whether the underlying tort claim is based on strict liability or involves a dangerous product.\(^{99}\) Observed the *Frontier Insulations* Court:

> Defendants have failed to establish that all of the underlying bodily injury claims satisfy the time and place prerequisites of the product-hazards exclusion. The exclusions, by definition, cannot apply to accidents or occurrences that allegedly took place while Frontier’s installation work was in progress because the offending product – the asbestos insulation – was not relinquished from Frontier’s control until installation was complete. In fact, a number of the plaintiffs in the underlying lawsuits expressly allege that Frontier’s “negligent installation” of the asbestos insulation caused their personal injuries. More importantly, none of the underlying complaints specify that the plaintiffs’ personal injuries occurred only after Frontier had completed installation and departed from the covered premises. Since asbestos fibers may be readily released into the air and inhaled while a contractor is cutting and

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\(^{97}\) 690 N.E.2d 866 (N.Y. 1997).

\(^{98}\) *See Frontier Insulations Contractors*, 690 N.E.2d at 869.

\(^{99}\) *See* Henderson, supra note 72, at 420.
sawing the product during installation, there is a reasonable possibility that any liability attributed to Frontier would stem from injuries that occurred during ongoing operations – covered events [under its general liability coverage]. Accordingly, [the insurers] have failed to establish as a matter of law that the product-hazards exclusions provide shelter from their duty to defend Frontier.\textsuperscript{100}

Although Frontier Insulations was a “duty to defend” case rather than an indemnity payment case, its rationale provides a persuasive assessment regarding the divide between a policyholder’s general operations hazard and the product/completed operations hazard. Frontier Insulations reflects a sounder analysis and better reflects the longstanding judicial and insurance industry approach to the products/completed operations hazard than does Wallace & Gale.

Where a third party’s claimed injury results from ongoing operations and begins prior to completion of construction, the claim should be treated as one of general liability rather than completed operations liability.

It appears that arbitration results regarding the issue are similarly mixed (although many arbitration awards remain confidential, which makes it difficult to assemble a policyholder-insurer scorecard). For example, in ACandS, Inc. v. Travelers Casualty & Surety Co.,\textsuperscript{101} a split panel of three distinguished arbitrators sided with the insurer’s effort to classify ongoing claims arising out of the policyholder’s asbestos insulation activity as subject to the aggregate limit for completed operations. The arbitration, conducted between parties to the 1985 Wellington Agreement between major asbestos defendants and insurers, provides a startling example of how even distinguished jurists can completely misjudge an insurance coverage question.

In addition to the Wellington Agreement, ACandS and Aetna Casualty and Surety Co (subsequently acquired by Travelers) had agreed in August 1988 to a presumptive allocation of claims and payments in which fifty-five percent of the amounts would be treated as products/completed operations coverage (which was subject to aggregate limits in the relevant policies) and forty-five percent as general operations coverage, which was not subject to an aggregate limit. As time went by, ACandS questioned this

\textsuperscript{100} See Frontier Insulations Contractors, 690 N.E.2d at 870 (citations omitted) (italics emphasis in original; boldface emphasis added).

\textsuperscript{101} See In the Matter of the Arbitration Between ACandS, Inc. v. Travelers Casualty and Surety Company (CPR Institute for Dispute Resolution, July 29, 2003).
apportionment contending that much more of its asbestos liability stemmed from general operations such as construction and insulation installation.\textsuperscript{102} ACandS was also undoubtedly hoping to maximize its insurance coverage by having more of its liability outside the aggregate limits restricting products/completed operations coverage. Travelers was just as eager to have more of the policyholder's liability classified as subject to the aggregate limits. In particular, the parties disputed classification of claims for the 1976-1979 policy years.

In addition to the dispute over claims classification, the parties had major differences over the scope of the arbitration, commenced by ACandS, and the relief the arbitrators could provide. ACandS took the position that since it had brought the arbitration and Travelers had not petitioned for relief from the 1988 Agreement, the arbitrators could either grant the ACandS request or leave the 1988 percentages intact. Travelers argued that the panel could make a downward adjustment in the general operations allocation as well. In addition, ACandS filed for bankruptcy in September 2002 while the arbitration was proceeding but nearly a year prior to the panel’s award. ACandS argued that the automatic stay of claims against the debtor provided by the Bankruptcy Code prevented any adjustment of the 1988 percentages in favor of Travelers on the ground that this would be unauthorized relief against the debtor. Both the panel majority and a federal district court disagreed.\textsuperscript{103} However, the Third Circuit found the bankruptcy stay to bar an alteration of the apportionment in favor of Travelers.\textsuperscript{104} Thus, the dispute remains unresolved in spite of the arbitration panel’s ruling.

Although ACandS may have been granted a reprieve on procedural grounds, the arbitration itself was a complete victory for Travelers on the question of claim classification, one the District Court was unwilling to overturn under any of the grounds provided by the Federal Arbitration Act.\textsuperscript{105} The “all-star” arbitration panel was comprised of former Eighth

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\textsuperscript{102} ACandS stands for Asbestos Construction and Supply, a name that itself strongly suggests that at least some significant amount of its asbestos liability stemmed from ongoing construction/insulation activities and not manufacture, sale, or distribution. Nonetheless, the panel majority did not bother to use even this common sense check on its ruling that not a single dollar of 1976-79 claims could be classified as general operations liability.


\textsuperscript{104} See AcandS, Inv. v. Travelers Casualty & Surety Co., 435 F.3d 252 (3d Cir. 2006).

\textsuperscript{105} The Federal Arbitration Act, 9 U.S.C. §§ 1-16, originally enacted in 1926, provides only limited grounds for vacating or modifying an arbitration award. See 9 U.S.C. § 11. In essence, an award can be changed only in cases of clear clerical error or set aside.
Circuit Judge and FBI Director William Webster (appointed by Travelers), University of Pennsylvania Law Professor Stephen Burbank (appointed by ACandS), and former Third Circuit Judge John Gibbons (selected by Webster and Burbank as the “umpire” of the arbitration panel). In a 2-1 decision, Judges Gibbons and Webster ruled for Travelers, holding that the percent of general operations liability for the 1976-79 period was zero.

Although Judges Gibbons and Webster are highly regarded, the majority opinion in the ACandS arbitration is riddled with error and misconceptions about the nature of liability insurance. After quoting the standard CGL language, the panel majority states that the “insuring agreement unambiguously requires an occurrence within the policy period” if there is to be coverage.106 This statement, of course, is dead wrong—the type of error that would result in a low or even failing grade for a student in an insurance or insurance law course. As discussed at length above, the triggering event for purposes of CGL coverage is injury or damage—not the occurrence ultimately leading to the injury or damage.107

This misconception of the panel majority created a chain reaction of incorrect analysis of the classification issue. Because the majority thought that there was general premises/operations coverage only if there was a covered occurrence taking place during the policy period, it incorrectly reasoned that there could be no general operations liability in the 1976-79 period because ACandS had “ceased using asbestos in its operations prior to those years.”108 With the certainty of a comic opera character, the majority further stated that the “unambiguous language of the policy requires an occurrence in the policy year”109 and that “[i]f ACandS were using asbestos in its operations in those years there would be operations coverage without aggregation. But it is undisputed that there were no

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106. See Arbitration Award at 7.
107. See supra Part III.
108. Arbitration Award at 7.
109. Arbitration Award at 8.
ACandS asbestos operations in those years. Thus, there could not be an asbestos operations occurrence during those years. 110

With this misstep and its insistence that there be active policyholder negligence or other liability-creating behavior during the policy period, the panel majority avoided undertaking any analysis of the history and purpose of CGL general operations coverage and the insurance industry’s understanding that the source of an injury—“the hazard”—was generally the key to determining whether the injury and resulting claim should be classified as a part of a general operations hazard or a products or completed operations hazard.

The panel majority’s assessment is particularly odd because it took the view that there must be an “occurrence” in order for coverage only with regard to general operations coverage. But the panel found that after general operations were finished, an injury taking place “qualified” as an occurrence if there is physical manifestation in the policy year 111 making this sort of covered matter a completed operations hazard subject to the policy’s aggregate limit. At this point in the opinion, the majority’s thought process crossed from the merely erroneous to the truly bizarre. There is simply no basis—in the CGL policy language; in its history; in its purpose; in custom and practice; in logic; or in equity—for suggesting that general operations coverage requires a liability-creating activity during the policy period but that products/completed operations liability requires only an injury.

In effect, the majority is creating from thin air two different triggers for operations and completed operations: a negligence trigger for operations and an injury trigger for products and completed operations. This dichotomy has no basis in law, fact, history, or insurance theory and in fact is squarely contradicted by these factors. In addition, when the majority was willing to use an injury trigger (for at least the completed operations claims), it chose an operational definition of the injury trigger that has been rejected by nearly all courts, most importantly, perhaps, the courts of Pennsylvania, the state of controlling law for the dispute.

Recall that the panel majority found injury only if there “is physical manifestation” of the injury during the policy year. 112 This, in essence, is an adoption by the panel of the “manifestation” trigger of coverage, which competed with the “exposure” trigger, the injury-in-fact or actual injury

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110. Arbitration Award at 8.
111. Arbitration Award at 9 (boldface in original).
112. Arbitration Award at 9.
trigger, and the continuous trigger. As discussed above, the continuous trigger has been the clear winner in this marketplace of adjudicatory ideas, having been embraced by the majority of states. As also noted above, the nature of asbestos-related injury makes the actual injury trigger in essence function as a continuous trigger because of the continuing ability of asbestos fibers in the lungs to inflict new injury over the years. Even under the exposure trigger, most famously embraced in Insurance Co. of North America v. Forty-Eight Insulations, a close analysis of the case reveals that the court in that case was really requiring that there be "injurious exposure" to trigger coverage. When the layers of the case law on are peeled sufficiently, the history of asbestos trigger litigation reveals only a few cases embracing a "manifestation" trigger, with some of those in essence overruled by subsequent cases rejecting manifestation as a trigger. Relatedly, it is important to emphasize that courts adopting an actual injury trigger have not required the injury to be palpable, visible, apparent, or otherwise manifest. For example, in one famous trigger case (albeit one involving prescription drugs rather than asbestos), the Second Circuit modified an otherwise well-reasoned district court opinion that required that the injury in question be medically diagnosable in order to be

113. See STEMPEL, supra note 6, at 14-42 to 14-44. The continuous trigger is also referred to as the "triple-trigger" in that for courts adopting this trigger, either exposure or injury or manifestation of injury acts to activate an occurrence CGL policy on the risk at the time of any of these events. Some courts have also used a "double trigger" in which either exposure or manifestation are regarded as activating the policy. See, e.g., Zurich Ins. Co. v. Raymark Indus., 514 N.E. 150, 160-61 (Ill. 1987).
114. See supra Part III.
115. See supra Part III.
117. See STEMPEL, supra note 6, § 14.09[b], at 14-48:

Despite the different verbiage, all of the approaches to bodily injury trigger when viewed in the light of the facts of the cases themselves can be seen as application of an actual injury trigger. But for many, probably most, of the claims, there was injury alleged or taking place from the initial exposure on to the time of manifestation. Consequently, the various triggers can be harmonized on their facts. For the most part, the trigger standard in the United States is an actual injury trigger, which is consistent with policy language, the purpose of the insurance, and the expectations of the policyholder.

This observation is particularly true for asbestos, because of the peculiarly perpetual injurious traits of the material.
a sufficient triggering "injury."\textsuperscript{118} Like the Second Circuit, most courts applying an injury trigger have found it sufficient that asbestos was causing injury even though the ability to detect that injury was years away. This was also the understanding of those involved in the development of the 1966 CGL Form. As a result, of course, the actual injury trigger tends to become a continuous trigger for asbestos matters.

This portion of the ACandS-Travelers panel majority opinion is a bit like the 13\textsuperscript{th} chime of the clock, calling into question the soundness of the clock and the accuracy of any of its time readings. First, the majority adopts two different triggers for different types of claims and then it uses an injury trigger that has essentially been relegated to the dustbin of litigation history. It is as if an astronomy department at a university evaluated a tenure candidacy on the basis of Tyco Brach (who thought the sun revolved around the earth) rather than Copernicus. More important, perhaps, Pennsylvania, the state of applicable law, is clearly on record as embracing an actual injury/continuous trigger in asbestos coverage cases—and not a manifestation trigger.\textsuperscript{119}

The majority opinion contains other substantial errors of assumption and analysis as well. First, it finds that the "insured has the burden of putting itself within the [general operations] coverage."\textsuperscript{120} Although it is true that the policyholder generally has a burden to show that it has suffered a covered loss, this burden was already satisfied almost as a matter of stipulation by the parties or concession by Travelers. Recall that ACandS and Travelers had an agreement as to presumptive coverage and even as to presumptive allocation, building in an ADR agreement to permit changes to the allocation percentages if a dispute as to those percentages should arise. Travelers had in effect agreed, as any reasonable insurer in the late 20\textsuperscript{th} Century must, that asbestos claims against the policyholder are torts covered under the CGL policy. It was conceded that ACandS, which has been the target of asbestos litigation for more than a quarter-century, clearly had been sued for asbestos liability and that the Aetna/Travelers policies provided coverage for that liability. Without doubt, then, ACandS had established a prima facie case of coverage and satisfied the basic "burden" of the policyholder to bring a liability claim within presumptive coverage.

In response to this prima facie case of coverage, Travelers was essentially arguing that the coverage was restricted or capped because of


\textsuperscript{120} See Arbitration Award at 8.
the policies' aggregate limit for products/completed operations claims. In essence, Travelers was arguing that although ACandS had established coverage, the nature of the liability claim should result in a reduction in coverage because the type of claim for which there was admitted coverage was subject to a particular limitation for such claims. This argument is in the nature of invoking an exclusion in the policy to avoid coverage. As such, it is actually the burden of Travelers to demonstrate that any limitation on coverage applies, just as it would be the burden of Travelers to establish the applicability of an exclusion.\textsuperscript{121}

The panel majority relied substantially on the district court's opinion in \textit{Wallace & Gale}, finding that it was "[t]he only judicial opinion that has considered the question whether occurrences 'after such operations have been completed or abandoned' are treated as Products or Non-Products [general operations] claims . . . ."\textsuperscript{122} Throwing aside the majority's continued error in focusing on the time of occurrence rather than the time of bodily injury, the statement suggests further problems with the majority opinion. As discussed above, the \textit{Frontier Insulations} decision of the New York Court of Appeals is at least as relevant to the question as is \textit{Wallace & Gale}.\textsuperscript{123} Yet the panel majority recognizes and defers to \textit{Wallace & Gale} while ignoring \textit{Frontier Insulations}.

The majority also appeared to have turned the venerable ambiguity doctrine on its head. ACandS expert witness Richard Stewart, a former New York Superintendent of Insurance and widely recognized authority, was regarded by the majority as "conced[ing] that the construction of the policy we adopt is certainly plausible."\textsuperscript{124} Therefore, reasoned the

\textsuperscript{121} See supra text and accompanying notes 20-34, (describing respective burdens of persuasion of policyholder and insurer in coverage litigation).

\textsuperscript{122} See Arbitration Award at 9.

\textsuperscript{123} See supra text and accompanying notes 90-99, (discussing \textit{Wallace & Gale} and \textit{Frontier Insulations} opinions).

\textsuperscript{124} See Arbitration Award at 13. Although Stewart's willingness to consider the insurer's linguistic argument about the meaning of the completed operations definition in the CGL is admirable in its non-partisanship, I find it too charitable to Travelers and other insurers attempting to classify any post-completion injury as completed operations injury. Although the insurer argument is not quite frivolous if one focuses only on the definitional language in isolation, it is a stained textual argument based on hyperliteralism. More important, the argument is clearly incorrect when one considers the background and purpose of the CGL policy, historical insurer understanding and practice, and the context and source of the asbestos liability claims. Consequently, my view is that the Travelers argument is not even "plausible." Much of the asbestos liability of ACandS, \textit{Wallace & Gale}, and other insulation contractors, arose out of its ongoing general operations. Such claims are properly classified as premises/operations claims no matter how long the asbestos for which the defendant/policyholder is responsible continues to cause injury.
majority, ACandS had failed to carry its burden to show coverage because it had failed to demonstrate that its interpretation of the policy was the only reasonable understanding of the policy. Of course, the majority stacked the deck some more with its bizarre conclusion that the language of the completed operations definition clearly made any matter of injury after completion a completed operation regardless of the source of the injury or its onset. But in essence, the majority was reversing the traditional doctrine of contra proferentem. Normally, the ambiguity doctrine requires that the drafter of the policy, normally the insurer, exclude all other reasonable interpretations of the contested policy provision. In the hands of the panel majority, however, it appeared that the nondrafter policyholder was now charged with negating all other reasonable interpretations in order to prevail.

The majority dismissed concerns about double coverage raised by Stewart (going so far as to label his argument a “straw man”) by stating that the CGL dealt with the issue through its “other insurance” clause. Again, the majority betrays a misunderstanding of insurance in that the other insurance clause is generally regarded as coordinating concurrent overlapping insurance coverage but not speaking to the issue of coordination of coverage responsibilities among consecutively or successively triggered liability policies.

Further, the panel majority does not address the issue of whether the abandoned materials exception to the definition of completed operations might apply, even if the majority were correct in its view that any injury taking place after completion was a completed operations injury even if the source of the injury were regular, general, ongoing construction and insulation operations. Unlike the Fourth Circuit’s Wallace & Gale opinion, there is no discussion of waiver or policyholder failure to raise the

125. See Arbitration Award at 14.
126. See STEMPEL, supra note 6, § 14.10; William R. Hickman and Mary R. DeYoung, Allocation of Environmental Clean-Up Liability Between Successive Insurers, 17 N. Ky. L. Rev. 291, 305 (1990). See also Susan Randall, Coordinating Liability Insurance, 1995 Wts. L. Rev. 1339 (1995) (focusing on other insurance clauses as means of coordinating overlapping concurrent coverage). To be fair to the majority, the same error was made by an even more distinguished judge, David Bazelon, who authored the famous opinion in Keene Corp. v. Ins. Co. of No. Am., 667 F.2d 1034 (D.C. Cir. 1981) (applying general legal principles), cert. denied, 455 U.S. 1007 (1982). But Judge Bazelon wrote more than 20 years before the ACandS panel majority, at a time when asbestos coverage litigation was in relative infancy, with the issues of consecutively triggered coverage and allocation of insurer (and perhaps policyholder) coverage responsibility was not even fully articulated. By the 21st Century, two similarly well-regarded judges should have known better.
127. See Arbitration Award.
issue, although it appears that ACandS did argue the applicability of
general operations coverage via the abandoned materials exception.
Perhaps the panel majority found it unnecessary to address the issue since
the initial injuries caused by abandoned materials began prior to the policy
years in question. In effect, the abandoned materials exception became
another casualty of the majority’s error in thinking that there could be no
general operations coverage unless operations and liability-creating
conduct took place in the policy period.

By contrast to the majority’s error-ridden analysis, the Dissenting
Statement of Professor Burbank is well-reasoned and persuasive,
appreciating the background, function, and operation of the CGL policy.
Professor Burbank also concluded that the panel could not change the
percentage of claims classified as general operations claims in Travelers’
favor, 128 a procedural point on which he was vindicated by the Third
Circuit’s ruling. 129 As the dissent observed:

Travelers’ interpretation requires us to lash a “hazard” under
the 1976-79 policies to the concept of “bodily injury”
temporally, even though – contrary to the view taken by my
colleagues – there is no such temporal link required of an
“occurrence,” and even though a “hazard” (“a source of
danger or risk”) is logically prior to an “occurrence.” An
asbestos bodily injury claim brought against ACandS by
someone who was exposed during and as a result of one of
its installation contracts is an operations claim. The source
of the risk is not a completed operation, and the persistence
and/or progression of injury across policy years, triggering
coverage in those years, does not change the source of the
risk. On this view, in such a case, the relevant “bodily
injury,” even though occurring during the policy period, is
inseparable from the “bodily injury” during the period of
first exposure and thus cannot be said to occur, at least
entirely, “after such operations have been completed or
abandoned.” ACandS’s expert medical testimony, the only
such testimony offered, supports this view of the asbestos
disease process.

128. Arbitration Award Dissent at 1.
2006) (applying federal bankruptcy law).
[T]he analyses of the changes made in the 1966 form CGL policy by Gilbert Bean of Liberty Mutual (in documents accompanying Mr. Stewart's expert report) [Bean was one of the drafters of the 1966 CGL Form] quite clearly recognize that the change from focus on the time of the accident or occurrence to the time of the bodily injury would lead successor insurers to inherit unknown risks under premises/operations coverage. Moreover, those discussions assume that the hazard does not change.

In sum, I believe that the policy language can sustain more than one reasonable interpretation, which under Pennsylvania law requires that the interpretation favoring the insured be adopted. 130

At the risk of being accused of occupational jingoism, it seems unmistakable that in the AcandS arbitration, the law professor got it right, while two noted judges completely misconstrued basic matters of insurance as well as the specific issue before the tribunal.

Although the AcandS arbitration panel decision provides some significant comfort to insurers attempting to limit asbestos coverage, the analytical defects of the majority opinion and Professor Burbank's far more persuasive analysis in dissent may limit its precedential utility for insurers.

A different Wellington Group proceeding provided a much sounder assessment of the issue, relying significantly on expert testimony from insurance industry experts, and should prove more persuasive to future tribunals. Armstrong World Industries, Inc. v. Aetna Casualty & Surety Co. 131 was a Wellington Agreement arbitration in which the Trial Judge (essentially an arbitrator despite the litigation nomenclature) expressly found that asbestos installation claims are general liability matters and are not subject to characterization as completed operations merely because injury from asbestos released during installation continues beyond the date installation ceases.

In particular, the arbitrator heard testimony regarding the derivation of the CGL and concluded that the historical view of the insurance industry was that claims are to be categorized according to the source of the injury and did not change character over time even if the injury was continuing. Of course, this did not stop the insurer in the arbitration from asserting that

130. Arbitration Award Dissent at 4.
there was such metamorphosis in asbestos claims, particularly with millions of dollars hinging on the potential application of aggregate limits. This arbitrator, also a distinguished former judge, rejected the insurer's attempt to convert general operations claims into completed operations claims in order to reduce its coverage responsibilities.

[T]o adopt [the insurer's] construction would result in the unprecedented holding that a hazard under one policy could be reclassified to a different hazard category in subsequent policies. This would be contrary to industry practice and indeed, the entire "hazard" concept. Liberty Mutual’s William Upham, for example, was not aware of any cumulative injury claim that Liberty Mutual had ever classified as a nonproducts [general premises/operations] claim under one policy, but as a products/operations claim under later policies. Testimony from other witnesses was in accord. The insurers’ expert and the claims managers for Century, Reliance, the London Market Insurers, and Travelers were unaware of any claims that the insurers had ever classified as one hazard under one policy, but as another hazard under other policies. . . . According to [an insurance company claims supervisor, if a claim] “started out as an operations claim, it stayed an operations claim; if it started as products, it stayed as products. I don’t have a recollection having one changing in midstream.” . . .

[T]he record in this cases makes it clear that in practice the insurers do not reclassify claims over time. Indeed, such reclassification runs contrary to the very concept of hazards in the insurance industry [and is] contrary to industry practice.132

VI. THE CGL AND CHANGES IN POLICYHOLDER IDENTITY AND OPERATIONS

A. ASSIGNMENT AND TRANSFER OF POLICY RIGHTS

The general rule of contract law is that contract rights may be freely transferrable and may be assigned. As one leading authority notes, “[i]f the

132. See id. ¶¶ 107, 108, at 44-45 (emphasis added; citations omitted).
rule were otherwise, our modern credit economy could not exist. Delegation of contract duties is somewhat more restricted in that the duty to perform a contract cannot be delegated if this will materially increase the other contracting parties’ risk of non-performance or inferior performance. Although this can be a significant restriction on personal service contracts (e.g., the multimillionaire who hires U-2 to play at her 50th birthday party will be more than a little annoyed if a tribute band should show up in lieu of Bono and the rest of the real group) or where there are pronounced differences between delegator and delegatee (e.g., company that hires Cisco Systems for its internet wiring will not be pleased to find the task delegated to an untested start-up company), it is not a significant restriction on alienability of contract rights and responsibilities. Most transfer of contract rights and obligations takes place between commercial entities that have equivalent capability to perform contractual obligations.

Insurance policies, of course, are contracts, and are subject to this general rule or free alienability—as well as the general rule that the ordinary “default” rules of contract can be specifically modified by contracting parties. Although insurers might successfully argue that the assignment of policies intrinsically increases risks in an unacceptable manner and unduly undermines the underwriting process, insurers have made such debates largely academic by routinely including in their policies provisions prohibiting assignment in the absence of the insurer’s consent. Policyholder assignment of the policy’s protections are generally ineffective without the insurer’s consent.

At least this is the case where a policyholder assigns the policy and the assignee expects coverage for future property loss or liability claims that stem from the assignee’s activities. In such cases, insurers can persuasively argue that they issued the original general liability policy to a particular policyholder that presented a particular risk profile and not to the second purported policyholder that presented a significantly different risk profile. An obvious example might be issuing a CGL policy to a bookstore and then finding the policy assigned to the nightclub that purchased the

134. See STEMPEL, supra note 6, § 3.15.
property from the bookstore (even the wildest Barnes & Noble is unlikely to generate claims on a par with the volatile mixture of alcohol, violent patrons, bouncers, and youthful hormonal activity found in the average nightclub).

But where the liability-creating events predate the assignment of a liability policy and where the identity of the new policyholder played no role in the risk involved or the third party claim, courts have long permitted such assignments notwithstanding clear anti-assignment or consent-to-assignment language.136 After a loss or injury has occurred, there is by definition no increase in the insurer's risk if the policyholder simply assigns its rights under the policy to a successor entity or another third party.

This common sense exception to the enforceability of policy language restricting assignment has significant potential impact for asbestos coverage or other long-tail torts such as pollution, prescription drugs, or insidious disease caused by toxins. If Company A manufactured, distributed, or used asbestos in its operations, there is of course more than a little chance that Company A will be sued. If Company A is sold to or acquired by Company B and Company B receives an assignment of the CGL policies of Company A, Company B will understandably want to use those rights should it be sued over asbestos as successor to Company A.137

Historically, this type of hypothetical would present no significant difficulty for insurers or courts—the CGL insurer would be required to


137. See generally STEMPPEL, supra note 6, § 3.15.
defend and indemnify Company B as it would Company A, even if the insurer had not consented to the assignment. Although there may be a technical violation of any anti-assignment language in the CGL policy, it brought no harm to the insurer where the events giving rise to the asbestos claims took place when Company A was conducting business. In this type of case, the assignment of the insurance policy is like an assignment of any other asset. There was no risk to the insurer that Company B would engage in riskier behavior with asbestos than did Company A. The wisdom of this traditional approach is particularly apt in many asbestos situations where such assignments may well post-date the mid-1970s halt to the use of asbestos in the United States. Under such circumstances, the asbestos claims almost certainly are all centered on the activities of assignor Company A rather than assignee Company B. The same analysis should ordinarily govern not only asbestos but other long-tail claims such as pollution liability or pharmaceutical drug liability.

For the most part, these types of post-loss assignments have been freely permitted by courts (and are as a practical matter probably only challenged by insurers when the losses are large). Consequently, even though the asbestos mass tort has its roots in victim exposure that often took place many years and company changes ago, this has generally not reduced the insurance coverage otherwise available for asbestos claims. However, as discussed below, the California Supreme Court in its 2003 Henkel Corp. v. Hartford Accident & Indemnity Co. decision refused to enforce a transfer of policy rights with an analysis cutting against the grain of the traditional rule. Although the case was one involving a toxic tort from exposure to metallic chemicals, the implications for asbestos coverage are potentially significant both because of California’s size and its importance as a precedent-setting jurisdiction. By now, one would have expected asbestos claims to have run their course that policy assignment should not matter. But in view of the seeming perpetuity of the asbestos mass tort, one expects there are at least some significant cases posing the issue, although they may be out of the public eye due to arbitration or negotiation. As discussed below, Henkel is an extremely poorly reasoned decision providing a windfall to insurers, one I regard as part of the judiciary’s unconscious result-oriented balancing of the scales of insurance coverage litigation in response to the view that courts were too generous to policyholders in adopting the continuous trigger. But whether Henkel is wise or foolish,

139. See infra text accompanying notes 149-178.
140. Id.
if it continues to be followed in California or gathers support in other jurisdictions, it will have a significant coverage-restricting effect not only for insurance but for other long-tail liabilities.\(^{141}\)

**B. COVERAGE FOR POLICYHOLDER ACQUISITIONS**

Situations like *Henkel* and standard assignment of policies present the issue of whether there is insurance coverage when the initially applicable policy is transferred from the policyholder after the events giving rise to a third party claim. There is also a flip side to the transfer question: what happens when an insurance policy is issued to a policyholder that subsequently acquires other companies that had activity during the policy period that later gives rise to liability claims against the original policyholder, who still holds rights under the liability policy originally issued? This is a more difficult issue with less established precedent than exists on the question of assignment of policy rights after a loss or liability-creating injury has taken place.

Insurers argue that they should be relieved of the consequences of the liability claims against the original policyholder if the liability arises from activities performed by an entity acquired by the policyholder after the policy period—even though the claims themselves allege triggering injury during the policy periods and even though the policies as written apply to any business of the policyholder, including businesses that were acquired by the policyholder after the policy period. Although the insurers’ objections may seem initially compelling on the ground that the insurer should not be responsible for later changes that expand the policyholder’s potential liability exposure, closer examination suggests that insurers are incorrect in refusing to provide coverage in such situations.

First, the policies themselves—drafted by the insurers—frequently contain no such limitation. In the absence of any limiting language, the insuring agreement itself is of course the primary touchstone for determining coverage. The CGL insuring agreement simply states that the CGL insurer will pay “all sums” for which the policyholder may become liable. There is no exclusion or exception for policyholder liability that arises due to subsequent acquisition of a company with legal liabilities. To

the extent there is any uncertainty as to the application of the insuring agreement, doubts are required to be resolved in favor of the policyholder according to the ground rules governing insurance.

Second, the most natural reading of the type of policy language often found in older liability policies is that the insurer intended to provide coverage to all operations of the policyholder, regardless of when acquired. For example, the named insured endorsement in many policies issued during the 1945-1970 time period is particularly broad, naming as policyholder not only the named insured as currently comprised but also all related entities as currently or "hereafter constituted." With regard to the primary policies, it was not until the 1980s that ISO issued an endorsement for use by insurers in issuing policies where the insurer wished to exclude coverage for any acquisitions carrying liability that predated the policy period in question.\textsuperscript{142} This suggests that the insurance industry historically understood that coverage would be provided for all acquisitions of the policyholder without regard to the timing of such acquisitions.

Third, background information concerning the CGL policy suggests that insurers consciously assumed the risk posed by coverage for liability that accompanied changes in the policyholder's operations through either growth or acquisitions. Persons associated with the insurance industry have long stated the general rule that the expansion of policyholder assets and operations does not negate the insurer's coverage obligations. For example, one insurance company executive described the benefit of the CGL policy as follows:

Take each policy needed . . . weld them together in a Comprehensive coverage, limiting exclusions to a minimum and adding automatic coverage for any new venture an insured may care to undertake, and you have one of the most potent weapons for protection ever afforded a risk.\textsuperscript{143}

Elmer Sawyer, one of the architects of the CGL policy, stated that insurers expected the CGL policy to cover liabilities befalling a policyholder because of expansion of the policyholder's business, including expansion by the acquisition of other companies. Sawyer observed that the

\textsuperscript{142} See New Commercial General Liability Endorsements Filed, ISO CIRCULAR, July 30, 1984, at 5 (setting forth list summarizing CGL Endorsement GL 21 10 and describing it as "a new endorsement" that "[e]liminates any coverage for newly acquired corporations under the policy").

\textsuperscript{143} See Eglof, supra note 17, at 19 (emphasis added).
CGL was designed to provide “Automatic Coverage” for new activities of the policyholder business.

Under the multiple cover plan it has been customary to afford no automatic coverage or little automatic coverage with respect to additional locations, changes in the business operations of the insured or new hazards at the locations covered. Automatic coverage has more often been the subject matter of special, individual negotiation. To accomplish the objective of comprehensive general liability insurance, which is to cover all hazards of liability not excluded, it is necessary to provide a very broad automatic coverage.

The coverage can no longer be limited to the type of business in which the insured is engaged at the time the policy is written, but must follow his activities even though the nature of this business operations change completely. Consequently the coverage must apply automatically to all operations not specifically excluded. . . .

Neither can the coverage be limited to locations used by the insured at the time the insurance is written. The insured may acquire new locations by purchase, by lease, by the creation or acquisition of affiliates or in other ways. His business may expand to other States. Comprehensive general liability insurance must automatically apply to hazards of liability thus created.\textsuperscript{144}

Insurers appear to have regarded this view as a natural corollary to the comprehensive nature of the CGL policy, which was marketed as broad coverage designed to allay policyholder concerns regarding the need to purchase other, particularized liability policies. Instead, the broad CGL policy was designed not only to cover the risks not specifically excluded by the policy language but also to provided adequate liability protection for the the expanding business of the policyholder. Commenting on the term “Comprehensive” in the CGL policy, one major insurer stated:

This word means exactly what is says. For insurance purposes, it means that all operations, all commercial businesses, and all hazards of the commercial insured are

\textsuperscript{144} See Sawyer, supra note 9, at 26-27 (emphasis added).
covered. It means all-encompassing and all-inclusive. It indicates the broadest possible coverage for insureds with a variety of business exposures. By providing coverage on a comprehensive basis not only are all existing hazards covered, but newly arising hazards are covered without any further extension of the policy.  

An insurance industry insider described the breadth of CGL coverage for new products of the policyholder, an situation analogous to a policyholder’s acquisition of new operations or companies, in similar fashion:

New Products. It is not unusual for insureds to market new products during a policy’s lifetime without the knowledge of the insurer, and, therefore, without the insurer having an opportunity to evaluate the exposure. The query: Should some control on the automatic coverage afforded basically by the policy be introduced in the policy? The answer: This is not a general problem; it is encountered chiefly in the larger risk. It is possible, when desired, for companies to react to it in limited or broad fashion by restricting coverage to products existing at policy inception.  

In addition, insurers have traditionally used retroactive premium adjustment as a means of managing the risk of expanded policyholder liability due to expanded policyholder operations. The presence of retroactive premium provisions in the policies suggests that insurers were aware that a policyholder’s business operations could expand and increase the relative liability risk faced by the policyholder and subsequently its insurers. 

Adding and deleting subsidiary companies and operations is part and parcel to modern commercial activity. This can occur either through outright purchases of other companies or changes in the operations of a commercial policyholder. For example, a policyholder may begin operating an installation subsidiary that deals with asbestos simply by expanding its own operations rather than purchasing an installation

145. See [ANONYMOUS INSURER], supra note 53, at 4 (italics added; underlining in original).

company. The risk posed by either expansion of asbestos installation activities from within or by acquisition of a new subsidiary that installs asbestos insulation is the same. The insurer is at no greater risk merely because the liability-creating activity was the product of a subsequently purchased subsidiary business rather than additional activities by the parent company.

Case law is divided on the issue of insurance coverage for liability-generating occurrences that predate the policyholder's ownership of the entity whose actions are the source of the claim. Some cases support the insurer position against coverage for entities acquired by the policyholder while others support the policyholder position.\textsuperscript{147} The cases permitting coverage under policies held by policyholders acquiring other businesses (and their attendant liabilities) are better reasoned and more persuasive. \textit{K F Dairies}\textsuperscript{148} is particularly trenchant on this point. Referring to cases supportive of the insurer position, the Ninth Circuit found that such cases "are in conflict with generally established principles of insurance contract construction as articulated by the California Supreme Court. . . ".\textsuperscript{149} Continued the Ninth Circuit:

KF Dairies's insurance policy states that the insurer "shall have the right and duty to defend any suit seeking damages on account of . . . bodily injury or property damage" where the injury or damage is "caused by an occurrence." The policy defines an "occurrence" as "an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured." This language is unambiguous. Moreover, there is no


\textsuperscript{148} See K F Dairies, Inc. v. Fireman's Fund Ins. Co., 224 F.3d 922 (9th Cir. 2000) (applying California law).

\textsuperscript{149} 224 F. 3d at 925.
language in the policy stating that the insured’s liability, as opposed to the damage that serves as the basis for that liability, must arise within the policy period. An exclusion or limitation on policy coverage cannot be read into the insurance contract; rather, such provision must be “conspicuous, plain, and clear.” ¹⁵⁰

In a slightly different context involving the question of whether the third party claimant must have owned the injured property at the time of injury, another court observed:

[U]nder the terms of the insurance policies . . . the event triggering coverage is one that cause[d] “physical injury to or destruction of tangible property” during the policy period. Nowhere do the policies say to whom that property must belong, save that it must not belong to the insured. In other words, the policies themselves do not expressly require that the eventual claimant own the property at the time the property is damaged for coverage to ensue; they merely require that the damage . . . take place during the policy period. ¹⁵¹

Both this analysis and that of KF Dairies are correct. The language, structure and purpose of the CGL policy do not require either that claimants have had a property interest at the time of injury or that the policyholder have owned the liability-creating entity at the time of injury. The CGL is instead focused simply on injury as trigger. It is sufficient if there is ownership at the time of the claim. If an insurer wishes not to assume this broad risk, it can simply exclude the coverage rather than use retroactive premiums as its vehicle for recouping any increased costs from additional coverage responsibility.

Courts permitting insurers to avoid coverage merely because the company responsible for the liability was not acquired during the policy period in effect convert an occurrence-basis CGL policy into a product more like the less valuable claims-made policy. A claims-made policy by its express terms requires that claims against the policyholder be made and reported prior to the expiration of the policy period. Coverage is lost not because of the nature of the injury or ultimate liability but merely because

¹⁵⁰. See 224 F.3d at 927-28 (bracket in original; internal citation omitted).
¹⁵¹. See Garriott Crop Dusting Co., 270 Cal. Rptr. at 682.
of accidents of the timing of litigation. There is no such timing requirement in an occurrence-basis CGL policy such as those sold to asbestos defendants prior to the 1980s. However, cases barring coverage for the liabilities that came along with the policyholder’s acquisition of a company (despite the liability resulting from injury beginning during the policy period) are essentially engrafting an unwritten exclusion onto the CGL policy by requiring that the source of the injury be owned by the policyholder both at the time of injury and at the time when the claim is made. In effect, courts adopting the insurer viewpoint have rewritten the CGL policy to make it less favorable to policyholders and more favorable to the insurers that drafted the instrument. This is at odds with the drafting history of the CGL policy.

VII. ASBESTOS BANKRUPTCIES AND INSURANCE

Asbestos defendant bankruptcies provide both a contentious legal battleground and an illustration of the degree to which insurers have largely fared better than their policyholders. Although society and the legal system should not mistake the real victims of the asbestos mass tort (the persons who lost health and life due to asbestos exposure), asbestos defendants can make a good case of victimhood by pointing to many bankruptcies of asbestos defendants resulting from the weight of the mass tort’s claims. Although the asbestos mass tort has resulted in the apparent demise of a few insurers and has certainly forced some painful reorganizations (the Lloyd’s-Equitas situation being the most prominent example), it seems clear that policyholders have suffered more than insurers. While there are a handful of insurer insolvencies linked to asbestos coverage, there are more

152. Although commentators may differ as to who is most “at fault” for the asbestos problem and whether some have profited exorbitantly as a result of the problem, there is no disagreement that asbestos liability litigation has been the major civil litigation phenomenon of the late 20th Century and early 21st Century. See generally CASTLEMAN, supra note 63; BRODEUR, supra note 63 (reviewing history of asbestos, discovery of its dangerous properties, and early asbestos litigation; casting primary blame on manufacturers; describing bankruptcy of Johns-Manville in Chapter 10). See also WALTER K. OLSON, THE RULE OF LAWYERS Ch. 6 (2003) (finding economic incentives for lawyers largely to blame as well; finding that (at 205) “chaotic” asbestos litigation [in the tort system] “makes no sense whatsoever as a means of providing surrogate social insurance” and that “[t]he litigation, like the mineral . . . proved inextinguishable”; “Past estimates of the scope of asbestos liability have all had one thing in common: They have been far too low. Most mass torts peak and then subside, but asbestos litigation just grows and grows . . . ” (at 206); “Companies that made a point of settling cases generously and early, so as to avoid wasting money on lawyers’ fees, went broke. And so did those who followed the opposite strategy” (at 207)).
than seventy bankruptcies of asbestos defendant policyholders. But for the insurance industry as a whole, the asbestos problem is estimated to be only a 1-3 percent drag on earnings.\textsuperscript{153} Even for the so-called "Dirty 30" of insurers with the greatest amount of asbestos coverage responsibility, asbestos is thought to be only a 3-6 percent drag on earnings.\textsuperscript{154} Economically, at least, it appears that insurers have done better than many of their policyholders facing asbestos claims. The doctrinal battle over coverage for bankrupt companies attempting to settle asbestos claims remains ongoing, although insurers seem to have the edge.

Bankruptcies have affected not only the major manufacturers of asbestos and those that knew of the material's dangerous properties but failed to warn society and its potential victims, but also what many term "peripheral" asbestos litigation defendants who had no knowledge of the dangers of asbestos and merely used the material in their own products or activities. For example, building material manufacturers may have used asbestos in their products. Further, the asbestos content may have been low and the product one that was not likely to give rise to airborne asbestos fibers that damage the human lung.

During the first wave of asbestos litigation in the 1970s and 1980s, these asbestos defendants were largely left alone by plaintiffs who instead logically pursued the core manufacturer and large installer/insulator defendants that possessed large assets, including substantial insurance coverage. But as these defendants ran out of insurance (perhaps because claims personnel and counsel were too quick to characterize all asbestos liability as subject to the aggregate limit for the products/completed operations hazard discussed in Section V, supra), they sought refuge in bankruptcy, further limiting their potential as sources of compensation for plaintiffs even in cases of Chapter 11 reorganization bankruptcy rather than Chapter 7 liquidation bankruptcy.

Anxious to continue to pursue claims, victim compensation, and counsel fees, plaintiffs and their attorneys brought forth the so-called "second wave" of asbestos mass tort claims against "peripheral" defendants not normally regarded as companies responsible for asbestos use and injury. The consequences were a startling rise in the number of asbestos claims during the 1990s and early 21st Century, a time well beyond any 1980 observer's predictions as to the longevity of the asbestos mass tort. Many of these peripheral defendants had fewer resources of their own or limited insurance. They may also have been embroiled in significant

\textsuperscript{153} See V.J. Dowling, supra note 30; Baker, supra note 7.

\textsuperscript{154} See id.
coverage disputes with their insurers, depriving them of a strong defense to the claims, many of which were regarded as strained by some observers—but which nevertheless posed substantial individual risk of tort liability and in the aggregate posed a substantial burden for the peripheral defendants.

The sheer bulk of the asbestos claims created potentially company-ending liability for some asbestos defendant policyholders, even if the individual asbestos claims ultimately prove to reflect only modest injury—or even if the claims prove to be unmeritorious. The experience of asbestos defendants has historically been that their costs of defense in relation to amounts paid in judgments or settlements of asbestos claims is essentially the same, at a ratio of approximately 1:1. Asbestos defendants in the absence of bankruptcy protection, would be required to defend perhaps thousands of asbestos claims, often from their own pockets in the absence of insurance or where insurers were disputing coverage. As a result, a rational asbestos defendant facing thousands of claims will find the notion of global omnibus settlements quite attractive.

For a variety of reasons, this second wave of asbestos defendants sought bankruptcy protection, as had many of the first wave core of asbestos defendants. The economics and practical litigation logistics of

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155. See Stephen J. Carroll et al., Asbestos Litigation Costs and Compensation: An Interim Report vii, 60 (2002) ("Carroll/RAND Study") ("transaction costs", primarily legal costs, "have consumed more than half of total spending on asbestos") (defense costs exceed claims payments during 1980s litigation and were roughly a quarter of total expenditures during 1990s litigation); J.S. Kakalik et al., Variation in Asbestos Litigation Compensation and Expenses (1984) ("Kakalik/RAND Study") (of total amounts spent related to asbestos litigation, approximately one-third went to plaintiffs' legal fees, one-third to defendants' legal fees, and one-third to actual compensation of victims); Letter from Jennifer L. Biggs, Chair, Chair, Mass Torts Subcommittee, American Academy of Actuaries, to Sen. Bill Frist, Majority Leader (R-Tenn.), March 24, 2004, at 2 [hereinafter Biggs Letter] ("More than half of the costs relate to plaintiff and defense attorney fees."). For some defendants and some claims, asbestos defense costs have exceeded the amounts paid in judgment or settlement.

156. See Carroll, supra note 155, at vi-vii, 40, 47 (more than 6,000 companies named as asbestos defendants and "litigation has spread far beyond the asbestos and building products industries"; annual filing of claims "has risen sharply"); claims against nonmanufacturer defendants "are growing most rapidly"); Statement of Jennifer L. Biggs, Chair, Mass Torts Subcommittee, American Society of Actuaries (July 10, 2003), at 1 [hereinafter Biggs Statement] (congressional hearing on "Proposed Resolution Regarding the Need for Effective Asbestos Reform") ("As the initial targets in the [asbestos] litigation have become unable to pay their share of damages, plaintiffs[] attorneys have named additional peripheral defendants (who did not manufacture asbestos . . . .) (many defendant companies believe they are not getting a fair legal evaluation of their cases in court . . ."); Randy J. Maniloff, Asbestos: Insurance Coverage Issues On a Changing Landscape, Mealey's Litigation Report: Insurance, July 9, 2002, at 4 (noting trend of asbestos litigation in which "The Peripheral Asbestos Defendant Becomes A Target"); Angelina,
the asbestos tort litigation phenomenon have pushed more than seventy asbestos defendants into bankruptcy.\textsuperscript{157} Many asbestos defendants found bankruptcy a prudent alternative, particularly to the degree it facilitated global settlement. Commentators, although not uniform in assessment, appear to agree.\textsuperscript{158} In addition, asbestos defendants discovered that a 1994

\textit{supra} note 1, at 18 (Tillinghast-Towers Perrin consultant notes that, in defiance of predictions, asbestos claims have grown dramatically during late 1990s and 2000 even though use of asbestos has been effectively banned for 25 years); General Cologne Re, \textit{The Reemergence of Asbestos: More Claims, More Defendants, More Dollars, HAZARDOUS TIMES}, Nov. 2001, at 1. \textit{See also Biggs Statement} at 4 (noting that “[r]oughly 50,000 to 70,000 new claimants filed lawsuits per year from 2000 to 2002”, a rate “significantly higher than the average of approximately 20,000 per year experienced by several major defendants in the early 1990s.”) and at 12 (noting differences between typical tort claim and asbestos mass tort claim).

157. \textit{See Georgene Vairo, Mass Torts Bankruptcies: The Who, The Why and The How, 78 AM. BANKR. L.J. 93, 106-07 (2004) (“Over seventy companies are in bankruptcy court as a result of their asbestos exposure, and most parties familiar with the area expect that most, if not all, “traditional” asbestos defendants will have filed for bankruptcy by the end of 2004.”); Biggs Statement, supra note 156, at 20 (listing asbestos defendants filing for bankruptcy during the period of 1982 to mid-2003, ranging from a “target” defendant like major manufacturer Johns-Manville to “peripheral” defendants such as Kentile Floors and Swan Transportation). Accord, Lee L. Bennett, \textit{Defense Community Issues: New Liabilities and How to Respond to the Plaintiffs’ Bar, DEF. COUN. J., July 2002, at 273, 277-78 (describing asbestos litigation as a “Lazarus Phenomenon” that will not die, noting “skyrocketing filing of new asbestos claims” that “is causing numerous asbestos-related bankruptcies as peripheral defendants become targets); Angelina, supra note 1, at 18 (preferring more contemporary, commercial metaphor); Robert P. Hartwig, Testimony before U.S. Senate Judiciary Committee (June 4, 2003) (“Solving the Asbestos Crisis: S. 1125; The Fairness of Asbestos Injury Resolution [Act] of 2003”) (Arguing in favor of legislation to resolve asbestos claims because of high costs of addressing such claims through tort system) (Hartwig is Senior Vice President and Chief Economist of the Insurance Information Institute); American Insurance Association, Myths and Facts About Asbestos Litigation (March 2003) (available at 222.http://www.aiadc.org).

158. \textit{See Alan N. Resnick, Bankruptcy as a Vehicle for Resolving Enterprise-Threatening Mass Tort Liability, 148 U. PA. L. REV. 2045, 2092 (2000) (Exhibit C-54) (“The bankruptcy system provides an appropriate framework for resolving enterprise-threatening mass tort liability”). See also S. Elizabeth Gibson, \textit{A Response to Professor Resnick: Will This Vehicle Pass Inspection?}, 148 U. PA. L. REV. 2095, 2116 (2000) (Exhibit C-55) (expressing some reservations about efficacy of bankruptcy solution to mass tort problem but noting that “Professor Resnick has stated well the advantages of utilizing bankruptcy as a vehicle for resolving mass torts. Bankruptcy has many procedural and conceptual features that can be applied to permit a resolution of all of the claims facing a beleaguered mass tort defendant.”); Vairo, \textit{supra} note 157, at 98 (noting that bankruptcy system, although presenting some problems, “provides an important vehicle to resolve mass tort liabilities” because it “seeks to provide equality of distribution to creditors in a proceeding that encompasses the interests of all parties while mitigating the effect that a huge mass tort liability may have on the worth of a business.”) and at 131-52 (Reproducing as Appendices U.S. Judicial Conference Committee on the Administration of the
amendment to the Bankruptcy Code permitted asbestos defendants to seek a “prepackaged” bankruptcy that could potentially reduce both their asbestos liability exposure and the costs and time normally associated with bankruptcy. The 1994 Amendment, codified at 11 U.S.C. § 524(g), was patterned after the Johns-Manville reorganization that had commenced with the company’s 1982 bankruptcy petition.

Essentially, a pre-packaged bankruptcy is one in which the asbestos defendant/prospective debtor negotiates with its creditors, particularly counsel representing asbestos claimants, regarding resolution of claims against the policyholder or likely to be made against the policyholder from asbestos claims “in the pipeline.” If three-fourths of the creditors approve a negotiated settlement, this can be embodied in a court-approved bankruptcy plan that is in essence ready to be approved upon the filing of the bankruptcy petition (hence the term “prepackaged” bankruptcy). The bankruptcy court then issues a “channeling injunction,” which requires all asbestos claims against the debtor to be brought before the bankruptcy court where they are subject to the pre-petition settlement agreement concerning such claims and the agreed schedule of payments to claimants, including eligibility criteria for compensation.159

In the Johns-Manville litigation, the victim compensation Trust funded by insurance and company stock and the criteria for compensation were developed during the course of the bankruptcy. In a prepackaged bankruptcy, this is negotiated prior to the petition and the court is presented with a plan for funding the Trust, criteria for determining asbestos claimant eligibility, and a schedule for compensation depending on the degree of asbestos-related injury or impairment.

Passage of the Bankruptcy Reform Act of 1994, which added Section 524(g) to Title 11 of the Bankruptcy Code, can be read as an expression of congressional intent and national public policy in favor of resolving asbestos liability problems for beleaguered companies through the global settlement mechanism. The Act added detailed provisions to section 524 for the purpose of confirming the legality and enforceability of the trust mechanisms set up in the Johns-Manville, UNR, and other asbestos-related Chapter 11 cases in the 1980s to benefit asbestos victims, while protecting debtor manufacturers from future liability. The amendments also confirm the enforceability of channeling injunctions that enjoin asbestos-related

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claimants from pursuing the reorganized debtor, thereby forcing them to seek recourse only against the trust.¹⁶⁰

In pursuing either a “regular” or a prepackaged bankruptcy, the policyholder facing substantial asbestos liability seeks to use the reorganization process, creation of a Trust for victim compensation, and a channeling injunction as a means of achieving global resolution of its asbestos exposure in one forum in a manner that will provide compensation to past and future claimants while preserving the company. Insurers tend to oppose such a global solution on the ground that it might accelerate the otherwise gradual payments they will inevitably be forced to make. This can create a pointed conflict between insurer and policyholder.

By now, some of the insurer objections to negotiated bankruptcy resolution of asbestos claims are familiar in that they tend to mirror insurer objections to mass or inventory settlements of asbestos claims generally. The argument against such resolution is that it tends to result in the settlement of large blocks of cases in the hands of a few law firms in which compensation is paid after truncated review that is far less searching than the scrutiny such claims would get at trial or even if vetted through the pretrial process normally attending individual claims. A somewhat revised addition to this long-standing criticism notes that certain prominent asbestos plaintiff law firms tend to repeatedly use the same medical diagnosticians who manage to find asbestos injury at astonishingly high rates using suspect methodology.¹⁶¹ There are also, particularly from


In 1994, Congress amended the Bankruptcy Code to provide a restructuring model for asbestos-related bankruptcies. Section 524(g) represents a congressional response to the need for an effective mechanism to facilitate reorganization of companies facing massive numbers of asbestos claims. A variety of efforts to achieve such relief outside Chapter 11 has not proven successful. Section 524(g) codifies the approach that [Johns-Manville] used in its bankruptcy in the mid-1980s to deal with the asbestos claims against it. (footnotes omitted).

See also Bennett, supra note 157, at 278 (although concerned about risk of accelerated payment obligations for insurers, insurance defense lawyer states that “bankruptcy may be the only alternative for these [asbestos defendant] companies since the U.S. Congress has refused to act, the U.S. Supreme Court essentially has made settlement class actions unworkable, and most trial courts have refused to dismiss claims involving asymptomatic, unimpaired claimants.”).

¹⁶¹. See Lester Brickman, On The Applicability of the Silica MDL Proceeding To Asbestos Litigation, 12:2 CONN. INS. L.J. 35 (2006); Lester Brickman, Contingent Fees
Professor Brickman, criticisms of the high fees garnered by claimant counsel.\footnote{162}

The core of criticism against such arrangements is that they constitute a settlement "mill" in which resolution is mass produced without relation to the merits of individual claims. Insurers further argue that even if these arrangements are good for policyholders in that they achieve global peace at lower cost than individualized defense of claims, it unfairly deprives insurers of their right to individualized control of covered claims and tends to at least accelerate insurer payments if not to increase overall payments as well. Defenders of the bankruptcy solution and prepackaged negotiations of asbestos claims counter that for many asbestos defendant policyholders, bankruptcy is not only the clearly superior approach but perhaps the only practical approach for acceptably satisfying asbestos claims and permitting the policyholder company to survive. Although insurers may have an expectation that most liability coverage expenses will take place over an extended time period, this is not part of the insuring agreement. Rather, the insurer accepts the policyholder's premiums in return for taking the risk that liability claims payments may be large or small, fast or slow, etc.

The pro-bankruptcy argument has powerful equitable persuasiveness even if it is in tension with concepts such as individual adjudication of claims and particularized insurer control over claims handling and defense. If an asbestos defendant bravely defends and settles claims on an individual basis but then sinks under the weight of asbestos claims, there are severe costs. Although the first asbestos claimants may receive full value for their claims, when the money runs out, asbestos victims remaining in the queue receive only a small percentage of claim value or perhaps receive no compensation at all.

An early global settlement may undercompensate some seriously injured asbestos victims that would have obtained large damage awards at trial (or from settlement on the proverbial courthouse steps) and it may undercompensate future claimants who are not "on the scene" to argue for their rights and who by definition will get less attention from a lawyer representing a block of current claims and anticipating a large "contingency" fee. Thus, individual asbestos claimants may receive less in a global arrangement. However, the group of asbestos victims as a whole

\footnote{Without the Contingency: Hamlet Without the Prince of Denmark, 37 UCLA L. REV. 29 (1989).}

\footnote{162. See Brickman, Contingent Fees, supra note 161 (noting that fees for some asbestos plaintiffs' counsel appear to be thousands of dollars per hour for quickly settling claims were liability is close to a foregone conclusion because dangerous properties of asbestos are well established).}
probably does better, provided that there is some reasonable differentiation between seriously injured claimants and those with only minor lung scarring or pleural plaque. Almost by definition, an early global settlement, particularly one coupled with a pre-packaged bankruptcy, should dramatically reduce the dispute resolution costs that ordinarily are equal to what the defendant (or its insurers) pay out in compensation to victims.

In addition, if the global settlement prevents a policyholder company from liquidating itself into the mists of history, this would clearly appear to be a net social gain resulting from bankruptcy-related resolution of asbestos claims. Unless the policyholder company operates in a shoddy manner or engages in only unwanted activity, the company almost certainly hires, pays taxes, and generally contributes to the economic well-being of the community. Although there are perhaps some business entities that deserve to die, that is presumably the exception rather than the rule. Consequently, permitting reasonable policyholder resort to available bankruptcy law would seem to be an important public policy goal.

Certainly, the public policy choice has been made in favor of continued existence be virtue of the Bankruptcy Clause of the Constitution\(^{164}\) and the Bankruptcy Code,\(^{165}\) including 524(g), as well as government's frequent efforts to protect many businesses from liability or obligations viewed as threatening the companies' continued existence. Ironically, some of the core asbestos defendants may present among the strongest cases for permitting a company to fall under the weight of liability rather than to survive through reorganization. Companies such as Johns-Manville produced and distributed without warning an inherently dangerous product that injured millions and had at least constructive knowledge of the danger. It would be hard to imagine any business entity (other than perhaps tobacco companies) that so appropriately deserves to die when the liability chickens come home to roost. But the legal system permitted Manville to survive and Congress subsequently approved the Manville model for other asbestos

\(^{163}\) This same principle holds not only for the availability of bankruptcy and insurance for businesses but is also reflected in prevailing Justice Department norms that where there is corporate wrongdoing, the individuals responsible should be pursued criminally but that the entity itself should not be criminally prosecuted (although it may be heavily fined or otherwise punished through devices such as a bar to government contracting). The prosecution of now-defunct accounting firm Arthur Andersen was a notable exception, one reversed by the Supreme Court (see United States v. Arthur Andersen, 125 U.S. 2129 (2005)) and viewed by many observers with considerable regret as an example of prosecutorial overkill.

\(^{164}\) See U.S. Const., Art. I, Sec. 8, Cl. 4.

defendants in desperate liability straights. This seems a rather strong indicator that public policy factors favor policyholders rather than insurers on the issue of asbestos bankruptcy and insurance coverage.

Whatever any personal qualms members of the public may have regarding the cosmic justice of the situation, the positive law of the United States appears to hold that the greater good is in preserving business entities where some reasonable amount of liability compensation can be accomplished with the company continuing in some form. Further, this implicit decision to favor continued survival over liquidation is not irrational or intrinsically in derogation of justice. To be sure, some officials at core asbestos defendants such as Manville engaged in reprehensible behavior. But many or most of the company employees did not. And even a business that had asbestos as its primary activity also engaged in socially useful activity. Even if one's concept of a perfect world would include full compensation to asbestos victims, life in an imperfect world requires some compromises. The judicial system has implicitly adopted this view in permitting asbestos defendant bankruptcy reorganization, including prepackaged bankruptcy.

But notwithstanding these advantages, global settlements pursuant to bankruptcy reorganization, especially prepackaged bankruptcy, is often vigorously contested by insurers. Although the ostensible grounds for these objections are insurer contentions that such arrangements unfairly deprive them of the right control defense of claims, it is quite apparent that a major driving force is the insurers' desire to obtain the anticipated economic benefit of the elongated nature of asbestos claims and gradual payment over time with inflation-affected dollars.

Policyholders pursuing bankruptcy as a solution for asbestos liability should not be deprived of insurance purchases years earlier and on which insurers have earned premium income for decades. There remain closer issues of the terms under which insurers must pay and the timing of the payments. Even prior to the 1994 enactment of § 524(g), a potentially important decision held that confirmation of a bankruptcy plan provides for an immediate trigger of liability insurer coverage obligations.166 In *UNR Industries, Inc. v. Continental Casualty Co.*,167 the Seventh Circuit concluded that confirmation of the bankruptcy plan and Trust arrangement constituted settlement or adjudication of claims and required insurer payment of policy proceeds to the Trust.168

166. See UNR Indus., Inc. v. Cont'l Cas. Co., 942 F.2d 1101, 1104-05 (7th Cir. 1991) (applying Illinois law).
167. 942 F.2d 1101 (7th Cir. 1991).
168. Id. at 1104-05.
For insurers, who essentially profit by holding on to policyholder premiums and related investment income for as long as possible, this aspect of insurance bankruptcy was seen as a significant threat, but one that for several years appeared unlikely to materialize in significant manner. However, with the 1990’s second wave of asbestos litigation against peripheral defendants and the surge in bankruptcy filings of asbestos defendants, the picture changed and brought the issue of bankruptcy-related triggering of insurer coverage to the fore. In addition, another decision in the vein of UNR suggested that more than one court might reach the same conclusion resulting in accelerated insurer payments due to policyholder bankruptcy. Fuller-Austin Insulation Co. v. Highlands Insurance Co., 169 also ruled that the settlement of asbestos liability claims as part of a bankruptcy reorganization is the equivalent of settlement or judgment for purposes of triggering an insurer’s obligation to pay policy proceeds.

As expressed by the UNR court, the judicial rationale for requiring a debtor-policyleholder benefits under its liability insurance policy at the time of bankruptcy plan approval is that the:

[B]ankruptcy reorganization was a judgment or settlement and so triggers CNA’s insurance obligations. The reorganization required UNR to pay a sum certain (the stock, which had a market value of $150 million) in satisfaction of the asbestos claims. The order confirming that reorganization was final and appealable. And the order is binding. The parties may not re-litigate the matter. Under any definition of judgment or settlement, this qualified. Having suffered an adverse judgment or settlement, UNR has suffered a “loss” within the meaning of the CNA [excess general liability] policy. 170

The UNR Court further noted that under a common excess general liability policy, the insurer has:

[T]he option not to defend. Instead, it could make [the policyholder] defend itself after the exhaustion of [the policyholder’s] primary coverage and later indemnify [the policyholder] for the costs that it insured. . . . [Where the

170. UNR Indus., Inc. v. Cont’l Cas. Co., 942 F.2d 1101, 1104-05 (7th Cir. 1991).
policyholder settles a claim under these circumstances, the insurer need not pay] "collusive or overly generous or unnecessary settlements by the insured at the expense of the insurance carrier." . . . This case presents no such danger because the [bankruptcy] reorganization could not have taken place with the consent of just UNR and the asbestos victims. UNR's other creditors all had to approve, and they had strong reason to fight for as low a valuation of the asbestos claims as possible. The lower the valuation, the greater the portion of UNR's assets these other creditors could reach. This antagonism of interests removes any significant danger that the $254 million valuation of the asbestos victims' claims might contain any artificial inflation at CNA's expense. In short, CNA is bound by the $254 million valuation of the asbestos victims' claims in the reorganization. 171

Insurers and their counsel have been critical of the UNR and Fuller-Austin decisions and have consistently complained that under the UNR and Fuller-Austin approach they will be required to pay policy proceeds at an earlier date than planned and suggested that asbestos-related bankruptcies be opposed or conditioned on insurer consent. As noted above, UNR appears not to have received much attention in the earlier years after the decision. However, Fuller-Austin received considerably more adverse attention by insurers, with insurer consternation sometimes bordering on the apoplectic, 172 most likely because insurers had faced an additional


172. See, e.g., Gary A. Saunders & Stefanie J. Birbrower, Debtors avail themselves of trusts, Nat'l L.J., Aug. 9, 2004, at 23 ("Fuller-Austin set an unsettling precedent for insurance companies and underscored the possibility that asbestos bankruptcy cases can fix and accelerate insurance companies' liabilities -- even absent the insurance companies' participation in the bankruptcy process and irrespective of the language in the plan preserving their rights to disputes liability.") (Attorneys Saunders and Birbrower are with King & Spaulding, a firm that regularly represents insurers); Leonard P. Goldberger, Sorry, We Don't Allow That Here, 22 Am. Bankr. Inst. J. 38 (2003) (insurer attorney criticizes Fuller-Austin and UNR) (Goldberger is a partner in White & Williams, a firm that regularly represents insurers); Leonard P. Goldberger, Strangers in a Strange Land: A Road Map for Insurer Strategies in Bankruptcy Cases, CGL Reporter, 2003 Supplement, at 1 (contending that bankruptcy courts are "inhospitable" and "no friend of insurers"); Laura A. Foggan, Bankruptcy Perils: Asbestos illustrates the risks insurers can face when policyholders go
decade of bankruptcy-related coverage litigation, where they tend to see the forum as excessively concerned with maximizing policyholder assets, and because of the late 1990's upsurge in asbestos claims and bankruptcies substantially raised the financial stakes of adopting the approach of UNR and Fuller-Austin.

The Fuller-Austin trial court ruling was also particularly vexing to insurers in that the insurers had not been permitted to intervene in the bankruptcy proceeding (although they were able to commence parallel coverage litigation) and because, like the UNR court, the trial court found that confirmation of the bankruptcy plan was a final adjudication that bound the insurers to pay immediately and that the amounts and terms of the settlement could not be questioned.173

On appeal, the insurers were successful in obtaining reversal and remand, with California's Second District Court of Appeals holding that because the bankruptcy plan confirmation of asbestos claims was based on a negotiated settlement, it lacked the binding power of an adjudication. Consequently, as would be the case whenever a policyholder settles without an insurer's consent, the policyholder must establish the insurer's improper failure to defend or cover the claim. Further, the insurer may challenge the reasonableness of the settlement amount or the collusiveness of the settlement.174 If the insurer should prevail on these grounds, the settlement is set aside, even where the insurer was guilty of abandoning the policyholder. (However, the policyholder would logically continue to have


174. See Fuller-Austin Insulation Co., 38 Cal. Rptr. 3d at 741.
a right to negotiate a second, more reasonable arm’s length settlement that would subsequently bind the insurer).

Most helpfully for insurers, the appellate court ruled that a finding of the estimated present value of the current and future asbestos payments required by the policyholder’s global settlement did not require immediate payment by the insurers.\textsuperscript{175} Rather, it appears that under the appellate court’s view, insurers would be permitted to pay covered settlements on a rolling basis as the actual costs of the settlement become apparent. (Recall that the nature of a large asbestos inventory settlement is based on an estimate of validity of current claims, the severity of injuries among the group (e.g., proportion of mesothelioma as opposed to pleural plaque), and the number and composition of future claims). Alternatively (and this appears not to be foreclosed on remand), insurers may be required to pay their policy limits to the trust established by an omnibus settlement, with pro-rata refunds owed to insurers if the actual number and severity of claims does not exhaust the trust fund.\textsuperscript{176}

Although the trial court decision in \textit{Fuller-Austin} was reversed on appeal, the threat remains for insurers. First, the California Supreme Court, which has shown an oscillating tendency regarding policyholder-insurer coverage battles, could restore the trial court approach (it could also, of course, embrace the insurers’ phobia about such decisions).\textsuperscript{177} Second and more likely, the trial court on remand may again support accelerated insurer payment if additional findings support this approach. The appellate

\textsuperscript{175} \textit{Id}. at 746.
\textsuperscript{176} The \textit{Fuller-Austin} appellate opinion is not specific, or even particularly clear on these points regarding administration of any approved settlement.
\textsuperscript{177} Policyholders wishing to attack the appellate opinion can not only argue that the appellate panel was too solicitous of insurer desire for calculated damages for each asbestos claimant but also point to a part of the opinion that suggests some lack of sophistication on the part of the panel. On a subsidiary point, the panel found that the trial court had erred on a part of the case controlled by Louisiana law because the trial court applied a continuous trigger rather than the exposure trigger endorsed by Louisiana courts. Where asbestos is concerned, the nomenclature is often misleading. \textit{See supra} text accompanying notes 35-63. When courts speak of exposure to asbestos, they usually mean injurious exposure. Because asbestos continues to have “exposure-in-residence” in the victim’s lungs, the exposure trigger, the actual injury trigger, and the continuous trigger usually tend to provide the same result regarding asbestos claims and insurance trigger. The \textit{Fuller-Austin} appellate opinion seems oblivious to this and undertakes no analysis of whether the trial courts embrace of a continuous trigger actually brought a different result than would self-conscious use of an exposure trigger. \textit{See Fuller-Austin}, 38 Cal Rptr. 3d at 726. This part of the appellate opinion is disturbingly formalist and superficial and provides something of a 13th chime of the clock to an opinion, that although not a model of clarity, generally reflects an appellate court conscientiously and sensitively trying to come to grips with a difficult problem and resolve it in a fair manner consistent with the contract rights of the affected parties.
court in *Fuller-Austin* did not close the door completely to the type of relief and coverage sought by the policyholder/debtor. In fact, the *Fuller-Austin* appellate opinion endorsed the longstanding general rule that if an insurer fails to defend a policyholder or is adverse to the policyholder, the defendant/policyholder is entitled to negotiate a settlement without insurer consent and receive coverage as long as the settlement was reasonable and made in good faith.\(^{178}\) The appellate court found the trial record insufficient on the question of reasonableness and hence remanded the matter.\(^{179}\) Third, of course, is the possibility that other courts will be less concerned about these issues than the California Court of Appeals and more concerned about the efficiency and finality benefits of bankruptcy and global settlement and will approve declarations of insurance coverage on trial records similar to that of *Fuller-Austin*.

Even if the *Fuller-Austin* appellate opinion should become the dominant approach to the problem of insurance coverage and asbestos bankruptcy, it is hardly a “Get Out of Jail Free” card for insurers. Much of the Second District’s analysis supports policyholder claims of a right to enter into global asbestos settlements as part of bankruptcy (pre-packaged or conventional) without insurer consent or loss of coverage under certain circumstances. As the court observed:

Summarized, California law provides that a defending insurer must consent to a settlement order for there to be coverage, but if an insurer erroneously denies coverage and/or improperly refuses to defend the insured in violation of its contractual duties, the insured is entitled to make a reasonable settlement of the claim in good faith and may then maintain an action against the insurer to recover the amount of the settlement. [However,] the trial court erred in finding that these principles mandated the conclusion that appellants had surrendered their right to consent solely by reserving their rights and not undertaking the defense of the matter. An insurer does not breach any duty to the insured merely by reserving its rights under the policy.\(^{180}\)

\[\ldots\]

178. See *Fuller-Austin*, 38 Cal. Rptr. 3d at 716-38.

179. See id. at 746-51.

180. See id. at 736 (internal citations and quotations omitted). Continued the court: “Thus, by reserving their rights to contest coverage, appellants did not wrongfully deny coverage in violation of their policies. Moreover, appellants did not breach any duty to defend Fuller-Austin, as their policies did not contain any defense obligations.” Id.
[The jury verdict form stated that no insurers breached their policies prior to confirmation of the Fuller-Austin bankruptcy plan.] Accordingly, neither the law nor the facts supports the trial court's conclusion that appellants waived their right to consent to the Plan because they breached their policies by erroneously denying coverage or refusing to defend.\(^{181}\)

Notwithstanding these findings, the appellate court left open on remand considerable opportunity for the trial court to nonetheless find that the global settlement was enforceable against non-consenting insurers. As the court first noted, the Fuller-Austin excess insurance policies did not contain a duty to defend but did contain language permitting the excess insurer to participate in or even take over defense of claims.

[B]ecause appellants were neither acknowledging coverage nor providing a defense, and therefore were in no way exercising control over the asbestos claims brought against Fuller-Austin, we find it difficult to permit appellants to rely, without qualification, on a consent provision that is designed to protect defending insurers. \ldots\  Indeed, appellants [insurers] have not directed us to a case holding that a nonbreaching excess insurer with knowledge of an impending settlement may decline to participate in settlement negotiations, yet then rely on the policy's consent provision to avoid responsibility under the settlement.\(^{182}\)

\ldots

\[A\]n excess insurer, although not contractually obligated to take an active part in the defense of an insured, still owes its insured a duty of good faith when faced with an offer of settlement that exhausts the underlying policy limits.\(^{183}\)

\ldots

It would impose an unnecessary burden on primary insurers and parties to an underlying action to hold that an excess insurer has an absolute right to withhold its consent to a settlement, while at the same time decline to participate in the action.\(^{184}\)

\(^{181}\) Id.

\(^{182}\) Id. at 736-37.

\(^{183}\) Id. at 737.

\(^{184}\) Id. at 738.
... 

Allowing Fuller-Austin to enter into a global settlement in the bankruptcy court without appellants' participation, while permitting appellants to challenge the bankruptcy Plan for fairness, reasonableness and lack of fraud or collusion in the instant action, does no violence to the policy language requiring appellants' consent. We do not believe that the policies can be read to permit an excess insurer to hover in the background of critical settlement negotiations and thereafter resist all responsibility on the base of lack of consent.... On remand, appellants will be entitled to litigate the issue of whether, as to them, the bankruptcy Plan is unfair, unreasonable or the product of fraud or collusion. 185

In short, the recent Fuller-Austin appellate opinion has something for both insurers and policyholders. Although insurers clearly won this round of the Fuller-Austin "battle," the court's groundrules for further determination on remand suggest that policyholders might well be able to prevail in the continuing "war" over policyholder and insurer prerogatives regarding global asbestos settlements and bankruptcy. Importantly, the appellate court affirmed the long-standing view that where an insurer fails in its obligations to the policyholder, the policyholder is not strictly bound by consent-to-settle or similar language of the policy. In such cases, the policyholder may take prudent steps to protect itself from devastating liability exposure and litigation expense by negotiating reasonable omnibus settlements in good faith, just as a policyholder may do so regarding individual claims where insurers deny coverage or refuse to defend.

The hard part, of course, devolves to the devilish details of particular insurer conduct, asbestos settlements, and bankruptcy arrangements. To a large extent, correct resolution of these insurer-policyholder conflicts will be highly situation specific and contextual. For example, insurers will argue that a reservation of rights letter, no matter how extensive, is only a reservation and (per the Fuller-Austin appellate opinion), a "mere" reservation of rights is not the sort of insurer misconduct that free the policyholder to protect itself with the best settlement possible. Alternatively, policyholders will look at these same letters and find that they are in practical effect a denial of coverage or that they establish adversity between insurer and policyholder that further makes it unwise to give literal enforcement to consent or cooperation clauses. In addition,

185. Id. at 741.
policyholders and insurers will both argue that particular conduct supports their position. If insurers fail to acknowledge coverage, agree to coverage-in-place agreements, or attend briefings, policyholders will find this the equivalent of denial of coverage or the type of "hovering in the background" condemned by the Fuller-Austin appellate panel. If policyholders fail to appraise insurers of developments and provide some reasonable opportunity to assume defense or settlement of claims, insurers will argue that it is the policyholder rather than the insurer that is in breach.

Beyond these situation-specific disputes, there is a broader gulf separating insurers and policyholders due to the importance of the time value of money. In my view, these differences auger in favor of permitting policyholders who become asbestos mass tort defendants substantial leeway in negotiating settlements and pursuing bankruptcy — unless its insurers are serving the CGL policy's function of providing protection to the policyholder facing this sort of "bet-the-company" liability.186

Insurers argue that UNR and Fuller-Austin unfairly deprive insurers of their rights under the standard CGL policy and common excess liability policies through essentially bypassing the adjustment, defense and seriatim settlement of claims that would ordinarily occur for tort matters. Similarly, the bankruptcy plan resolution of asbestos liability, by bundling resolution of asbestos matters and establishing an administrative system of compensation with set damage awards prevents insurers from deriving a typical benefit of liability insurance — the elongated path between the initial claim and final payment of the claim.

Where the insurer is required to make payments in a bloc or to fund a trust after only a few months or a couple years of bankruptcy maneuvering, this is quite different economically for the insurer than defending and paying claims seriatim over the course of many years or perhaps even several decades. Insurers make their money less from underwriting profit (i.e., taking in more in premiums dollars than they pay in claims) and more from the "float" of holding policyholder premiums to general investment income for as long as possible before paying claims. In addition to this obvious incentive to pay claims later rather than sooner, insurers also profit from delay because later payments tend to cost less in real dollars due to inflation. As the industrialist John Paul Getty put it well, "a billion dollars doesn't go as far as it used to."187 A billion dollars in 1955 (when asbestos

186. Although excess or umbrella liability policies are not, strictly speaking, CGL policies, most excess policies "follow-form" to the underlying primary CGL policy. Even stand-alone or modified excess policies largely echo the coverage provided in the CGL.

187. See Stephanie Mansfield, Billionaire behavior, St. Petersburg Times, Nov. 8, 1992, p. 5D, col. 1 (quoting Getty); Bella English, A little advice for the Donald, Boston
was in wide use) would equate to $6.874 billion in 2005. In essence, a dollar paid by insurers on a 1950s liability policy is the equivalent of thirteen cents today.

The net effect of these basics of insurance economics is to give insurers a distinct advantage over policyholders in dealing with the financial consequences of unforeseen mass tort liability. When a mass tort such as asbestos produces a rush (perhaps even an avalanche) of claims, this is more than a little frightening—and economically threatening—to even the largest commercial entities. Although such a rush of claims is hardly good news for insurers, neither is it as immediate a concern. The insurer is by definition more diversified and frequently has far more capital than all but the largest manufacturers, contractors, or retailers. Most important, the insurer may have the luxury of time and it attendant effect on money. By contrast, the policyholder must take immediate action to fend off claims, settle them, or through some combination discourage more such claims.

The Federal Rules of Civil Procedure give the tort defendant only 20 days to respond and begin to mount a defense. Although this deadline is routinely extended, the point remains: for policyholder defendants in a mass tort situation, peril is close at hand. For insurers, the day of reckoning is further in the future. In practice, of course, commercial policyholders typically tender mass tort claims to their insurers swiftly after receipt, which places pressure on at least the primary liability insurer to make a reasonable and expeditious decision regarding defense of the claim or risk exposure to a bad faith claim by the policyholder. But even with the potential equalizer of bad faith, the deck is still largely stacked in favor of the commercial liability insurer.

The CGL insurer may agree to defend mass tort claims but due so under a “reservation of rights,” essentially refusing to commit to indemnity coverage until further information becomes available and the insurer is able to make a final assessment. The insurer may even commence a simultaneous declaratory judgment action seeking a ruling that it has no duty to indemnify or defend the claim. In the case of long-tail tort claims such as asbestos that extend over many years, several different policy periods and primary insurers may be implicated, leading to insurer

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GLOBE, June 11, 1990, p. 17 (quoting Getty). Further, this article, in which the author notes the current financial distress of Donald Trump, who 15 years later would again be perceived as mega-wealthy and have television star status, also illustrates that much can happen over time to permit insurers and other businesses to soften financial blows.


189. See Fed. R. Civ. P. 8(b) and 12(b).
hesitancy to commit to defense or coverage while they argue among themselves as to relative responsibility.

Excess and umbrella insurers are in an even better perch for playing a waiting game with policyholders. Excess and umbrella insurance typically does not “attach” until primary insurance is exhausted. Although this is not a particularly problematic requirement or difficult determination in the average case, it can become a ground for dispute and delay in long-tail mass tort situations. Insurers can raise questions and then contend that they need make no coverage decision until these questions are resolved. When is primary insurance exhausted for a particular policy period? What is the effect of insolvency of primary or other excess insurers? How should any deductibles or retentions be applied? How are the underlying claims to be classified, as general operations matters for which there is no aggregate limit or as products/completed operations matters subject to an aggregate limit?

Even if this insurance version of 20 questions is completed, the net effect is to put excess insurers in an advantageous position relative to policyholders. While the policyholder faces an immediate mass tort problem that may even destroy the company, the excess insurer is simply waiting to be judicially required to pay a limited amount of money pursuant to a contract for which the excess insurer was paid years ago, since investing the premiums. In addition, most excess policies provide that any amounts spent on defense reduce the policy limits otherwise available for indemnity payments. The excess insurer thus typically does not face the primary insurer’s dilemma of whether to expend more on defense in hopes of avoiding policyholder liability or reducing the amounts spent in settlement or judgment. Absent bad faith liability, the excess insurer’s maximum liability is capped at the policy limits (at least per-occurrence limits and perhaps aggregate limits as well) whether it spends its millions or defense or tribute.

In addition, notwithstanding requirements that the insurer make a relatively expeditious decision on providing a defense and the liberality of duty-to-defend doctrine (which requires not that coverage be established but only that the allegations of the third party’s complaint create a “potential for coverage”), insurers as a practical matter take considerably longer than 20 days to decide whether the policyholder will receive a defense. In the meantime, a mass tort may mushroom into an even bigger problem for the policyholder as the notoriety of the claim spreads and well-funded plaintiffs’ counsel gather more plaintiffs through advertising.

Although a commercial policyholder normally has the resources to fund its own defense, at least for some time, while its liability insurers
assess their position, even the best-heeled of policyholders will soon feel the pinch. If the liability insurance for which the policyholder has already paid does not provide a relatively quick, vigorous defense or put a sound dispute resolution strategy in place, the policyholder will soon face a cash-flow emergency and perhaps even true insolvency in which current liabilities exceed current assets. At that point, bankruptcy may evolve from option to practical necessity for the policyholder.

In short, mass torts such as asbestos are no picnic for liability insurers, particularly the primary insurers that must defend claims without defense expenditures reducing the amounts they may owe to pay judgments and settlements (particularly if aggregate limits do not apply). But mass torts are a far worse problem for policyholders, one which suggests that policyholders should be given wide room to pursue protection through bankruptcy, including inventory or prepackaged settlements triggering insurance coverage. If insurers will not provide an adequate defense and coverage commitment to policyholders facing mass tort liability, the bankruptcy alternative seems more than reasonable both as a matter of the insurance contract agreement, the relative equities of the parties, and national public policy.

Congress was aware of the UNR bankruptcy and presumably was at least constructively aware of the role played by insurance coverage in the UNR reorganization and settlement of asbestos claims. Under these circumstances, it is fair to assume that the Congress that enacted current 11 U.S.C. §524(g) had no objection to requiring insurers to fund such trust arrangements as part of a reasonable global settlement of asbestos claims and to requiring earlier payment of policy proceeds than what might be preferred by insurers. Section 524(g) would thus appear to effectively precludes literal application of the cooperation and consent-to-settle provisions typically found in liability policies where the asbestos defendant policyholder is seeking bankruptcy protection.

In “ordinary” tort liability matters, the claim is tendered to the insurer and settled or defended-and-settled, occasionally reaching trial, verdict and appeal (but often with settlement pending appeal). Under these typical circumstances, the liability insurer is of course entitled to insist on its contractual right to control the defense and settlement of the case (assuming that its interests are not adverse to those of the policyholder) and to refuse to pay any settlements negotiated by the policyholder as “lone wolf” without the consent of the insurer. Bankruptcy mass torts, however, suggest that these parts of the insurer-policyholder relationship must be enforced under a rule of reason rather than one of linguistic literalism.
Consider a hypothetical bankruptcy scenario not much different from actual cases. The mass tort asbestos defendant is facing thousands of claims. Defending the claims seriatim is not a realistic option because of the cost. The policyholder has decades of primary insurance backed by several layers of excess or umbrella insurance. However, the insurers have been slow to agree to take on the burden of defending and resolving the claims. They argue among themselves (but to the detriment of the policyholder) as to which policies are triggered, which primary carriers should initially defend which claims, when excess coverage attaches, the effect of insolvencies, the apt apportionment of coverage responsibility, and other matters. They may even assert complete defenses to coverage such as the intentional act exclusion or the pollution exclusion. Even though these defenses are unlikely to succeed, they create an additional lawyer of uncertainty and exposure for the policyholder, as insurers deny coverage or reserve rights. Some insurers may even join in a declaratory judgment action seeking a determination of no coverage.

In the meantime, the policyholder needs to try to preserve its ongoing business. It cannot realistically bear the burden of simultaneously running that business, fighting with its insurers, and defending mass tort claims. Bankruptcy reorganization is an attractive solution because it permits the policyholder to reduce a huge looming liability to a large but calculable liability that has parameters as to compensation levels and provides a controlled process of settlement payouts within the financial means of the policyholder (assuming there is as lease significant available insurance). It also dramatically reduces defense and other disputing costs for the company. The policyholder gains an economically sound resolution of a company-threatening liability with insurers generally paying less for asbestos claims under this approach than if they had been allowed to fester for years. Society avoids the complete liquidation of the company and its more severe economic consequences to shareholders, employees, and the community.

The policyholder negotiates a plan with creditors. All it wants now is for insurers to pay their fair share of the compensation amounts. But insurers object, arguing that there can be no enforceable asbestos mass tort settlement without the insurers’ express consent and that the policyholder’s efforts to resolve the imbroglio are in fact breaches of the policy’s cooperation clause. Under these circumstances, are the insurer objections well taken? I think not. Although insurers should certainly be able to object and insist on bankruptcy court scrutiny of the debtor’s overall plan
and in particular the asbestos settlement system, insurers should not have a right to veto or thwart an otherwise sensible bankruptcy merely because the insurance policies contain control-of-defense, consent-to-settle, and cooperation provisions designed for more ordinary torts and times.

This is particularly true where the insurers are adverse to the policyholder or have denied coverage or otherwise abandoned the policyholder – and where the insurers have failed to attempt in good faith to participate in the bankruptcy resolution. (By the same token, the insurers should be included in the negotiation of the settlement to the extent feasible). In mass tort bankruptcy situations, there is little justification for cleaving to a formalist approach to insurance coverage. Rather, the focus should be on whether the negotiated resolution of asbestos claims is fair and reasonable and the product of good faith conduct on the part of the policyholder. If this standard is met, there is essentially nothing about which the insurer can complain – it is providing the same or less coverage than it would be required to provide had there been no bankruptcy-produced global settlement of asbestos claims. The only “harm” to the insurers is that they will generally pay out their shares of the settlement sooner than would be the case in the absence of bankruptcy. Although this a legitimate business concern of insurers, it is not a legitimate basis for denying policyholder recovery.

The mechanics of the § 524(g) prepackaged bankruptcy change the dynamic somewhat in that the bankruptcy plan can arguably be “crammed down” by a three-fourths vote of the claimants – which as a practical matter means that asbestos tort claimants (most of whom will be in the stable of clients of a few high-powered plaintiffs’ firms) can reach a settlement with the policyholder even where other creditors find the terms of the arrangement suboptimal. In this sense, the UNR Court’s confidence in the policing power of creditor approval appears reduced in the § 524(g) bankruptcy as compared to a regular bankruptcy. But even in the § 524(g) situation, the bankruptcy judge is not required to approve a defective plan. The court still retains equitable control over the bankruptcy process and logically should be providing some supervision and policing of these agreements.

Of equal importance to insurers is that even if the global settlement and overall plan is lopsided in favor of asbestos claimants and in derogation of other interests, the insurers retain the right to challenge the settlement plan,

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191. See id., supra note 190; Fuller-Austin, 38 Cal. Rptr. 3d at 738 (noting that UNR preceded enactment of § 524(g)).
both as to eligibility criteria and amount of compensation in relation to particular injury. If the insurers can demonstrate that the asbestos global settlement was collusive, otherwise in bad faith, or simply too generous, the insurers should not be required to fund the settlement and should be able to force settlement negotiations back to the metaphorical drawing board.

Although the new world of asbestos, bankruptcy and prepackaged bankruptcy differs from the ordinary liability coverage matter, there is ample precedent for this approach to assessing insurer obligations under bankruptcy-related global settlements. It is the natural corollary of the well-established doctrine that policyholders may settle a claim when insurers fail to shoulder the claim and the insurer must pay so long as the policyholder-generated settlement is reasonable. What insurers should not be able to do is thwart asbestos global settlements in bankruptcy merely because they are asbestos global settlements in bankruptcy. This would reduce 524(g) to a nullity.

Further, it seems undeniable that the reasonableness of asbestos mass tort settlements is more easily and accurately gauged than that of individual tort claims or emerging mass tort claims. In 1989, mass tort expert Francis McGovern labeled asbestos a "mature" tort, introducing the concept that were a type of tort claim is mature, questions of liability, medical evidence, applicable defenses, and the range of verdicts and judgments is well-established while these questions may be quite open (even wide open) for new, emerging, or individuated tort claims. Under these circumstances, it is far easier for mature mass tort litigants and courts to assess whether the criteria for proving up claims and the amounts specified in a settlement agreement are reasonable.

The asbestos mass tort is so sufficiently mature that major congressional legislation has adopted a payment schedule for asbestos claims. Although the asbestos resolution bill will probably falter on the


194. See Fairness in Asbestos Injury Resolution Act of 2005, S. 852 (or "FAIR" Act) (this is the main asbestos resolution bill under debate and championed by Judiciary
shoals of partisan politics\textsuperscript{195} or fears that the proposed trust would be inadequately funded,\textsuperscript{196} objections to the bill tend not to argue that the payment schedule is too generous. Almost by definition, any settlement that provides for a payment schedule significantly below the amounts of the congressional legislation would appear to be per se reasonable, at least as to amount.

There remains, of course, room for debate as to whether particular settlements have adequate mechanisms for validating claims. Insurers and their counsel have been particular critical of the posited tendency of bankruptcy-related settlements to involve log-rolling between counsel, defendants, and claimants without the true adversity of full-dress litigation.\textsuperscript{197} Although the limited funding available because of the magnitude of mass torts, insurance policy limits, and the resources of companies in bankruptcy (or contemplating bankruptcy) undoubtedly encourages cooperation, this hardly makes such settlements collusive. Individual examination is required, with some deference to the financial realities presented by the now-mature asbestos mass tort. Depending on the facts surrounding bankruptcy and global settlement, insurers may well prevail in their arguments that the arrangements are unenforceable.\textsuperscript{198}

Committee Chair Arlen Spector). The FAIR Act provides the following compensation schedule:

\begin{itemize}
\item $25,000 for evidence of asbestos-related injury without impairment;
\item $100,000 for asbestosis with pleural plaque;
\item $200,000 where an asbestosis victim has “other cancer” not specifically earmarked as an asbestos-induced cancer;
\item $400,000 for severe asbestosis;
\item $850,000 for disabling asbestosis;
\item Amounts ranging from $300,000 to $850,000 for lung cancer depending on whether the victim is a smoker, ex-smoker, or non-smoker;
\item $1.1 million for mesothelioma.
\end{itemize}


\textsuperscript{197} See Plevin, supra note 190; Brickman, supra note 161. See also Francis E. McGovern, \textit{The Tragedy of the Asbestos Commons}, 88 VA. L. REV. 1721, 1728-35 (2002) (positing that litigation system’s lack of incentives for cooperation are major part of the asbestos mass tort problem).

\textsuperscript{198} See, e.g., \textit{In re Combustion Engineering}, 391 F.3d 190, 245-46 n.66 (3d Cir. 2005).
But the need for scrutiny over particular settlements should not obscure the overall insurance coverage picture. Insurers arguing that they are entitled to literal enforcement of consent-to-settle clauses, cooperation clauses, or related provisions restricting policyholder authority to settle asbestos claims are simply wrong – unless the insurer is properly defending the policyholder or otherwise firmly committed to coverage (subject to any discrete, targeted, non-frivolous reservation of rights based on the specific nature of a problematic claim. By this point in the asbestos saga, it is too late for insurers to credibly rely on boilerplate objections to coverage regarding the much litigated (cum overlitigated) asbestos mass tort.

VIII. EQUILIBRIUM EFFECTS: OVERLOOKED INSTANCES OF INSURER VICTORIES IN ASBESTOS AND RELATED COVERAGE BATTLES

Insurers and their counsel have done an effective job of highlighting the degree to which the asbestos mass tort has been a bane to the insurance industry. Although insurers as a class have not successfully portrayed themselves as victims relative to those injured by asbestos, their efforts have succeeded to the extent that many observers appear to see insurers as more severely and unfairly impacted by the asbestos mass tort than asbestos defendant policyholders. As discussed above, particularly in Section VII concerning the impact of bankruptcy on insurance coverage,\textsuperscript{199} and as further elaborated in Section X, below,\textsuperscript{200} insurers appears to have suffered the least damage of any entity touched by the asbestos tragedy and mass tort. By any reasonable objective measure, the asbestos mass tort has been more of a burden to those injured, society in general, and to commercial policyholder asbestos defendants than to insurers.

This pattern would appear not only to continue but to be codified should congressional asbestos legislation be enacted in the form currently discussed. The primary bill most likely to pass in some form (should any bill pass, which is unlikely)\textsuperscript{201} provides for a $140 billion fund to

\textsuperscript{199} \textit{See supra} text and accompanying 152-179.
\textsuperscript{200} \textit{See infra} text and accompanying 248-255.
\textsuperscript{201} \textit{See} Elihu Inselbuch, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005) (contending that proposed omnibus asbestos legislation has proven such a highly effective lever helping Republicans raise funds from businesses and insurers favoring the bill while helping Democrats raise similarly substantial funds from plaintiffs' trial lawyers that generally oppose the legislation; as a result, neither party really is motivated to actually enact some form of legislation and remove this mutually effective fundraising device).
compensate current and future asbestos victims, with two thirds of the fund the fund financed by asbestos defendants and one third from liability insurers. Policyholders are thus expected to pay more than their insurers in this attempt to bring global peace to the asbestos mass tort. But the amount demanded of insurers by Congress appears to be considerably less than the limits of the unexhausted liability policies in force, at least if I am correct regarding the proper classification of general operations claims and completed operations claims (as discussed in Section V, supra). An alien landing on Earth with a basic knowledge of insurance would immediately conclude that insurers are walking away from the asbestos negotiating table with money in their pockets while policyholders are turning theirs inside out. Having insurers pay less to the settlement fund than policyholders would make sense if the amount required reached or exceeded the limits of available coverage. It makes no sense to embrace an omnibus asbestos solution in which insurers pay less than what they would presumably pay in the absence of such legislation.

But thus far, everyone in Washington and at this Symposium seems to think this is fair and reasonable, or at least not odd, which is itself a mark of how successful insurers have been in shaping the debate and perceptions of fairness regarding payment for the asbestos mass tort. To recap: Under the main congressional proposal for a global legislative resolution of the asbestos mass tort, the liability insurers will pay less than their policy limits for claims that are clearly within coverage even though the amount of the liability clearly exceeds those policy limits. However, this is not because claimants have agreed to take such a deep discount that policy limits are never reached. Rather, policyholders would be required to pay billions of dollars of their own money for this global resolution even though they have not exhausted their available insurance. Further, even the policyholders appear to be think of such a result as a victory. This can only be

203. See supra text and accompanying notes 70-131.
204. And, it appears that the policyholders are correct. Although it appears that insurers benefit vis-a-vis policyholders under the congressional proposals, it also appears that policyholders would ultimately gain from a global resolution either by paying lower aggregate compensation costs, lowering disputing costs, achieving the business benefits of certainty or some combination of these factors. See Hanlon, supra note 202. See also John Bowman, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 4, 2005) (plaintiffs' trial lawyer views proposed legislation as have net effect of reducing victim compensation); Craig Berrington, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 4, 2005) (insurer representative sees legislation lowering overall ultimate cost of asbestos mass tort by lowering disputing costs).
characterized as a tremendous public relations coup for insurers as well as a good deal should the proposed legislation be enacted. Congress appears to share the judiciary’s sympathy for the purported plight of asbestos liability insurers and appears to accept the insurer argument that the industry has already paid enough and that policyholders must do more.

This is not to say that policyholders have not won some important victories in their coverage battles with insurers. Prominent policyholder lawyers such as Eugene Anderson, Robert Saylor, Jerold Oshinsky and Scott Gilbert have careers launched by or built upon their success in asbestos coverage matters. But, as discussed below, the major policyholder victories were achieved relatively early in the asbestos coverage wars. During the past 15 years, insurers have tended to win the greater share of coverage victories, in both asbestos matters and other coverage disputes.

My thesis posits that many of these insurer victories, discussed below, were undeserved or at least problematic or presenting close questions. Yet insurers—who perennially maintain that they always lose in a rigged game of ambiguity analysis, reasonable expectations, and bad faith claims—have nonetheless assembled a surprisingly good track record in recent years, arguably one good enough to tip the overall balance in favor of insurers as against policyholders. Although not all of these insurer victories are in asbestos cases, they may have indirect impact on asbestos coverage and provide insurers with ample ammunition for future coverage battles. These underappreciated doctrinal victories by insurers form the basis for a world of future coverage disputes in which insurers will probably do better than they deserve, in at least some part because of the judiciary’s over-correction to what are perceived as some very pro-policyholder developments arising from the asbestos mass tort.

205. Mr. Anderson, name partner in the well-known policyholder firm of Anderson, Kill, was the lead attorney for Keene Corporation in its successful effort to obtain the favorable trigger of coverage rulings discussed. See supra text accompanying notes 35-63. Mr. Saylor, a partner in Covington & Burling, was a well-established commercial lawyer who turned to representing asbestos defendant policyholders and achieved significant victories during the 1980s and 1990s, perhaps most prominently in Armstrong World Indus. v. Aetna Cas. & Sur. Co., 45 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690 (Cal. Ct. App. 1996). Mr. Oshinsky is a prominent coverage attorney and partner at Dickstein, etc. who represented policyholders in the early seminal asbestos coverage litigation such as Forty-Eight Insulations. See supra text and accompanying note 6. Scott Gilbert, a former Covington partner who formed Gilbert, Heintz & Randolph, has long represented asbestos defendant policyholders in coverage litigation and was chief author of the Wellington Agreement. He also appears to be the policyholder attorney most associated with policyholder efforts to prevent insurers from too quickly classifying insulation and construction asbestos liability as products/completed operations liability in order to take advantage of aggregate limits for these types of claims.
As a general matter, courts and other social institutions appear to seek equilibrium between competing perspectives and to maintain a basic, stable status quo. After rendering decisions that arguably shift the status quo in favor of certain interests, the judicial system tends to render countervailing decisions that seek to restore the status quo or at least the pre-existing balance of power. In a battle of long-running antagonists such as policyholders and insurers, courts simply get uncomfortable if either side racks up too long a string of victories.

As a general matter, this is a healthy tendency of the judicial system, one that mitigates against abrupt or radical change that may be unwise or unduly disruptive. It also reflects a basic judicial desire for objectivity and neutrality in which courts are not viewed as favoring certain interests over others. Properly functioning equilibrium tendencies can function to prevent doctrine or precedent from being oppressively applied. But this same tendency can also produce a less defensible form of equilibrium in which courts imitate a mediocre referee that alternates imposition of fouls or penalties, or over-corrects for a bad call by making a worse call for the other side.

Have the insurance coverage battles of the past quarter-century reflected a pattern of equilibrium? Has it been a sound equilibrium or mere alternating between one side and another. A summary examination of the coverage scorecard, beginning with the asbestos liability insurance trigger cases of the late 1970s and 1980s tends to show early policyholder victory followed by an increasing pattern of insurer wins in cases they probably should not have won. Legal developments concerning insurance coverage appear to reflect the equilibrium-seeking tendencies of law generally, but with a sub-optimal, unduly pro-insurer balance that may be the result not only of judicial error but also a perception that insurers had suffered enough from the policyholder’s early victories and the weight of the asbestos mass tort in general.

Examination of the overall judicial treatment of insurance coverage during the asbestos mass tort era suggests that on the whole, the asbestos mass tort has not been bad for insurers overall or in the long run in terms of legal doctrine. Although insurers may have paid more than preferred over asbestos claims, the insurance industry emerges from 25 years of asbestos coverage litigation with a significant number of doctrinal victories that give

it a greater comparative advantage in coverage disputes than it had before the asbestos mass tort arrived.

So, what is the rough scorecard in the continuing sage of insurer-policyholder coverage battles of the modern (asbestos mass tort) era? The most significant policyholder victory, of course, is the widespread adoption of the continuous trigger in which a asbestos victim’s continuing injury from asbestos in the lungs is deemed to be an injury during each of the successive policy periods going forward from the time of the claimant’s initial injurious exposure to asbestos.\textsuperscript{207} As discussed above, the continuous trigger is today seen by most as a natural consequence of a correct reading of the standard CGL policy, which establishes trigger based on “bodily injury” from an “occurrence” and does not require that the injury be manifest, detected or even diagnosable at the time the injury takes place.\textsuperscript{208} The CGL policy, which was or course drafted by the insurance industry, does not require any particular form or quantity of harm to trigger coverage. When combined with the peculiar properties of asbestos, in which essentially indestructible asbestos fibers continue to inflict harm to the body for many years after inhalation, the continuous trigger results.\textsuperscript{209}

Insurers fought hard against the continuous trigger and tended to argue for a trigger jurisprudence that would confine asbestos liability coverage to

\textsuperscript{207} See supra text accompanying notes 38-66.


a single policy.210 They lost this battle, largely because the CGL policy language pretty clearly establishes trigger based on injury, even slight injury and because asbestos is able to cause injury over the course of many years.211 But insurers continue to act as though the widespread judicial adoption of the continuous trigger were some type of radical leftist jurisprudence unmoored from insurance policy text or basic principles, which is clearly incorrect. The continuous trigger is the logical result of the insurance industry’s own adoption of an actual injury trigger combined with the relentlessly ability of asbestos to inflict injury over many years.

As discussed in Section III, supra, when adopting the 1966 version of the occurrence basis CGL policy and more clearly focusing on the date of injury (rather than the date of negligent conduct or activity giving rise to liability) as the trigger of coverage, the insurance industry anticipated that multiple insurance policies could be triggered if injury took place in more than one policy period.212 The ability of asbestos to cause injury in so many policy periods and the overall magnitude of the asbestos mass tort was undoubtedly not anticipated by insurers, who, as a general rule expected the overwhelming number of claims subject to CGL coverage to take place in one clearly defined space and time. But it cannot credibly be said that judicial rulings establishing the continuous trigger are at odds with CGL policy language, industry understanding, or the physical properties of asbestos. Consequently, insurers with asbestos coverage liability due to the

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210. However, insurers were not always consistent and sometimes took inconsistent positions on trigger depending on the particular case and the insurer’s own place in the chain of potentially implicated liability policies. Thus, perhaps unsurprisingly, insurers on the risk during the early years of a claimant’s exposure could be found arguing for a “manifestation” trigger that required asbestos related disease to be more apparent while insurers on the risk in later years argued for a trigger based on mere “exposure” to asbestos so that the early year carriers would be implicated. See Eugene R. Anderson & Nadia V. Holober, Preventing Inconsistencies in Litigation with a Spotlight on Insurance Coverage Litigation: The Doctrines of Judicial Estoppel, Equitable Estoppel, Quasi-Estoppel, Collateral Estoppel, "Mend the Hold," "Fraud on the Court" and Judicial and Evidentiary Admissions, 4:2 CONN. INS. L.J. 589 (1998).

211. See Stempel, supra note 6, § 14.09[b].

212. See supra text accompanying notes 35-63. Although the 1955 CGL form used the term "accident" rather than "occurrence" and the drafting history surrounding the 1966 Form is clearer on this point, the adoption of the occurrence trigger represents a recodification of the injury-based 1955 accident trigger and was not intended to change the operation of the CGL. Trigger was always to be based on injury. Prior to 1966, there may have been some division among insurers as to whether an accident to span multiple policy periods. The 1966 changes resolved the issue by embracing the view that triggering injury could take place in multiple policy periods.
continuous trigger should be given no more sympathy than any other contracting party that suffers economic loss through miscalculation.

Although they were correctly decided on the merits, there is no denying that the continuous trigger precedents greatly benefitted policyholders by making more liability policies potentially applicable to a policyholder's asbestos claims, thereby tending to increase the amount of coverage. Of almost equivalent important were judicial decisions, like those discussed in Section IV, supra, that tended to regard each injury to a separate asbestos claimant as a separate occurrence,\(^{213}\) although there were decisions to the contrary.\(^{214}\) If courts instead had chosen to define an occurrence as the mining of asbestos, manufacture of asbestos, or bulk sales or distributions of asbestos, the amount of available coverage would have been considerably reduced. As with the continuous trigger, however, the occurrence jurisprudence of the courts was not a gift to asbestos defendant policyholders but resulted from objectively correct application of basic insurance principles and the common sense conclusion that each claimant's own exposure to asbestos is the occurrence out of which bodily injury arises for purposes of the CGL. But, as also noted in Section IV, occurrence-counting jurisprudence is not a model of consistency.\(^{215}\) One can certainly envision courts having veered to a more restrictive view of occurrence-counting, which would have limited insurer responsibility in spite of the absence of aggregate limits.

Other policyholder victories in the asbestos coverage wars were perhaps even more prosaic but nonetheless important in providing coverage. In the early stages of asbestos coverage litigation, insurers routinely asserted the "intentional act" defense, which bars coverage where the injury to the third party claimant is "expected or intended from the standpoint of the insured" (a limitation more often today applying broadly to "an insured" or "any insured"). Courts have for the most part correctly rejected this defense, reasoning that even if a policyholder fully intended to make, sell, distribute or use asbestos, this hardly proves that the

\(^{213}\) See supra text accompanying notes 64-69.


\(^{215}\) See supra text accompanying notes 64-69.
policyholder did so with the subjective expectation of injuring third parties, much less an intent to injure.\textsuperscript{216}

The closest cases for applying an "expected or intended" defense are those in which personnel of a core asbestos defendant had knowledge of the harmful properties of the material and wilfully failed to warn of the danger or attempted to conceal it. There is evidence of such misconduct for a few such asbestos defendants but little suggestion that insulation contractors, flooring tile makers, or such other peripheral asbestos defendants ever had any such mens reas in the conduct of their activities giving rise to asbestos-related liability.\textsuperscript{217} Further, although a company employee may be "an insured" under a liability policy as well as a creator of vicarious tort liability for the company, a single employee or small group of employees cannot reasonably be regarded as "the insured." The language of the older liability policies applicable to most asbestos claims thus itself tends to preclude successful assertion of the intentional act defense, even in cases of significant corporate culpability.\textsuperscript{218}

Insurers have generally failed in attempting to interpose policy exclusions for pollution-related liability as a barrier to asbestos claims. For the most part liability policies tended not to contain any sort of pollution exclusion until the late 1960s and the qualified pollution exclusion did not become standard a 1970 ISO endorsement and the 1973 version of the CGL Form.\textsuperscript{219} As is now well-chronicled, the pollution exclusion of that era excepted pollution liability stemming from a "sudden and accidental" release of pollutants into the air, ground or water. As a result, many courts correctly read the exclusion as pertaining only to dispersed outdoor harm rather than toxic torts of bodily injury. In addition, approximately half the courts found the "sudden and accidental" criteria for coverage satisfied where the pollution discharge was unintentional,\textsuperscript{220} a helpful factor for

\textsuperscript{216} See Stemple, supra note 6, § 1.05[a][1] (describing the concept of the intentional act exclusion and the application of expected or intended defense to liability insurance coverage).

\textsuperscript{217} See Olson, supra note 152, at 181-208; Castleman, supra note 63; Brodeur, supra note 63.

\textsuperscript{218} See Stemple, supra note 6, § 1.05[a][1]; Jeffrey W. Stemple, A Mixed Bag for Chicken Little: Analyzing Year 2000 Claims for Insurance Coverage, 48 Emory L.J. 169, 226-231(1999) (concluding that the intentional act defense should not bar coverage for Y2K liability claims simply because policyholders eventually came to understand that there was risk in continuing to operate their legacy computer systems).

\textsuperscript{219} See Ostrager & Newman, supra note 20, § 10.03.

\textsuperscript{220} See Stemple, supra note 6, § 14.13; Jeffrey W. Stemple, Reason and Pollution: Correctly Construing the "Absolute" Exclusion in Context and in Accord with its Purpose and Party Expectations, 34 Tolv & Ins. L.J. 1, 5-7 (1998-1999); William P. Shelley & Richard C. Mason, Application of the Absolute Pollution Exclusion to Toxic Tort Claims:
asbestos defendants facing claims arising out of construction activity, debris, or abandoned materials that were not specifically sold or distributed as a commercial enterprise.\textsuperscript{221}

Policyholders also tended to defeat insurer efforts to defeat coverage based on any uncertainties as to the causation of asbestos-related injury. Although some diseases such as mesothelioma are signature asbestos diseases caused by no other material, victims of lung cancer may owe their unfortunate condition not only to asbestos but also to cigarette smoking or proximity to coal or other industrial materials. Consequently, an asbestos maker or its insurer may well successfully defend a plaintiff’s tort claims on causation grounds.\textsuperscript{222} However, pending the outcome of any such trial, there is obviously at least the potential that a judge or jury will determine that asbestos is at least partially to blame for diseases such as lung cancer or other injury in which the causation may also result from factors other than asbestos. As a result, causation-based defenses are a part of the liability insurer’s duty to defend rather than a ground for avoiding the duty.

\textsuperscript{221} Will Courts Choose Policy Construction or Deconstruction?, 33 TORT & INS. L.J. 749, 750-51 (1998). The inefficacy of the qualified pollution exclusion led the insurers to adopt the "absolute" pollution exclusion in the 1986 revision to the CGL form. Because the 1986 CGL form also included a broad asbestos exclusion (see Section IX, infra), there has been little attempt to use the absolute pollution exclusion as a bar to asbestos claims.

Outside the asbestos context, insurers have avoided coverage by invoking the "absolute" or "total" pollution exclusion in situations where coverage should probably have been required. See, e.g., Reliance Ins. Co. v. Moessner, 121 F.3d 895 (3d Cir. 1997) (applying Pennsylvania law) (holding that liability stemming from carbon monoxide poisoning due to furnace malfunction was excluded from CGL coverage); United States Liab. Ins. Co. v. Bourbeau, 49 F.3d 786 (1st Cir. 1995) (applying Massachusetts law) (holding that liability stemming from child’s ingestion of flaking lead paint chips in apartment was not covered); Deni Assoc., Inc. v. State Farm Fire & Cas. Ins. Co., 711 So.2d 1135 (Fla. 1998) (holding that there was no coverage under CGL policy where liability stems from accidental tipping of blueprint machine and spillage of chemicals during office move). See generally Stempel, supra note 220; Jeffrey Stempel, Unreason in Action: A Case Study of the Wrong Approach to Construing the Liability Insurance Pollution Exclusion, 50 FLA. L. REV. 463 (1998) (addressing Deni Associates and companion case in detail and criticizing the Florida Supreme Court for permitting absolute pollution exclusion to bar coverage in circumstances far afield from the “pollution” intended to be excused by 1986 CGL revision).

\textsuperscript{222} See Hensler, supra note 3; James Early, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005), James Stengel, Comments for the University of Connecticut Asbestos Litigation Symposium, 12:2 CONN. INS. L.J. 27 (2006). See also Hanlon, supra note 202 (discussing degree to which differences in proof of causation have influenced valuation range of certain asbestos injuries in discussions over appropriate schedule of benefits under proposed federal legislation).
In addition, judicial fealty to established doctrines such as construing ambiguities against the insurer/policy drafter undoubtedly aided policyholders in this emerging coverage controversy. So, to did the rise of the reasonable expectations approach/doctrine, which was named and popularized in Judge Keeton’s famous 1970 Harvard Law Review article published on the eve of the new era of asbestos coverage battles.\footnote{See generally Robert E. Keeton, Insurance Law Rights at Variance with Policy Provisions, 83 Harv. L. Rev. 961 (1970).} But the ambiguity approach was hardly a newfangled doctrine added in the late 20th Century to benefit policyholders\footnote{The principle of construing ambiguous language against the drafter applies to contract law generally, not only insurance contracts and has been an established axiom or canon of construction for at least 200 years. See Farnsworth, supra note 133, §§ 7.7-7.14; Stempel, supra note 6, § 4.08.} and the reasonable expectations approach, although of course helpful to policyholders at the margin, has not been self-consciously invoked by many asbestos coverage decisions and tended to be applied only when courts found ambiguity, so it did not become the major coverage revolution feared by insurers in the immediate aftermath of Keeton’s article.\footnote{See Jeffrey W. Stempel, Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role, 5:1 Conn. Ins. L.J. 181 (1998); Mark C. Rahdert, Reasonable Expectations Reconsidered, 18 Conn. L. Rev. 323 (1985).} Although policyholders have of course won other coverage victories during the past 30 years, these did not directly involve asbestos and in large part can be viewed as simply reaffirming the traditional approach to insurance policy construction in the face of insurer efforts to curtail coverage.\footnote{See Vandenberg v. Superior Court, 982 P.2d 229, 246 (Cal. 1999) (CGL coverage not barred merely because claim against policyholder styled as “breach of contract” rather than tort where claim alleges physical injury to tangible property due to policyholder’s conduct); Hazen Paper Co. v. United States Fidelity & Guaranty Co., 555 N.E.2d 576, 578-79 (Mass. 1990) (“potentially responsible party” letter from EPA regarding policyholder duties to remediate contamination pursuant to CERCLA qualifies as “claim” under CGL policy). But see Foster-Gardner, Inc. v. Nat. Union Fire Ins. Co., 959 P.2d 265 (Cal. 1998) (PRP letter not a claim triggering CGL duty to defend) and Traveler’s Ins. Co. v. Eljer Mfg., Inc., 757 N.E.2d 481 (Ill. 2001) (rejecting under Illinois law trigger based on incorporation of defective plumbing components embraced by Judge Richard Posner in Eljer Mfg., Inc. v. Liberty Mut. Ins. Co., 972 F.2d 805 (7th Cir. 1992) (applying Illinois and New York law), requiring that there be actual leakage of plumbing and damage to homes before builder’s CGL coverage is triggered).}

On the whole, asbestos defendant policyholders were successful in obtaining substantial amounts of insurance coverage—but often were thwarted and arguably received less coverage than they were entitled to under the policies. As the sun finally appears to be beginning to set on the
asbestos coverage wars, policyholders are largely left with only two
doctrinal victories of major impact (the continuous trigger and a liberal
approach to occurrence counting, which benefits policyholders if the
deductible or retention is not large and there are no aggregate limits). By
contrast, during the past dozen years, insurers have won significant
victories in perhaps a half-dozen major issues bearing directly or indirectly
on asbestos coverage as well as having significant potential application in
future years. As discussed in Section VI, supra, insurers have at least
obtained mixed results concerning coverage for liability stemming from
acquired operations - an area were the correct analysis suggests insurers
should have consistently lost.227 As discussed in Section V, supra, the
same is true regarding classification of claims as general operations or
products/completed operations claims, enabling insurers to more often
obtain the protection of aggregate limits in cases that should have been
classified as general operations liability matters not subject to an aggregate
limit.228

The most significant victory for insurers involves allocation of
insurance policy limits to different policy periods.229 Because of the long-
tail nature of the asbestos tort and the trigger of insidious injury from
exposure to asbestos, asbestos claims often trigger multiple liability
policies. For example, an asbestos plaintiff may have been initially
exposed to asbestos dust at a power plant in 1955 and continued to work
there until his retirement in 1985, bringing a claim when he developed
mesothelioma in 1990. The asbestos defendant policyholder may have had
30 separate one-year CGL policies and 30 different excess insurers.

In determining how to deploy the triggered liability insurance, the
policyholder and these 60 insurers might be in quite a bit of tension. The
policyholder would like to be able to direct deployment of all triggered
policies in a manner most likely to maximize the coverage it has purchased
over this 30-year period. For example, if its 1970-1980 policies are
exhausted due to payment of other claims or insurer insolvency, the
policyholder would like to use an unexhausted policy to defend and pay

227. See supra text accompanying notes 133-151.
228. See supra text accompanying notes 71-132.
229. For background information on the problem of liability insurance allocation, see
generally STEMPBEL, supra note 6, § 14.11, and Jeffrey W. Stempel, Domtar Baby:
Misplaced Notions of Equitable Apportionment Create a Thicket of Potential Unfairness for
Insurance Policyholders, 25 WM. MITCHELL L. REV. 769, 774-76, 807-24 (1999), and
Garrett G. Gillespie, The Allocation of Coverage Responsibility Among Multiple Triggered
Commercial General Liability Policies in Environmental Cases: Life After Owens-Illinois,
15 VA. ENVTL. L.J. 525, 570-71 (1996), and Hickman & DeYoung, supra note 126.
this claim, including use of the excess insurance from that policy year if necessary. By contrast, both the primary and excess insurers would prefer that the respective insurer liabilities be spread across the 30 years of injurious exposure, which has the effect of limiting any particular insurance year to a maximum of 1/30th of the claim and eliminating the chance that a particular policy year (e.g., 1981) would be required to pay the entire mesothelioma claim. Excess insurers would further prefer that responsibility for the claim be spread across all of the primary insurers and that each responsible primary carrier pay its share before the primary insurance could be considered sufficiently "exhausted" to permit attachment of any excess insurance.

Although the issue is relatively complex, the policyholder position essentially is that it paid for triggered insurance and should get the full benefit of its triggered insurance, without any allocation of multi-year claims that has the effect of reducing coverage and forcing the policyholder to expend its own funds on asbestos matters while their remains untapped, triggered insurance. In addition, policyholders note that the CGL policies of the era state that the insurer will pay "all sums" the policyholder is required to pay on covered liability claims, not merely a portion of the sums for which the policyholder is liable. In contrast, insurers argue that the CGL makes the insurer responsible only for injury that takes place during its policy period, thereby requiring apportionment even if this has the effect of diminishing the policyholder's otherwise available coverage. Excess insurers further argue that they are entitle to full payment by applicable primary insurance before they must pay, because excess insurance should only be available after primary insurance is exhausted and because excess liability premiums are significantly lower than primary CGL premiums based on the assumption that primary insurance will provide front line liability protection for policyholders.230

Pro-ration of insurance coverage across years of triggered policies makes perfect sense as a means of intra-insurer allocation of coverage responsibilities and can provide a useful template for determining questions of contribution and indemnity among multiple triggered insurers. But where imposition of pro-rata apportionment by years acts to prevent policyholders from being able to access triggered coverage under policies they purchased long ago, such allocation is indefensible.231 Notwithstanding my strong objections to such apportionment, many state

230. See Stempel, supra note 229.
231. See id. at 824-906.
high courts have endorsed it, including those in Minnesota,\(^{232}\) New Jersey,\(^{233}\) and New York.\(^{234}\) A common version of the apportionment formula considers not only time on the risk of each triggered insurer but also the respective policy limits of the triggered insurers.\(^{235}\) A few decisions have even permitted pro-ration of insurer defense obligations,\(^{236}\) although this seems the minority view,\(^{237}\) and is even less (pardon the pun) defensible because the duty to defend has traditionally been viewed as an indivisible, all-or-nothing matter. Although a substantial number of states have rejected apportionment of insurer responsibility by time on the risk,\(^{238}\) the net tally in this portion of the insurer-policyholder scorecard reflects a significant doctrinal and financial victory for insurers.

Because the case for prorating insurer coverage and allocating responsibility to the policyholder while trigger policies remain unexhausted is so weak, this appears to be an area in which courts have provided insurers with a counterweight to the continuous trigger. Several of the courts endorsing apportionment see it as an inevitable corollary of the continuous trigger that is necessary if the continuous trigger is not to result in overpayment to the policyholder.\(^{239}\) Of course, this is incorrect on at least two levels. First, the trigger of coverage (i.e., what makes a policy


applicable) is a distinct concept from the scope of coverage (i.e., what the policy must provide if triggered). There is not logical linkage between a continuous trigger and pro-rated apportionment of triggered policies. Second, a pro-policyholder rule of continuous trigger does not equate either to inequity for the insurer or overcompensation for the policyholder. The insurer promised to pay full policy limits if there was coverage and is therefore given a windfall at the expense of the policyholder if coverage is reduced through temporal proration. The policyholder is not overcompensated when it has yet to receive the full amount of its liabilities (up to applicable policy limits) from its insurers. As the many asbestos defendant policyholder bankruptcies (see Section VII above) show, policyholders were not overpaid (through insurance payments or otherwise) by the asbestos mass tort.

Insurers have also prevailed in avoiding coverage for punitive damages even in cases where insurer bad faith arguably led to the punitive damages. And, of course, punitive damages against insurers are limited as a result of the U.S. Supreme Court’s decision in State Farm v. Campbell, which reduces policyholder leverage (and insurer caution) regarding not only asbestos coverage disputes but all claims matters. Insurers obtained

241. See Stempel, supra note 229.
242. See supra text and accompanying notes 152-179.
244. In Campbell, the U.S. Supreme Court significantly tilted the constitutional law of punitive damages in favor of defendants, particularly insurers. Reiterating that there were federal constitutional limits on punitive damages awards (a view disputed by Justices Scalia, Thomas, and Ginsburg), the Court continued to emphasize basic guideposts for reviewing the award such as the reprehensibility of the defendant’s conduct, the ratio of the punitive award to the compensatory award, and its comparative severity as measured against statutory penalties. In addition to arguably sugar-coating the degree of State Farm’s wrongdoing (which was, of course, within the jurisdiction of the Utah courts, not the Supreme Court), the Court adopted a more stringent view of permissible punitive/compensatory ratios. In particular, the Court suggested that ordinarily, a 9:1 ratio would be the likely outer limit, at least where the compensatory award was of significant size. Earlier opinions of both the Supreme Court and other courts had been far less confining in terms of acceptable ratios of awards, frequently accepting double-digit multipliers.

Perhaps most important, in Campbell, the Court declared that defendant wealth was not a factor to be considered, even though this would seem a logical evidentiary datum since the purpose of a punitive award is to punish a defendant and to deter future such conduct, by that defendant and others. Put simply, a $100,000 punitive damages award would more than
additional leverage with the 1997 California decision of \textit{Buss v. Superior Court}\textsuperscript{245} which permitted liability insurers to reserve the right to seek recoupment of defense costs expected upon uncovered claims even though the standard liability policy obligates the insurer to defend “suits” rather than “claims”. Although the criteria for pursuing fee recoupment as set forth in \textit{Buss} are limited,\textsuperscript{246} the decision nonetheless increases insurer leverage in negotiating with policyholders as to the parameters of defense, coverage, and reservations of rights. Although some states have rejected \textit{Buss} outright,\textsuperscript{247} it has been endorsed by other courts, arguably the majority.\textsuperscript{248} In addition to being advantageous for insurers, \textit{Buss} seems to get the attention of most people but would be only pocket change to Warren Buffett. Insurers, of course, are tremendously wealthy companies even if insurance stocks are not always the darlings of Wall Street. Removing wealth from the punitive equation is a major victory for insurers. Previously, even a large award like that reversed in Campbell ($145 million) would be only a small micro-percentage of the assets of the insurer, a factor that plaintiff's could use to persuasively argue that even large punitive awards are not excessive. Those days are gone. Today, insurers have a colorable argument that any punitive award exceeding nine times the plaintiff's injury is excessive, no matter how trivial to the insurer's bottom line and no matter how bad the insurer's conduct. It may not completely solve the pain of asbestos coverage, but Campbell is a big benefit to insurers.

\textsuperscript{245} 939 P.2d 766 (Cal. 1997).

\textsuperscript{246} \textit{Buss} held that where an insurer defends a lawsuit containing both covered claims and those that are not even potentially covered under the policy, the insurer may, after defending, seek recoupment of defense cost expenditures related to defense of the uncovered claims. The requirements for a \textit{Buss}-style recoupment are stringent in requiring the insurer to demonstrate that particular expenditures were for only uncovered matters rather than a mix of matters in a multi-count complaint. Nonetheless, \textit{Buss} provides a powerful lever to insurers in negotiating defense and coverage in place agreements in that the insurer can maintain the threat of a recoupment action if a policyholder does not accept defense cost sharing proposed by the insurer. \textit{Id.} at 770-75.


simply wrongly decided. The typical liability policy promises that the insurer will defend “suits,” which suggests that the insurer must defend the entire action as part of its duty to defend even though its obligation to indemnify is limited to covered actions. In addition, the Buss holding needlessly complicates an already complex area of law and runs counter to the comprehensive “peace of mind” promised by insurers through the CGL policy.

Finally, a relatively recent decision from the nation’s largest state has cast some shadow on the continued vitality of the traditional rule that insurance policy benefits could be freely transferred after a covered loss or liability-creating event had taken place. *Henkel Corporation v. Hartford Accident & Indemnity,* held that Henkel Corporation was not covered for toxic tort liability stemming from its acquisition of certain operations of Amchem Products and apparently would not have had rights under the policies even had there been a formal assignment of these contracts to Henkel, a ruling that provoked considerable attention and commentary. In doing so, the *Henkel* Court appears to have adopted a more stringent view of assignment than that traditionally established by insurance law precedent. If the *Henkel* approach should “catch on” with other courts, the recoupment is the early and important asbestos coverage case *Insurance Company of North America v. Forty-Eight Insulations, Inc.*, 657 F.2d 814 (6th Cir. 1981) (applying Illinois and New Jersey law).

249. See Buss, 939 P.2d at 784 (Kennard, J., dissenting).

250. 62 P.3d 69 (Cal. 2003).

availability of insurance to corporate successors could be significantly curtailed, reducing available insurance coverage for lurking claims against the company for long-tail torts such as asbestos and pollution.

Sustained analysis of *Henkel*, a potentially import case with highly problematic reasoning, reflects the degree to which courts are on occasion handing insurers some dramatically undeserved victories in the coverage wars. The story of the *Henkel* claim began with Amchem, a Pennsylvania corporation with two product lines: agricultural chemicals and metallic chemicals. Amchem obtained liability insurance from Hartford and other insurers. In 1977, Union Carbide acquired Amchem through a stock purchase and merger. In 1979, Union Carbide created a new subsidiary called Amchem Products, which was a Delaware Corporation (mercifully referred to as "Amchem No. 2" by the California Supreme Court). As part of this process, Amchem (No. 1) transferred all of its metallic chemical business to Amchem No. 2, with the new company also accepting all liabilities of the first Amchem. Thus, after the 1979 transaction, there was Amchem No. 1 (specializing in agricultural products) and Amchem No. 2 (specializing in metallic chemicals). In 1980, Union Carbide sold all of the stock in Amchem No. 2 to Henkel Corporation, with a Henkel-Amchem No. 2 merger resulting. In 1986, Union Carbide sold Amchem No. 1 to Rhone Poulenc (today known as Aventis CropScience USA), with Rhone obtaining the rights and obligations of Amchem No. 1.

As the saying goes, you can’t tell the players without a scorecard – and a reasonably detailed scorecard was required to keep track of the two Amchems and their successors. The chain of custody resulting from these events was roughly as follows:

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Amchem >>>> Union Carbide (1977) >>>>>

Amchem (1979)(original) Amchem Products (1979)(spin-off)
(ag products) (metallic chemicals)

(Aventis Crop Service) (Sale and Merger)


*Lockheed Employees v. Aventis* (1992) (stipulated dismissal)
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All of this would probably not be important except for the ensuing litigation and insurance coverage battle. In 1989, current and former employees of Lockheed, the aerospace company, sued Henkel and "Amchem Products" for alleged injuries arising out of the use of the metallic chemicals sold by the "old" Amchem that were used to assist in painting metallic surfaces during the 1959 to 1976 period. Henkel, on the basis of the old Amchem insurance policies it acquired with the purchase of Amchem No. 2 (the metallic chemicals wing of old Amchem) tendered the claim to Hartford and the liability insurers, all of which denied coverage.

In 1992, the Lockheed employees also sued Rhone Poulenc for Amchem-related liability. This litigation was stopped by quashed service. Rhone Poulenc argued that according to the terms of the various transformations of Amchem, it was Henkel that was responsible for any lingering Amchem liability that stemmed from the sale or sue of metallic chemicals. The Lockheed employee plaintiffs apparently agreed, stipulating to dismissal of their claims against Rhone Poulenc. This left the Lockheed plaintiffs' suit against Henkel, which was settled in 1995 for $7.6 million.

Henkel then turned to its insurance carriers for indemnity as well as reimbursement of defense costs. The insurers again refused coverage, arguing that the policies were invalid without the insurers' consent to the transfer of the policies to Henkel. Henkel, in turn, argued that under well-settled principles of insurance law, assignment of an insurance policy prior to a covered occurrence generally requires insurer consent (because the risk may change) while assignment after the loss has occurred is subject to the general rules of contract permitting assignment absent special circumstances such as a personal service contract (because, after loss, the risk to the insurer is unchanged by a change in the identity of the policyholder). As a result, argued, Henkel, the insurance policies should generally be viewed as assets acquired along with other property as part of a corporate sale or acquisition. In a bizarre and disappointing opinion, the California Supreme Court not only departed from the ordinary ground rules of insurance policy succession but also essentially relieved the liability insurers of obligations they would otherwise have had there been no acquisition of Amchem.

As Justice Moreno, the lone Supreme Court dissenter noted, the Court's decision was a windfall for the insurers, who collected years of premiums in connection with Amchem's operations but were not required to provide any coverage notwithstanding that their risk and exposure appear not to have increased at all as a result of the corporate mergers resulting in Amchem becoming a part of Henkel. Also troubling to the
dissenting Justice was that the California Supreme Court appears to have changed the rules regarding insurance policy acquisition and assignment in a way that benefits insurers without admitting that it has departed from what I thought was settled law. Even if the *Henkel* Court majority had been a bit more candid about what it was doing, the decision is also troubling because the reasons supporting the Court’s newfound protection of insurers are so weak.

Applying the “general rule” to the *Henkel v. Hartford* situation would presumably lead to coverage for Henkel. Although the attorneys working on the various corporate transactions should in hindsight have also included formal assignment of insurance policies, this almost certainly would have provided no ultimate benefit. The Supreme Court majority opinion language states that insurance policy rights do not follow from *either* the acquisition of assets or the formal assignment of specific insurance policies. But surely this was a case for which the traditional general rule counseled transfer of the policy rights. The basis of the Lockheed plaintiffs’ claims arose out of alleged injurious exposure to Amchem metallic chemicals during the 1959-1976 time period, a juncture well before the change in Amchem from separate company, to Union Carbide subsidiary, to Amchem No. 1 & Amchem No. 2, or to part of the current Henkel. The alleged “loss” or liability had clearly been triggered well before the assignment of the insurance, even if there were yet to be claims under the policy and not yet a settlement or judicial resolution.²⁵²

More important, transferring the old Amchem policies to Henkel well after the end of the policy period did nothing to increase the risk to insurers. Either something has happened during the policy period or it has not. Assigning the insurance from Amchem to Henkel will not effect this. Although occurrence basis insurers may feel unfairly imposed upon by “long-tail” latent injury claims from the past, this problem results from the language of the policies (which the insurers wrote) and the nature of toxic tort claims, it is not a problem created by assignment. Put another way, Hartford and the other insurers are no worse off because Henkel (rather than the old Amchem) is the policyholder tendering claims to them. Consequently, after reading the facts of the case recited by the Henkel Court, a reasonable person versed in insurance law would have thought that

²⁵² As noted above, the Amchem-Henkel policies were “occurrence” basis policies that provide coverage if the policyholder is alleged to have caused an injury during the policy period. Under prior California laws as well as the law of most jurisdictions, occurrence policies are deemed triggered if injury is alleged to take place during the policy period even if the injury has not become palpable, manifest, or known until years later. *See* Montrose Chemical Corp. v. Admiral Ins. Co., 913 P.2d 878 (Cal. 1995).
the Court would have voted unanimously to uphold the transfer of the policies. Instead, it voted nearly unanimously against transfer of the policies. How did this happen?

First, the Henkel majority appears to have changed the “rules” of assignability (the meaning of precedent) in the middle of the “game” (the dispute between Henkel and its insurers), a point noted by only one dissenting Justice.253 Instead of following the prevailing precedent that post-loss assignment is normally permitted, the Henkel Court implied that “consent-to-assignment” clauses were universally enforceable, specifically citing to prior California law decisions, Greco v. Oregon Mut. Fire Ins. Co.,254 and Bergson v. Builders Ins. Co.255 However, both these cases involved attempts to assign insurance policies prior to the occurrence of a loss or claim. Thus, these cases are consistent with the general rule of no assignment (without consent) for pre-loss matters but assignment being acceptable after the loss has taken place. More important, these cases are inapposite to the Henkel situation and in fact counsel in favor of permitting Henkel to exercise rights under the policies originally sold to Amchem.

The Henkel majority acknowledged the general rule and cited cases supporting it, but then distinguished the cases on the basis of the division of Amchem during the course of the corporate mergers.256 With this rhetorical move, the Henkel Court changed the general rule of exceptions to the anti-assignment rule. In California, it is no longer enough for the loss event to have taken place in order for an insurance policy to become assignable (even in the face of anti-assignment or consent requirement language in the policy). Instead, the loss must not only have taken place but must “have been reduced to a sum of money due or to become due under the policy.” Instead of merely requiring an occurrence, injury, loss or claim, the Henkel Court required that there must have already been a

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253. See Henkel, 62 P.3d at 77. (Moreno, J., dissenting). The dissent also collects case law representative of the pre-Henkel general rules of assignability:

It is unclear from what source the majority’s novel conclusion is derived. The majority cites [prior California cases] for the proposition that benefits under an insurance policy can be assigned notwithstanding a contractual provision barring the assignment of such benefits. Yet the majority ignores the actual rule articulated in these cases, that an insured can assign policy benefits once the loss insured against has occurred.

Id. at 77 (emphasis in original) (also referring to majority’s “abandonment of the general rule”).

255. 38 Cal. 541 (1869).
256. See Henkel, 63 P.3d 69 at 75.
judgment or settlement. Although the *Henkel* Court does not admit it, it has dramatically changed the law in this regard.\(^{257}\)

Second, the *Henkel* Court was reluctant to permit transfer of insurance policy rights on the ground that it might be unfair to the liability insurers because it presented the possibility of confusion as to which of the Amchem successor entities was entitled to a defense.\(^{258}\) Although the Court’s concern is understandable, it is overdone, both as a general matter and in light of the specific facts of the *Henkel* case. As Henkel Corporation noted, the possibility of forcing the liability insurers to fight a two-front war was eliminated by the Lockheed plaintiffs’ agreement to leave alone Rhone Poulenc, the other successor to the original, pre-split Amchem. The Supreme Court was unmoved, finding that “if the Lockheed plaintiffs had refused to dismiss their suit against Rhone Poulenc, defendants would have faced the dilemma whether to defend Rhone Poulenc, Henkel, or both.”\(^{259}\)


Although in some of these cases (e.g., assignment of a bad faith claim after an adverse jury verdict in excess of policy limits), the loss was reduced to a set figure, it hardly follows that this is essential. In fact, from a risk management and insurance theory perspective, it matters not at all whether the pre-assignment loss has been liquidated into a certain amount. What is important is that the loss precede the assignment so that assignment not impact the risk faced by the insurer. Consequently, one might consider the Court’s differentiation of previous cases upholding assignment to be the lawyer’s proverbial “distinction without a difference.” When one focuses on the core of the pre- *Henkel* cases in California, one finds that what is key to the inquiry is the time of loss, not the stage of claims proceedings arising out of the loss or occurrence.

258. *Henkel*, 62 P.3d at 76.

Even assuming enforcement of the no consent clauses requires a showing of additional burden or risk on the insurer, *Henkel* cannot prevail. An additional burden may arise whenever the predecessor corporation still exists or can be revived, because of the ubiquitous potential for disputes over the existence and scope of the assignment. If both assignor and assignee were to claim the right to defense, the insurer might effectively be forced to undertake the burden of defending both parties. In view of the potential for such increased burdens, it is reasonable to uphold the insurer’s contractual right to accept or reject an assignment.

*See id.*

259. *Id.*
In the face of this potential (but only potential rather than actual) dilemma, the Court found it appropriate to permit the insurers to insist upon strict compliance with their consent-to-assignment clauses.

Although the Court's concern for the insurers is touching, it tends to ring a little hollow in the real world of insurance coverage litigation. First, of course, the "two-front war" problem was not at issue in the case. Second, the long-standing law of the duty to defend generally requires a liability insurer to defend an action if there is so much as a "potential for coverage" under the applicable policy. In the *Lockheed-Amchem-Henkel* case, there clearly was such potential. At the very least, the law of post-loss assignability was unsettled, if not in favor of Henkel. Third, in the actual case, Henkel Corporation did defend the claims and resolved them. Although a $7.6 million price tag is large, there is no suggestion in the opinion that the amount of the settlement was excessive or that the Lockheed plaintiffs had a weak case as to liability. Unless the settlement was unreasonable, one is hard-pressed to see what the insurers are complaining about — at least as respects the duty to indemnify.

Further, insurers in the real world are hardly the vulnerable confused lambs suggested by the *Henkel* Court. If an insurer is faced with a post-loss assignment that legitimately creates uncertainty as to which of several entities is owed the defense, the insurer may commence a declaratory judgment to resolve the issue, something insurance companies are quick to do when it is in their interests to pursue judicial declaration. In addition, the *Henkel* Court's concerns seem overblown in light of the Court's own precedents establishing an liability insurer's rights to obtain recoupment of defense costs spent in connection with uncovered claims. As discussed above, prior to *Henkel*, the Court in *Buss v. Superior Court*, the Court found that insurers may seek reimbursement of defense costs expended in defending uncovered claims. Although, this has not been a right commonly used by insurers in practice (because of the stringent requirements of a *Buss*-style reimbursement action), the problem of defending the correct corporate successor would appear to be one of those rare cases where *Buss* may benefit both policyholders and insurers.

Although the *Henkel* decision can be arguably justified based on considerations of fairness toward insurers and adherence to contract language, the Court seems not to have engaged at all in any serious reflection about the public policy, risk management, and compensation issues presented by the case. In addition, a major rationale for commercial insurance is to facilitate economic activity and growth by providing risk

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management protection for economic actors. To the extent that insurance protection (for past but possibly unknown losses) may be more freely assigned as part of corporate recombinations, this lowers transaction costs and facilitates economic activity and wealth enhancement. Consequently, the general rule permitting post-loss assignment is a good rule — which is why the courts have crafted it over the years even though it appears to contradict the clear text of many insurance policies and the courts’ expressed fidelity to contract language. The post-loss exception to the general rule of restricted insurance assignability is a venerable rule borne of experience and practicality. After Henkel v. Hartford, it appears that the law of post-loss assignment has been made much narrower in California which may have substantial negative implications for the law of insurance assignability in general.

In addition to the reasons previously set forth, Henkel is a very problematic decision in that it appears to run counter to both basic contract law and basic insurance law and principles. In addition to the problems of assignability noted above, Henkel is at odds with the prevailing notion that contract rights are property rights that deserve fulfillment and that Disproportionate Forfeiture and absurd results should be avoided.261 The Henkel v. Hartford opinion may simply be the an unusual result driven in part by the Court’s perhaps subconscious effort to provide a legal victory to an insurance industry that has to a large degree successfully portrayed itself as a victim of both the largest mass tort in history and of judicial rulings unduly favorable to policyholders. Henkel becomes potentially important to the question of insurance coverage for asbestos liability because, like toxic torts, pharmaceuticals, and pollution, asbestos claims are long-tail and are more likely than most tort claims to involve injuries taking place in distant policy periods. To the extent that the Henkel approach takes root in other jurisdictions, insurers will successfully avoid some asbestos coverage liability that rightfully should have been imposed.262 Although most of the

262. Henkel has influenced at least one other decision outside California. See Century Indemnity Co. v. Aero-Motive Co., 318 F. Supp. 2d 530, 540 (W.D. Mich. 2003) (refusing to permit assignee to obtain coverage under assignor’s policy). Henkel has of course been noticed by treatise writers, which makes it widely available to counsel and courts for reference in subsequent disputes. See e.g., Appleman & Appleman, supra note 35, §§ 1215 Supp., n. 64.11; 1293 Supp. n. 95.1; 4269, n. 1926; California Insurance Law & Practice §§ 8.1147.07[1], 11E.24, 80.01(2001); California Forms of Jury Instruction 1-3C, MB 300C.05 (2006); California Forms of Pleading and Practice 26-308 (2006); Stempel, supra note 6, § 3.15(d).

Vigorously contested litigation in Ohio may provide further clues regarding judicial reaction to Henkel Outside of California and the degree to which Henkel is an outlier or part
initial commentary in reaction to Henkel has been critical,\textsuperscript{263} the decision has its defenders\textsuperscript{264} and the insurance industry is likely to try to persuade other jurisdictions to take a similarly restrictive view of insurance policy transfer, which has significant implications for insurers for long-tail obligations under occurrence policies. At the very least, Henkel would appear to provide insurers with protection in some number of coverage disputes subject to California law.\textsuperscript{265}

My hypothesis is that bad decisions like Henkel result in significant part because courts on occasion strain to give insurers doctrinal victories out of a conscious or subconscious desire to even the score due to a perception that policyholders have benefitted from very favorable coverage decisions in the past, some arising from the asbestos mass tort. One need not be an extreme legal realist to regard much of the emerging law in this area as the result of compromise. On one hand, most jurisdictions give the

of a trend. In Pilkinson No. Am., Inc. v. Travelers Cas. & Surety Co., Case No. 3:01CV7617 (N.D.Ohio, W.D. 2005), assignee Pilkinson, which acquired policy rights from Libby-Owens-Ford, and now faces claims arising out of injuries arising out of the LOF activities, is seeking coverage for these toxic torts claims. Travelers has interposed a Henkel defense. In pretrial motions, the antagonists have brought in prominent insurance experts: Professor Tom Baker (Connecticut) for Pilkinson and Professor George Priest (Yale) for Travelers. A district court ruling or subsequent Sixth Circuit decision will undoubtedly help to determine if the Henkel decision creates a trend. Certification to the Ohio Supreme Court has been granted regarding three questions:

1. Is Pilkinson’s demand for a defend to the environmental claims a chose-in-action under Ohio law?

2. Do insurance policy anti-assignment clauses bar acquisition by Pilkinson or other successors from acquiring such chose-in-action rights?

3. Are insurance policy rights transferred by operation of law in situations such as the Pilkinson transaction with Libby-Owens-Ford?

See Pilkinson N. Am. v. Travelers Cas. and Sur., 105 Ohio St. 3d 1514, 826 N.E.2d 313 (N.D. Ohio 2005). Cases like Pilkinson may accelerate or retard Henkel’s influence depending on the outcome.

\textsuperscript{263} Perhaps most vigorously in STEMP\textsuperscript{6}, supra note 6, at § 3.15[d].

\textsuperscript{264} See e.g., May, supra note 141, at 911; Alan S. Rutkin, Movable Coverage: Successor Coverage May be Narrower Than Successor Liability, BEST’S REVIEW, May 1, 2003, at 62.

policyholder the benefit of a very “liberal” rule of triggering occurrence coverage based upon allegation of even sub-cellular damage rather than requiring more concrete and manifest injury to trigger coverage. But on the proverbial other hand, many courts have restricted policyholder recovery by requiring proration of multiple triggered policies, assigning coverage responsibility to the policyholder for some significant time periods. Many courts have also tended to take an arguably overbroad view of the pollution exclusion, which was substantially re-written in 1986 in response to such claims. Courts have also generally been unwilling to look behind policy language to the drafting history of such provisions and have also been reluctant to find insurers estopped by prior representations on the matter.

IX. INNOCULATION EFFECTS: HOW ASBESTOS-RELATED CHANGES IN LIABILITY POLICIES AND INSURER PRACTICES HAVE PROTECTED INSURERS

Although not “unfairly” required to provide substantial coverage for asbestos-related claims, insurers certainly had considerable cause to be displeased with the situation and its impact on their revenues. But, as discussed in Section VII above and addressed more in Section X below, asbestos coverage responsibility has been a manageable burden for insurers and only a contained drag on earnings from which most insurers, even those with the greatest concentration of asbestos policyholders, have recovered. In addition, facing the asbestos coverage problem forced insurers to consider changes in liability insurance product design and industry operations to reduce the risks of similar exposure in the future. These reactions have greatly reduced the risks of “another asbestos” for insurers and further shifted the balance of power toward insurers.

The asbestos mass tort, with some additional help from the environmental liabilities of the 1970s, prompted significant revisions in the standard CGL form. Most obvious is the exclusion for any asbestos-related liability coverage, which began as an endorsement but was not added to the CGL until the 1986 revision. The asbestos exclusion is broadly worded and its purpose and application clear in light of the asbestos mass tort. Insurers wanted no part (at least not at standard premium rates) of asbestos liability claims against policyholders, even if the policyholders used only trace amounts of asbestos in their products or services. The subsequent second wave of asbestos claims against peripheral defendants has underscored the industry’s wisdom in adopting a broad asbestos exclusion for the CGL rather than merely directing the exclusion at asbestos manufacturers or large contractors.
Of course, to some extent, the metaphorical cow had already escaped the barn even before the asbestos mass tort was apparent due to the occurrence basis format of the CGL and the insidious nature of asbestos disease. Nonetheless, it remains surprising that it took the insurance industry more than a dozen years from the time the asbestos mass tort became apparent with the rendering of the Fifth Circuit’s 1973 Borel v. Fibreboard decision. Borel recognized asbestos injury as a legitimate tort and rejected manufacturer defenses based on contractual privity, assumption of risk, employer negligence, and cost-benefit analysis. After Borel, there was no reasonable doubt that asbestos would be a major source of tort litigation and tort liability, even if observers could not then estimate the full magnitude of the mass tort that resulted. But insurers did not move to immediately exclude asbestos.

Perhaps the initial delay resulted not only from insurer underestimation of the size of the asbestos tort but also from underestimating the number of policies that would be triggered and the application of the per occurrence limits with so many individuals claiming bodily injury. However, by the mid or late-1970s, insurers logically should have seen a good deal of this coming because of coverage battles such as Forty-Eight Insulations v. INA and Keene Corporation v. Aetna being waged at the trial court level. By 1980, these coverage clashes had resulted in prominent appellate court opinions adopting broad trigger rules that were the talk of the industry. Yet the industry did not adopt the broad asbestos exclusion for another six years.

Although the hesitancy of insurers to embrace an asbestos exclusion is difficult to understand and difficult to explain through the archeology of policy drafting, it appears to have ushered in a new era in which insurers are much quicker to adopt blanket exclusions when faced with a looming mass tort or coverage risk. Compare the leisurely pace of the asbestos exclusion with the experiences of mold, silicon, or the Year 2000 problem. In these instances, insurers reacted with the alacrity of an urban SWAT team. The potential computer crashes and collateral damage of the Year 2000 problem was first noted in the early 1990s by a group of technological Cassandras, most notably Peter De Jager. But by 1997, the Y2K issue was big news worrying governments, business and insurers. Well before New Year’s Eve 2000, most insurers had responded with Y2K exclusions, frequently employing one of the exclusions drafted by ISO for use by the insurance industry.

266. See Borel v. Fibreboard Paper Products Corp., 493 F.2d 1076 (5th Cir. 1973) (applying Texas law).
Insurers have shown similar speed and flexibility in making other modifications in liability policies in reaction to particular court decisions or classes of claims. The first significant court decision requiring coverage for mold was rendered in 2001. By 2002, most insurers had revised or added mold exclusions to attempt to eliminate coverage for this type of liability or loss. When California’s 1995 Montrose decision adopted the continuous trigger for construction defect coverage claims, insurers quickly began including a “Montrose endorsement” in their policies, language that seeks to restrict coverage for a loss or injury to a single policy even if multiple policies are triggered. In response to court decisions finding coverage where an excluded cause of loss such as earth movement or flooding acted in combination with a covered cause of loss, insurers moved relatively swiftly to use of a broad “lead-in clause” to the list of excluded perils, providing that coverage was barred whenever an excluded cause was part of the chain of events leading to loss.

The lesson I draw from the comparison of the path of the asbestos exclusion (and the industry’s slowness in moving from a qualified to an absolute pollution exclusion during the same 1973-1986 period) as compared to more recent events is that the asbestos mass tort made insurers more cognizant of the potential for large coverage exposure due to a mass tort and prompted the industry to be more alert and to react swiftly. Rather than worry too long about adverse policyholder, regulator, or public reaction to constricting coverage, the new ethos of insurers appears to be one in which they will exclude first and ask questions later rather than risk fiddling while a new mass tort catches flame. Perhaps this is an overreaction to asbestos (and to pollution liability CERCLA clean-up), an example of “fighting the last war”. But this seemingly faster reaction time of insurers suggests we will never see insurers take the type of financial hit presented by asbestos coverage obligations.

The asbestos coverage imbroglio also spurred an number of changes to the CGL that are not asbestos-specific. Liability policies now routinely have an aggregate limit for all types of coverage, not just products/completed operations coverage. As a result, insurers are well protected from any future mass torts that might be subject to the continuous trigger or a finding of many occurrences based on many injured third parties. This move alone substantially limits the insurance industry’s exposure to any “next asbestos.”

The insurers can, of course, choose to take on risks excluded under the standard CGL and appear willing to do so if the price is right. Policyholders can “buy back” certain excluded coverages for an additional premium or may be able to purchase a particular “stand-alone” policy for a
particular risk. In what must undoubtedly surprise laypersons and tort reform advocates (who so often argue that tort liability makes insurance practically unavailable), even asbestos coverage can be purchased notwithstanding the broad general exclusion for such coverage in the average liability policy. General Re, a company controlled by Warren Buffett, has offered to reinsure asbestos coverage obligations in a product viewed as profitable by industry observers. Buffett did not become the world’s richest person (or second-richest, depending on the performance of the Bill Gates portfolio) by taking unreasonable risks. The General Re product suggests that even asbestos liability remains insurable to a degree and that observers such as Fitch, Dowling, and Baker are correct about asbestos obligations of insurers being manageable.

Perhaps more important, the new operating methodology of excluding problematic risks from the standard CGL form but addressing those risks individually almost certainly results in more advantageous insurance policy design and pricing by insurers. To the extent this business model is more successful than the previous model of aggressively offering comprehensive coverage to garner premium dollars and curb adverse selection, insurers paradoxically will find the asbestos mass tort to have been helpful. To the extent that the asbestos mass tort “burned” insurers, it has also had the potentially salutary effect of making insurers more careful about underwriting and pricing generally.

Another major product design innovation prompted by asbestos (with an obligatory continuing nod to pollution) is the claims-made liability policy. Although use of a claims-made form is not new (it has existed for some time in professional liability, director’s and officer’s liability and other specialized lines), it was not common for general liability insurance prior to the 1980s. But in reaction to the asbestos mass tort (and pollution and long-tail product liability claims generally), insurers and reinsurers prevailed upon ISO to develop a standardized CGL form with a claims-made trigger. Aggressive insurer efforts to make claims-made general liability policies the norm created a firestorm of litigation that even reached the U.S. Supreme Court among allegations of collusive behavior violative of the antitrust laws. Nonetheless, nearly every state regulator and the courts have approved use of claims-made CGL policies. Although the claims-made form has not supplanted the occurrence form, which is preferred by policyholders and is generally readily available except in very hard markets, the availability of claims-made insurance as an alternative to the occurrence policy gives insurers another powerful means of responding to mass tort coverage threats.
Under an occurrence form, coverage is triggered by injury during the policy period, even if the injury is undetected for years or claims are not made for years. The occurrence policy thus provides unlimited prospective coverage to the policyholder. If Acme Corp. causes injury to others through its use of asbestos in 1970, its 1970 CGL policy will provide coverage for claims that are not made until 2000. By contrast, a claims-made CGL form provides no prospective coverage (unless the policyholder purchases an extended reporting endorsement for injuries during the policy period that result in claims during later years). When the claims-made policy expires, so does the coverage. The claims-made policy does provide unlimited retroactive coverage, at least in theory (most insurers sell the policies with a “retroactive date” that prevents coverage for older injuries even if the claim is made during the policy period). But where insurance trigger is based on claims, insurers are in a good position to both reserve for claims payment and to monitor the potential emergence of a mass tort. If the insurer suspects that claims made in policy Year A are the tip mass tort iceberg (or even large tort debris), the insurer can simply refuse to sell liability coverage to the policyholder in Years B, C, D, etc. Alternatively, the insurer can also increase premiums or even cancel the policy.

Because of customer resistance and improving insurance underwriting conditions, the claims-made policy did not supplant the occurrence policy and debate subsided over the relative merits of the forms and the appropriateness of perceived insurer strong-arming of policyholders into the claims-made form. In fact, one might argue that an occurrence form is more profitable for insurers in the long run now that insurers seem to know how to quickly exclude unwanted coverages during the early signs of trouble, as reflected in the examples of mold, silicon, and Y2K. Under an occurrence form, the insurer faces the threat of the emergence of long-tail liability but in return has a longer period of investment income and pays claims in inflation-impacted dollars.

But the industry’s new focus on the claims-made form has increased its use not only in traditional areas such as medical malpractice and D&O liability but also has made claims-made underwriting more common in excess insurance, particularly high level excess policies such as those sold by Bermuda-based companies, other offshore entities, and captive insurers. ACE and XL, two large Bermuda insurers, began as the creation of brokers and policyholders attempting to deal with the hard insurance market of the 1980s, and adopted not only a claims-made trigger but also adopted other provisions favorable to insurers such as a New York choice of law clause and an arbitration agreement.
A classic complaint of insurers has long been that American courts, particularly lay juries, are unduly sympathetic to policyholders in coverage disputes. One obvious response for liability insurers is the inclusion in the policy of a clause requiring arbitration of disputes, replacing the jury and the judge with an arbitrator or panel of arbitrators. The conventional wisdom holds that arbitrators are not disposed to favor policyholders and are less moved by concerns of sympathy for the policyholder or third party claimant. Arbitration clauses are now commonly used in many commercial insurance forms, although the standard CGL has no arbitration clause, most likely because of perceived resistance from regulators. However, commercial CGL policies frequently provide for arbitration by endorsement. The widely used Bermuda forms not only provide for arbitration but also contain a choice of venue provision specifying that arbitration be in London pursuant to the procedures of the British Arbitration Act. The net effect is to make it considerably more likely that at least a majority of the arbitrators will be British. According to the conventional wisdom, British arbitrators are more favorably disposed to insurers than their American counterparts. Since the mid-1980s, U.S. law has favored the enforceability of arbitration and other alternative dispute resolution clauses, making it considerably more likely that such language in insurance policies will "stick" than was the case prior to the asbestos mass tort.

In addition, again led by the example of Bermuda insurers, liability policies now often contain choice of law clauses, which were comparatively rare prior to the asbestos mass tort. As any American lawyer knows, shopping for the most favorable forum and applicable law is a major part of litigation strategy. Although the choice of law factors focus on a state’s contact with the dispute rather than the forum in which the dispute is heard (an Nevada court may find itself applying California law or Florida law), there is a perceived tendency for courts to chose their own law in close cases because of the court’s familiarity with its own state’s law. A specific choice of law prevents this, and may further be coupled with a choice of venue provision so that policyholders may not site coverage battles in states perceived to have a more pro-policyholder judiciary or jury venire.

Through these provisions, insurers can ensure that disputes are governed by a body of law most acceptable to insurers. As noted above, New York law is particularly popular for Bermuda insurers and others in the industry because New York is viewed as a somewhat pro-insurer jurisdiction that has a few particularly favorable rules aiding insurers. Most importantly, choice of forum and choice of law clauses permit the
insurer to avoid the types of pro-plaintiff or pro-policyholder jurisdictions tort reforms have labeled “judicial hellholes”. Although this type of rhetoric is of course excessive, overly politicized, and misleading, it well illustrates the basic point: insurers would rather have coverage disputes decided under New York law and heard in Manhattan or London rather than face a jury in Madison County, Illinois presided over by an elected judge with substantial discretion to choose a body of law favorable to a policyholder.

Insurers have also expanded the scope of the intentional act/expected or intended limitation on coverage (sometimes expressed as an exclusion but now more often part of the insuring agreement) by providing that coverage may be defeated by the intent to injure not only of “the insured” but by “an insured” or “any insured.” Insurers have largely been successful in arguing that this slight change in language no longer makes it possible for innocent family members or other co-policyholders to obtain coverage where a single person insured under the policy has acted with the requisite disqualifying state of mind.

Although the asbestos mass tort did not create aggregate limits, broad or laser-like exclusion, more favorable policy language, choice of law, choice of forum, or arbitration clauses, it helped prompt the insurance industry to develop these sorts of tools of policy design and to deploy them more frequently and aggressively. The result is that insurers today are in a considerably better position for disputing coverage than was the case 30 years ago.

X. ASSESSING THE EQUITIES OF ASBESTOS AND INSURANCE

Having extensively reviewed the saga of the asbestos insurance coverage wars, it is time for an attempt at ultimate assessment: Have insurers been treated unfairly or suffered unduly as a result of the asbestos mass tort? The answer seems to be a resounding “no.” Asbestos may not have been the best thing to ever happen to the insurance industry but appears to be a storm insurers have successfully ridden out and will continue to ride out. Even the best known example of asbestos-based pressure on insurance industry – the troubles at Lloyd’s during the 1980s and the formation of Equitas – appears headed toward an acceptable if not classically happy ending.267 By comparison to the financial pressure

imposed on insurers by real storms such as Hurricane Katrina, the Northridge Earthquake, and Winterstorm Jeannette, the asbestos coverage exposure has been manageable.

As important as the question of financial impact is the question of justice. Even if asbestos is only a small drag on earning for liability insurers, this alone hardly justifies erroneous legal treatment of their contract disputes with policyholders. Although insurers complain about judicial decisions mandating coverage, it seems indisputable that these decisions have largely been correct and that insurers have won at least as many coverage disputes they deserved to lose. In addition, when one examines the overall justice of the asbestos coverage experience rather than only the more narrow question of particular litigant rights in a particular context, it also appears that insurers have not been forced to take on any asbestos liabilities for which they did not bargain and receive compensation.

An insurance policy, like any contract, allocates risk. Insurance policies are different from other contracts, however, in that risk allocation is to a large extent the main purpose of the contract, whereas risk allocation, although important, may be secondary in contracts involving sales of goods or real estate, situations in which acquisition of property or money is the core of the transaction. Under the insuring arrangement, the policyholder pays a premium to the insurer in return for the insurer’s acceptance of the contingent risk of suffering future third-party claims and adverse settlements or judgments.

Insurance by definition involves a policyholder’s incurring a relatively small but certain loss (i.e., payment of premiums) in return for obtaining protection from large but contingent and uncertain risks (coverage under the policy up to the policy limits, either per occurrence or aggregate). The very nature of the insurance undertaking is one in which the policyholder is at risk of needlessly paying for a product he never can use while the insurer bears the risk that it must pay amounts far larger than a particular policyholder’s premiums should substantial tort liability be visited upon the policyholder.

Either way, the parties to that insurance policy, an aleatory contract, are involved in an exchange that is certain to be unequal. Insurance scholars define an aleatory contract as one in which the outcome is affected by chance and that the number of dollars given up by the contracting parties will be unequal. The insured pays the required premium, and if no loss occurs, the insurance company pays nothing. If a loss does occur, the insured’s premium is small in relation to the amount the insurer will be
required to pay. In the sense that it is aleatory, and insurance contract is like a gambling contract.\textsuperscript{268}

Because of the emergence of the asbestos mass tort, more of those contingent risks resulted in claims and liability than was originally predicted by either the insurers or policyholder/asbestos defendant. Although this had adverse economic consequences for both the insurers and policyholders, it is no reason for relieving or reducing the insurance coverage responsibility of general liability insurers. On the contrary, there is every reason to hold the insurers to their risk-shifting bargain. Acceptance of this sort of risk is the essence of insurance. It is the reason American businesses pay premiums to insurers. Insurance markets, risk management, and commerce are adversely affected when insurers are allowed to escape their contractual commitments, with correspondingly adverse social and economic consequences.\textsuperscript{269}

Because insurers are by definition in the risk-acceptance and risk distribution business, liability insurers typically protect themselves in several ways. In addition to the product design protections detailed in Section IX, above, liability insurers diversify risks of all sorts, not merely asbestos, construction, or manufacturing risks. Insurers insured more than just asbestos-related businesses during the 1950s-1980s period and collected premiums from a variety of business, not merely those using distributing or using asbestos. Before one can accept the insurer proposition that it has unduly suffered because of asbestos coverage obligations under the CGL form (and pollution or other long-tail liabilities), one must look at the overall economic impact of the CGL and related policies. It appears that on the whole, the CGL has been a money-maker for insurers and that insurers as a whole have prospered during the time of the asbestos mass tort.\textsuperscript{270} Although asbestos stocks have not performed like Google, Microsoft, Intel, or Cisco Systems, neither have they been Enron,

\textsuperscript{268} See Vaughan & Vaughan, supra note 78, at 168; Edwin W. Patterson, Essentials of Insurance Law 62 (1955). See also George E. Rejda, Principles of Risk Management and Insurance 80 (4th ed. 1992) (aleatory contract “is one in which the values exchanged are not equal. Depending on chance, one party may receive a value out of proportion to the value that is given”; using example of homeowner paying $400 in premium but collecting $100,000 policy limits if home destroyed by fire) (italics in original).


\textsuperscript{270} See, e.g., Testimony of Wade Harrell (June 20, 1986) 144:20-21 (“I’ll also put in the record that over 50% of our policies are loss free.”) (testimony before Texas State Insurance Regulators seeking approval of new “claims-made” general liability policy) (Mr. Harrell was Vice President of Underwriting for Liberty Mutual).
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WorldCom, or Global Crossing. On the whole, insurers have done well by selling risk shifting to American businesses on a general liability basis.

Although selling CGL insurance to asbestos companies may prove in retrospect to be bad business for insurers, insurers undoubtedly had many liability policies during this time period that were profitable because of low claim incidence relative to premiums collected. In addition, insurers purchase reinsurance to cover their risks. Reinsurance is insurance purchased by an insurance company, in which a reinsurer essentially indemnifies or otherwise compensates an insurer for some or all claims payments above a certain amount. Thus, the insurer is protected to a large degree from surprisingly large or frequent CGL claims. Further, reinsurers are bound to "follow the fortunes" of the primary and excess insurers they reinsure and are bound by the judgments and settlements covered by the underlying policies. When primary and excess insurers have a bad loss experience, reinsurers must shoulder a good deal of the burden, which considerably softens the blow to front line insurers from the asbestos mass tort.

Where insurers have faced tough times, this has often been a creature of their own making and not the result of large tort awards or judicial decisions unduly favorable to policyholders. Instead, the insurance industry’s own cyclical underwriting and pricing behavior—alternatingly accepting problematic risks as bargain basement prices and refusing to write coverage or dramatically increasing premiums when investment conditions change—has produced the seesaw of soft and hard markets that both disrupts insurer income statements and frustrates policyholders and policymakers. At times, insurers appear to dramatically overreact to changes in market conditions or isolated adverse legal rulings.

271. See generally BARRY R. OSTRAGER & MARY KAY VYSKOCIL, REINSURANCE LAW AND PRACTICE Ch. 1, esp. § 1.02 (2d ed. 2000).


274. Sean M. Fitzpatrick, Fear is the Key: A Behavioral Guide to Underwriting Cycles, 10:2 CONN. INS. L.J. 255 (2004) (summarizing and reviewing traditional economic views of insurance and tendency of insurance pricing to be cyclical in response to interest rates and other factors; also contending that psychological factors such as fear and uncertainty by policyholders and insurers plays greater role than commonly acknowledged)
In addition, the insurance industry remains well known for paying relatively high sales commissions and maintaining a large separation between the sales, underwriting, and claims aspects of the operation. The result is that part of an insurer’s work force has an undue incentive to sell coverage to even shaky risks while another part of the organization has a strong incentive to be overly ungenerous in handling claims and providing defense as part of the company effort to profit and in reaction to inadequate pricing and overly aggressive sales of the initial policies.

Further, insurers tend to have high administrative expenses, which further erodes profit. Even where a carrier’s underwriting ratio is not bad, combined ratios are often poor because of the administrative expense of running an insurance company. As in other areas, insurers have improved in this regard since the advent of the asbestos mass tort, with greater use of computers and other technology and improved efforts to reduce disputing and transactions costs (which may of course be in part the unavoidable result of the U.S. judicial system). But these business operations remain primarily the domain of insurers and not the inevitable consequence of policyholder activities or the legal system.

To return briefly to a question raised by Professor Scales at this Symposium and the 2005 AALS Annual Meeting—that asbestos has been a “perfect storm” for disrupting insurance markets. At this juncture, it is not at all clear that the asbestos mega-tort is the cause of any significant, ongoing disruption of liability insurance markets. Instead, one might regard the asbestos problem as a “one-time only” event that despite its magnitude is largely confined to a particular type of product no longer in use. Despite its resemblance to the Energizer Bunny, the asbestos tort and related coverage issues will eventually pass. More long-standing problems for insurers and policyholders arguably include toxic torts generally, cyclical interest rates and investment results, natural disasters, terrorism, litigation inefficiencies and high transaction costs generally in policy administration and dispute resolution.

Further, as noted above, the asbestos situation arguably provided assistance to insurers in the long-run by prompting carriers to make structural changes in the policy form, underwriting, and pricing that perhaps should have been done long ago. The same appears true regarding

(Fitzpatrick is an executive with Chubb.); At Risk: A Survey of International Insurance, THE ECONOMIST, Sept. 25, 1982, at 4 (“Thus, in America last year, a whopping underwriting loss of $5 billion of property/casualty business was dwarfed by investment income of almost $10 billion”). In many asbestos matters, insurers have been able to profit for decades due to the float on policyholder premiums, a financial gain that surely salves the pain of having to for coverage years later.
other coverage pressures faced by insurers from pollution exposure, Hurricane Andrew, the Northridge Earthquake, September 11, and other large loss events that lack the elongated payout pattern of asbestos. One need not be a cynic to note that in the aftermath of large losses, policyholders are willing to pay more for insurance. Insurance executives themselves have made this observation. Distasteful as it may initially sound, disaster may be good for insurer profit margins in the long run.

Asbestos is primarily distinguished from other disasters and mass torts by its enduring (seemingly never-ending) quality. Large losses and capital shocks are always part of the risks presented to a general liability or all-risk property insurer. Asbestos is different in that it combines the “ordinary worst” of large losses with long-running repetition. Although this may make the asbestos coverage problem seem more oppressive than other problems facing insurers, a more sustained analysis suggests that the elongated time frame of the asbestos mass tort has favored insurers and made asbestos much less of a problem for insurers than more compressed losses such as the U.S. Hurricanes of 2004 and 2005. The long-running asbestos saga provided insurers with more breathing space and ability to profit from the float on premiums than was presented by the natural disasters and September 11. Further, as also discussed above, asbestos is a discreet, identifiable source of tort liability and a single substance that can be and has been specifically excluded.

Seen in this light, perhaps asbestos is no worse or even arguably better than other risks that turn out poorly for insurers (again, assuming that it is a “poor” outcome when insurers must pay large claims but then can more than recoup them charging higher premiums on policies with reduced coverage). What may present a greater risk to insurers is their own success in reaching out to new markets. Consider the impact if property insurance had been in abundance in late 2004 Indonesia, Sri Lanka, India, and East Africa or if Pakistan in 2005 were heavily insured. The financial impact to insurers from the 2004 Asian Tsunami or the 2005 Pakistan Earthquake would have made asbestos exposure look tame by comparison. Instead, insurers are largely, like the rest of us, only distant witnesses to these third world tragedies.

As a result of the asbestos experience, insurers are considerably wiser limiting their exposure to the unanticipated mass torts or natural disasters of the future. Paradoxically, the large asbestos liability payments of the past twenty-five years appears to be a bargain for insurers, providing the underwriting and policy drafting savvy to make insurance markets more stable in the future (albeit more expensive for policyholders).
CONCLUSION

The asbestos mass tort and attendant insurance coverage wars have inflicted substantial, sometimes grave, casualties on all sides. Although the seemingly perpetual nature of asbestos disputing continues to foreclose a final or definitive assessment, it appears that on balance, insurers have fared at least as well and probably better than other participants in this long-running drama. In terms of both legal doctrine and business economics, insurers appear to have weathered the asbestos storm just fine, perhaps considerably better than they have fared in relation to real storms and the catastrophic losses occasioned by natural disaster.