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Interpreting Insurance Policies

JEFFREY W. STEMPEL

Like any other contract, an insurance policy may become the subject of a legal dispute. When disputes arise over insurance coverage, lawyers must combine their skill in contract interpretation with their knowledge of insurance law, bringing both to bear on the special problems related to this type of contract. Each dispute has unique traits, but a few basic ground rules of contract law and insurance law can help you interpret insurance policies and resolve disputes over insurance coverage.

Applying the Basics: Contract Law

Virtually any court begins with the principle that insurance policies are contracts and subject to the ordinary rules of contract interpretation.¹ To deal with the occasional coverage dispute, you can go a long way simply by remembering and intelligently applying the standard rules of contract construction:

*The existence of an enforceable contract requires an offer, acceptance, and consideration.*² Don't overlook this principle, even if it seems obvious. It can be a defense for insurers in cases where the policyholder failed to pay a first premium (consideration) or let premiums lapse. Occasionally, detrimental reliance can provide the necessary consideration.³ Similarly, there must be evidence that the policyholder actually took out a policy and that the insurer actually issued a policy.⁴

*The courts will not enforce illegal contracts.*⁵ If an insurance policy does not conform to the requirements of the state insurance department, it may not be enforceable or may be construed against the insurer in close cases. Nor may insurance be obtained as a form of "wagering" or moral

hazard—the requirement behind the insurable interest doctrine, which requires the policyholder to have a concrete interest in the subject of the insurance.⁶ The insurable interest doctrine occasionally makes the news in cases of killings where the motive was to collect insurance proceeds. (Remember the old movie *Double Indemnity*?)

**Some nefarious
people have engaged
in murder for
insurance profits,
even when the policy
covers a relative**

However, some nefarious people have engaged in murder for insurance profits, even when the policy covers a relative or business partner.⁷

*The text of a contract (that is, the insurance policy) will ordinarily determine the meaning of the contract.*⁸ The courts are reluctant to interpret the meaning further unless the words are ambiguous or clearly contradicted by other evidence of the intended meaning.⁹

*The law attempts to enforce contracts to fulfill their intended purpose and the intent of the parties.*¹⁰ The contract is to be read as a whole, giving effect to all provisions if possible.¹¹

If a contract term is clear enough, a court may refuse to hear oral testimony or other extrinsic evidence intended to contradict the meaning of the

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contract's text.¹² This is the venerable parol evidence rule. It has lost some force over the years but still retains bite, especially if the contract itself purports to be an integrated and complete agreement that excludes parol evidence. However, if contract text is ambiguous, courts permit oral testimony and other extrinsic evidence to interpret, explain, or amplify a term.¹³ Even if the term is not particularly vague or ambiguous, some courts will receive extrinsic evidence to further explain or refine it, so long as the extrinsic matter does not contradict the text.¹⁴

*Contracts of adhesion are enforceable but may offer the adhering party protections unavailable with a contract custom-made for both parties.*¹⁵ Contracts of adhesion (which include many insurance contracts) are contracts offered on a take-it-or-leave-it basis; the other party must adhere to the offered contract if there is to be a deal. Unless

**Contracts of adhesion
are offered on a
take-it-or-leave-it
basis: Adhere
to the contract
or no deal**

the text of an adhesion contract is very clear, the adhering party may be protected by other contract ground rules and judges' wariness of unfair enforcement.

Even if the contract is custom-made, the rule of contra proferentem applies. According to this rule, ambiguities are construed against the author of the contract. In other words, any unclear word or phrase is interpreted to the detriment of the drafter unless the uncertainty is readily resolvable by a more reliable basis than the *contra proferentem* rule.¹⁶

*Contracts procured through fraud or deceit are unenforceable or may be rescinded or (in rarer cases) modified to prevent unfairness.*¹⁷ This principle of contract law works both ways in insurance disputes. Insurers cannot expect premiums for policies sold through high-pressure tactics and cannot avoid their obligations by fraudulently obtaining agreement to exclusions. Conversely, policyholders cannot obtain coverage by using misrepresentations to procure the policy or by making a fraudulent claim.¹⁸ In many cases, if a

policyholder grossly inflates an otherwise legitimate claim, he or she can lose all coverage.¹⁹

*Contract terms that violate applicable public policy are unenforceable.*²⁰ Therefore, even if the text of an insurance policy is clear, coverage will not be provided if doing so would offend public policy or undermine the way in which insurance operates.²¹ Perhaps the leading example concerns whether policyholders may receive indemnity for punitive damages they have been ordered to pay.²² The states are split,²³ with some holding that insuring punitive damages encourages or subsidizes wrongful conduct,²⁴ while others see punitive damages as simply another form of liability occasionally faced by defendants.²⁵ Some states permit indemnity for punitive damages that result from vicarious liability or recklessness or gross negligence but not for punitive damages arising from intentional conduct.²⁶

Insurance Policies vs. Other Contracts

Because the basic principles of contracts are relevant to insurance policies in so many ways, courts often state that insurance policies are "just like any other contract" for purposes of adjudicating disputes. Despite the frequency of such statements, they are not entirely true.

Contracting. To begin with, insurance policies are usually made differently than other contracts.²⁷ Most contracts occur at the point of transaction: phoning a broker and arranging to sell wheat; buying a sweater at the clothing store; ordering books by mail; discussing and accepting a job offer. In these situations, the contract may not be written or detailed, but it is final and agreed to by the parties in unison. By contrast, most insurance involves discussion and application, with the insurer processing the application through its underwriting department and making the decision to contract weeks or months later. Thus, the contract is usually "formed" only when the insurer says so.

An important variant to this scenario involves the sale of life insurance. Applicants for life insurance are typically given a "conditional receipt" that establishes coverage as of the date of the application, provided certain conditions are met or the policy is eventually issued. The terms of conditional receipts vary, and the courts have differed considerably in their enforcement for or against the insurers that use them. If an applicant for life insurance pays the first premium, obtains a conditional receipt, and dies before a policy is issued, predicting the outcome of the litigation is complex and depends on a variety of factors peculiar to this corner of insurance law.²⁸

Property insurers often issue "binders" establishing temporary coverage until they issue a full policy. The binder typically comes closer to a pure commitment of temporary insurance than does a conditional receipt, because the local agent can inspect the property in question. Evaluating a life

or health insurance risk generally requires medical tests, and the underwriting generally occurs in the insurer's home office.

Adhesion. When an insurance policy is issued and delivered, the policyholder may never have seen (let alone read) it. Even for those who read every word, a policy is for most consumers and small businesses a standardized form contract of adhesion.²⁹ This general contracting scenario usually makes courts hesitant to enforce insurance policy terms that may be unfair or surprising as applied to the consumer policyholder. In contrast, if the policyholder insisted on and obtained customized language or is a commercially sophisticated entity, courts are less apt to base decisions on the nature of insurance contracting and standardized forms and more likely to use the principles they apply to standard contract controversies. However, the sophistication of both parties may be relevant to applying the "reasonable expectations" doctrine discussed below.³⁰

Ambiguity. Because insurance policies are standardized, the *contra proferentem* doctrine is sometimes referred to as the "contra insurer" doctrine. However, insurance companies do not always lose linguistic battles. On the contrary, they win at least their fair share because they are professionals with vast experience in using (or at least trying to use) "airtight" language that will define covered claims firmly, if not always clearly.

In determining whether a term is ambiguous, courts usually give words their ordinary rather than technical meaning unless the parties' prior course of dealing or custom in the industry calls for application of a technical term.³¹ Dictionary definitions are not determinative unless they square with common usage. As one court remarked, "By their very nature, dictionaries define words in the abstract [rather than] in the context of a specific insurance policy."³²

In addition, courts will not invoke the ambiguity doctrine in order to provide coverage in bizarre situations obviously outside the intent or expectations of the parties or where the coverage sought would undermine the effective operation of the insurance markets or otherwise run afoul of public policy.³³ For example, a court would not permit an arsonist to recover under a homeowner's policy even if the insurer had omitted an exclusion for arson or other intentional destruction of the property.³⁴

Overall, then, courts approach disputes over insurance coverage as a subset of contract jurisprudence, but they are sensitive to the special nature of the insurance-contracting regime. Therefore, they give greater than average weight to contract doctrines wary of adhesion contracts and favorable to *contra proferentem* construction. In particular, states tend to be of three types regarding their enthusiasm for the *contra proferentem* doctrine. Some states seize upon virtually any uncertainty to construe the policy in favor of the policyholder.³⁵ At the other extreme are states

that invoke the ambiguity principle only as a last resort or even occasionally disavow the doctrine as too crude a tool for carving meaning from insurance policies.³⁶ The plurality of states take a middle ground, using ambiguity analysis as a tiebreaker when extrinsic evidence of meaning, party intent, functional analysis of the transaction, or other indicia have failed to determine coverage clearly.³⁷

Traditionally, the policyholder bears the burden to show that a loss falls within the agreement

Assigning and Shifting Burdens of Proof. The burden of proof in coverage disputes can vary according to the policy provision at issue, although courts themselves seem to vary according to how closely they observe these axioms. According to the traditional ground rule, the policyholder bears the burden to show that a particular loss falls within the terms of the insuring agreement.³⁸ Normally, this is relatively easy, because modern insurance policies are broadly written. After the insuring agreement in most policies come a set of conditions that the policyholder must fulfill to obtain coverage. Some are the so-called "conditions precedent" that must generally be fulfilled before the insurer has any obligation to defend or indemnify.³⁹ Conditions subsequent are events which, should they occur, terminate a contract obligation.⁴⁰

Also included in policies are lists of exclusions—items or events excluded from the broad coverage of the insuring agreement. If the policyholder has shown that a claim falls generally within the policy, the insurer has the burden of proof to demonstrate that the exclusion applies.⁴¹ Sometimes qualifications or exceptions are embedded into exclusions. If so, the burden to show whether the exception negates the exclusion may be assigned in various ways. Most states assign this burden to the insurer as part of its responsibility to demonstrate the applicability of an exclusion if it is to avoid coverage.⁴²

In a nutshell, the policyholder bears the burden to prove the applicability of a coverage clause, and

the insurer has the burden to prove the germaneness of an exclusionary clause, regardless of the labels attached in the policy.⁴³

Burden shifting can be important in close cases, but it seldom is determinative: Courts see a claim as either subject to an exclusion or outside it, no matter how the burden of proof has been assigned. Consequently, if you are arguing for cov-

**If you are
arguing for
coverage, do not
depend on the
assignment of
the burden**

erage, do not depend much on the assignment of the burden.

Notice. Burden shifting may have an impact regarding particular aspects of an insurance dispute, however. For example, insurance policies require the policyholder to provide timely notice of a claim to the insurer so that it may respond through investigation, defense, third-party claims, or other appropriate means. The insurer can defeat coverage if notice is late.⁴⁴

However, to prevail on this defense in the majority of states, the insurer must not only show that notice was late but also that it was prejudiced by the tardiness.⁴⁵ Unless the insurer can show that a key witness died, a key document was lost, property in controversy was irrevocably altered, or something similar occurred during the delay, this will be a virtually impossible burden.⁴⁶ Hence, assignment of the burden to prove prejudice often is determinative. A few states place the burden on the policyholder to prove lack of prejudice.⁴⁷ But in about a dozen states (including New York), the insurer need only prove lateness.⁴⁸

Seeking Reasonableness

Courts are also affected by a desire to make the insurance relationship work as it should. In theory at least, this notion is even-handed. (Policyholders should not pay premiums in vain, and insurers should not be fleeced by slippery policyholders.) In practice, the desire to give effect to a policy sometimes merges with ambiguity analysis to favor policy construction that finds or enhances coverage. For example, some courts state that when two

equally plausible interpretations of a disputed provision exist, the interpretation permitting greater indemnity will prevail.⁴⁹ Policyholders should get the coverage to which a reasonable person would be entitled under the circumstances, while insurers should not pay for losses outside the reasonably intended scope of the policy.

Courts construed policies this way for years before the tendency was formally named (by Robert Keeton in his famous law review article⁵⁰) the "reasonable expectations" doctrine. Under the classic Keeton formula, a loss will be covered where coverage is consistent with the policyholder's objectively reasonable expectations, even if a painstaking study of the insurance policy would negate those expectations. In other words, insurance companies may obtain the benefit of the policy's fine-print boilerplate but only if those coverage terms and limits are reasonable.

Although the reasonable expectations doctrine has been officially embraced in only about half the states and has been expressly rejected or criticized in about a dozen,⁵¹ this type of analysis often silently affects coverage disputes. Courts interpreting policy language, assigning persuasion burdens, dealing with adhesion and ambiguity, and assessing the fairness of a contract term are often influenced by whether a given result is more consistent with the objectively reasonable expectations of the litigants.⁵²

The key words are "objectively reasonable." Subjective, idiosyncratic, and bizarre expectations will not provide coverage. For example, an automobile policyholder who knowingly uses a car to carry and detonate a terrorist bomb will have a hard time collecting comprehensive coverage for the loss of the car after the bomb detonates.

This doctrine recognizes that expectations can vary between policyholder and insurer. Just as in general contract law a unilateral mistake will not make a contract voidable (although a mutual mistake will), the court will not nullify a policy where views differ. Rather, it must decide which party's expectation is more reasonable. These cases are often difficult and unpredictable. On one hand, the insurer is an expert entity regarding risk distribution and actuarial figures. The insurer can be expected to cover things that can be profitably covered and avoid promising to cover things that will lead to insolvency (e.g., nuclear war). On the other hand, the insurer may not have made the policy's limitations clear, may miscalculate, or may attempt to take advantage of a particular policyholder or class of policyholders to improve its bottom line or salve a bad underwriting year. In these cases, courts must exercise sound judgment to render a decision that makes the policy do what it was intended to do even if the parties now dispute that intent. In these instances, courts occasionally find or exclude coverage even if the most natural reading of the text of the policy is to the contrary.

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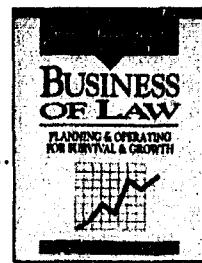
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Special Aspects of Third-Party Claims

Insurance disputes in first-party cases tend to be relatively straightforward; the battle lines are drawn with reasonable clarity. For example, the policyholder—a homeowner—wants to obtain coverage for damage caused by a botched fuel oil delivery, and the insurer resists, citing a policy provision that excludes pollution coverage. In contrast, third-party liability insurance raises additional issues. The insurer may be obligated to represent the policyholder, and the lawyer selected must be sensitive to possible conflicts of interest between the insurer and the policyholder.

The general rule, usually stated in the policy, is that the liability insurer selects and provides counsel of its choice. However, if the insurer's position conflicts with that of the policyholder, the policyholder may be able to insist on obtaining a lawyer of his or her choice. In addition, the policyholder may be able to override the policy provisions in some instances or may successfully object to the insurer's lawyer on grounds that the person lacks qualifications. Thus, an insurer who assigns a newly minted (but cheap) law school graduate to defend a commercial policyholder in a multistate pollution matter may have opened the door to judicial limitation on the insurer's right to select counsel.

Duty to Defend. All of these possible problems (which lie beyond the scope of this Law Note) arise because the third-party liability policy creates a duty to defend.⁵³ In other words, the policy is for litigation insurance as well as loss insurance. To determine whether the duty to defend has been triggered, courts look at the face of the complaint or, in certain circumstances, the demand letter or other evidence of a serious claim against the policyholder.

For purposes of determining the duty to defend, the allegations are assumed to be true, even if the insurer has evidence to the contrary. If the stated claim comes within the scope of policy coverage, the insurer must provide a defense.⁵⁴ If the insurer can demonstrate the inaccuracy of the allegations, it ordinarily should commence a declaratory judgment action seeking a judicial determination that it need not defend the claim.

In many states, the penalty for breaching the duty to defend is that the insurer must pick up the tab (even if it exceeds the policy limits) for whatever resolution of the matter ultimately occurs, even if the insurer could have shown that the claim was not properly subject to indemnity or that the amount of the settlement or judgment was excessive.⁵⁵ The rules in other states are less severe but nonetheless punishing to insurers that fail to defend.

The duty to indemnify is narrower than the duty to defend⁵⁶ and takes hold only if the claim actually succeeds and falls within the policy. For example, an insurer may need to defend a bogus claim of assault and battery when the policyhold-

er was the one assaulted and merely fended off the claimant. Similarly, a claim mixing negligence ("he carelessly knocked me over") with assault ("he purposely knocked me down") must be defended.⁵⁷ But the insurer will not need to indemnify if the claimant recovers only on the assault theory and the policy excluded coverages for intentional acts or conduct expected or intended from the standpoint of the policyholder.

Duty to Settle. Related to the duty to defend is the duty to settle. Suppose the holder of liability insurance faces a large pending claim that the insurer can settle within the policy limits for an amount that is reasonable in relation to the claim. Most courts will imply a duty to settle.⁵⁸ Failure to settle can constitute a bad-faith breach of the insurance policy, which can subject the insurer to damages. Some states treat bad-faith breach of the settlement or payment duty as a breach of

Some states treat bad-faith breach of settlement or payment duty as a breach of contract

contract.⁵⁹ The majority treat it as an independent tort; a policyholder who can demonstrate such a breach is entitled to sue the insurer for punitive damages.⁶⁰

Traps for the Unwary

Some issues recur in cases related to insurance coverage. You can prevent or resolve many problems by considering these issues when you review insurance policies.

Intentional Acts. Most insurance policies state that they do not cover intentionally created losses or specific losses clearly and concretely expected by the policyholder. Even if such language were lacking, many courts would imply this limitation, because insurance depends on fortuity. A policy that paid the policyholder for intentional misconduct, reckless behavior, or completely predictable expenses would undermine the random pooling of fortuitous risk that is necessary for an insurance system.

Courts vary in terms of the degree of intent they require to invoke the exclusion. Some courts

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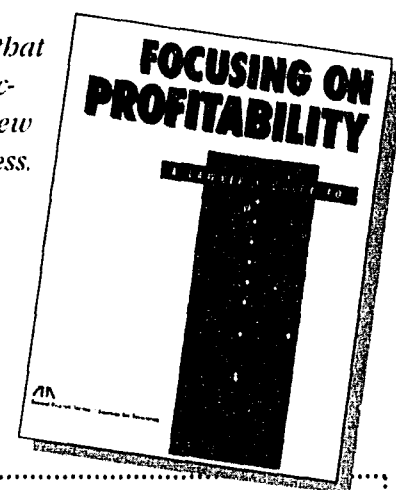
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take the pro-policyholder stance that only a specific intent to cause the specific loss in question negates coverage.⁶¹ A smaller number of courts at the opposite extreme maintain that coverage is voided by a generalized expectation of the possibility of the loss or some degree of foreseeability.⁶² The majority of courts take a middle view: Some policyholder knowledge of the possibility of loss does not void coverage, but knowledge of a sufficient probability of harm from conduct invokes the intentional-act exclusion.⁶³ For example, a

**A manufacturer
knowing its product
may pose a danger
may fall under
the intentional-act
exclusion**

manufacturer expects it will occasionally be sued for product liability by at least some disgruntled customers. This should not be a problem under the "expected or intended" exclusion. However, if a manufacturer knows that its product poses a particular danger, yet markets it without warning, its behavior may invoke the intentional-act exclusion.

Trigger of Coverage. Normally, determining when a policy is triggered is easy. For claims-made policies, the trigger is the making of a covered claim. For policies that cover an "occurrence," the trigger is the happening of a covered event. Most events take place at a set point in time. An auto accident occurs when the cars collide. A product liability claim occurs when the product malfunctions, causing injury. A trespass claim occurs when the property line is breached.

However, for long-latency, more subtle, less visible and verifiable losses such as asbestos-related injury, groundwater pollution, or insidious disease, the time of the event is not discrete and clear. Courts facing such claims have deemed policies to be triggered by exposure to offending matter,⁶⁴ manifestation of adverse symptoms,⁶⁵ actual injury-in-fact,⁶⁶ and combinations of these, including the so-called "continuous trigger"⁶⁷ that some courts use for deciding asbestos and product liability claims.

Allocation of Responsibilities Among Multiple Insurers. If the trigger of coverage is continuous or based on injury or exposure taking place over several years, the situation may implicate several dif-

ferent policies and insurers. In these cases, courts often apportion coverage liability among insurers. The most popular means of doing so are proration by policy limits,⁶⁸ proration by time on the risk,⁶⁹ proration by party,⁷⁰ and attempted proration by degree of injury occurring in each policy period⁷¹ (despite the obvious proof problems with this approach).⁷²

An alternative approach is to allow the policyholder to allocate covered losses among the applicable carriers.⁷³ This approach is often referred to as joint-and-several liability of insurers. The policyholder using it is more likely to maximize coverage by linking losses with maximum available insurance, but joint-and-several liability also lowers the transaction costs of litigating and determining apportioned injury.

The proration approaches are simple to apply and give the policyholder less license to pick and choose. They may be inequitable, however, as some policies and policy years may have only a tangential link to the losses and may have been written under different assumptions than the court is using.

Complexities Abound

Issues related to insurance coverage can be complex, particularly when the dispute involves several entities and years of coverage or large numbers of claimants with long-latency injuries. However, by applying the right mix of insurance law, contract doctrine, and a dose of common sense, you can successfully resolve most of these disputes.

NOTES

1. See *Red Panther Chem. Co. v. Insurance Co. of Pa.*, 43 F.3d 514, 517 (10th Cir. 1994) (applying Mississippi law); *Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467 (Ind. 1985), cert. denied, 479 U.S. 1060 (1987); *Standard Venetian Blind Co. v. American Empire Ins. Co.*, 503 Pa. 300, 469 A.2d 563 (1983).

2. E. Allan Farnsworth, *Contracts*, Chs. 2, 3 (2d ed. 1990).

3. See *Restatement (Second) of Contracts* § 90 (1981); Jeffrey W. Stempel, *Interpretation of Insurance Contracts: Law and Strategy for Insurers and Policyholders* §§ 6.6-6.9 (1994).

4. This seemingly simple aspect of an insurance controversy can become problematic if the policyholder does not keep good records long enough. Although the insurer's files are subject to discovery, they occasionally do not contain the relevant policies. In a well-known case concerning asbestos coverage (*Insurance Co. of N. Am. v. Forty-Eight Insulations*, 633 F.2d 1212 (6th Cir. 1980) (applying Illinois and New Jersey law)), the manufacturer suggested that it might have had coverage for some of the years at issue but could not locate policies to prove coverage. In the absence of policies or evidence sufficient to establish the existence and content of policies, the court found the manufacturer uninsured for those years. Consequently, the manufacturer's responsibility for the losses was prorated with that of the insurers over the three decades during which the policyholder's product allegedly caused damage by an "occurrence."

5. See Farnsworth, *supra* note 2, Ch. 5.

6. See Stempel, *supra* note 3, § 1.4.

7. See, e.g., *New England Mut. Life Ins. Co. v. Null*,

605 F.2d 421 (8th Cir. 1979) (applying Missouri law where a grossly inflated life insurance policy was purchased on a business associate who was killed); *Rubenstein v. Mutual Life Ins. Co. of N.Y.*, 584 F. Supp. 272 (E.D. La. 1984) (applying Louisiana law where a grossly inflated life insurance policy was purchased on a low-level employee who was killed).

8. See *National Fidelity Life Ins. Co. v. Karaganis*, 811 F.2d 357 (7th Cir. 1987) (applying Illinois law); *IBM Poughkeepsie Employees Fed. Credit Union v. Cumis Ins. Co. Inc.*, 590 F. Supp. 769 (S.D.N.Y. 1984) (New York law); Stempel, *supra* note 3, § 3.4.

9. See Farnsworth, *supra* note 2, § 7.11.

10. See *id.* §§ 7.8-7.14.

11. See *Red Panther Chem. Co.*, 43 F.3d at 517.

12. See *Gianni v. R. Russel & Co.*, 281 Pa. 320, 126 A. 791 (1924); Farnsworth, *supra* note 2, § 7.2.

13. See, e.g., *Employers Casualty Co. v. Northwestern Nat'l Ins. Group*, 109 Cal. App. 3d 462, 471, 167 Cal. Rptr. 296 (1980).

14. See, e.g., *Berg v. Hudesman*, 115 Wash. 2d 657, 801 P.2d 222 (1990).

15. See Stempel, *supra* note 3, § 3.5.

16. See Farnsworth, *supra* note 2, § 7.11; Stempel, *supra* note 3, §§ 5.1-5.9.

17. See *Foremost Guar. Corp. v. Meritor Sav. Bank*, 910 F.2d 118, 123 (4th Cir. 1990) (applying North Carolina and Virginia law); Stempel, *supra* note 3, Ch. 4. Contracts may ordinarily be rescinded on grounds of mistake, impossibility, commercial impracticability, and frustration of purpose as well as fraud. These contract doctrines apply to insurance but rarely become the subject of controversy. More commonly, insurance litigation focuses on insurer efforts to avoid coverage on the basis of specific recision grounds set forth in the policy, such as nonpayment of premiums, failure to cooperate, failure to give notice, concealment, or fraud and misrepresentation.

18. See *Putnam Resources v. Pateman*, 958 F.2d 448 (1st Cir. 1992) (applying Rhode Island law); Stempel, *supra* note 3, §§ 14.1-14.3.

19. See, e.g., *Lykos v. American Home Ins. Co.*, 609 F.2d 314 (7th Cir. 1979), *cert. denied*, 444 U.S. 1079 (1980) (applying Illinois law); Stempel, *supra* note 3, § 31.7.

20. See Farnsworth, *supra* note 2, §§ 4.1-5.9; Stempel, *supra* note 3, Ch. 7.

21. See *L'Orange v. Medical Protective Co.*, 394 F.2d 57, 60 (6th Cir. 1968) (applying Ohio law and finding "the violation of public policy is measured by the tendency of the contract to injure the public good rather than by actual injury under the particular circumstances").

22. See Stempel, *supra* note 3, § 7.3.

23. See Robert G. Schloerb et al., *Punitive Damages: A Guide to the Insurability of Punitive Damages in the United States and Its Territories* 38-41 (1988).

24. See, e.g., *St. Paul Ins. Co. v. Talladega Nursing Home, Inc.*, 606 F.2d 631 (5th Cir. 1979) (applying Alabama law).

25. See, e.g., *Lazenby v. Universal Underwriters Ins. Co.*, 214 Tenn. 639, 383 S.W.2d 1 (1964).

26. See Stempel, *supra* note 3, § 7.3.

27. See *id.*, Ch. 2 (Contract Formation).

28. See *id.* § 2.5.

29. See *id.* § 3.5.

30. On the sophisticated policyholder defense and the impact of policyholder identity on coverage questions, see *id.*, Ch. 24.

31. See, e.g., *Farm & City Ins. Co. v. Potter*, 330 N.W.2d 263, 265 (Iowa 1983).

32. *New Castle Co. v. Hartford Accident & Indem. Co.*, 933 F.2d 1162, 1193 (applying Delaware law).

33. See, e.g., *Eastern Assoc. Coal Corp. v. Aetna Casualty & Sur. Co.*, 632 F.2d 1068, 1075 (3d Cir. 1980) (applying Pennsylvania law and holding court should not "torture" the policy language to find an ambiguity);

Connick v. Teachers Ins. & Annuity Ass'n, 784 F.2d 1018 (9th Cir.), *cert. denied*, 479 U.S. 822 (1986) (California law). See Stempel, *supra* note 3, Ch. 5.

34. This is because the insurance system will not work unless losses are "fortuitous"—that is, by chance rather than expected, intended, or planned by policyholders seeking to fob off their problems on society at large through the process of risk spreading through insurance. See Stempel, *supra* note 3, § 1.5.

35. See, e.g., *A.Y. McDonald Ind. v. Insurance Co. of N. Am.*, 842 F. Supp. 1166, 1170 (N.D. Ia. 1993) (applying Iowa law and holding, "Because insurance policies are in the nature of adhesive contracts, we construe their provisions in a light favorable to the insured").

36. See, e.g., *American Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 565 F. Supp. 1485 (S.D.N.Y. 1983), *modified on other grounds*, 748 F.2d 760 (2d Cir. 1984); *Darnier Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 140 Ariz. 383, 682 P.2d 388 (1984); *Continental Ins. Co. v. Paccar, Inc.*, 96 Wash. 2d 160, 634 P.2d 291 (1981).

37. See, e.g., *Harbor Ins. Co. v. Continental Bank Corp.*, 922 F.2d 357, 366 (7th Cir. 1990) (applying Illinois law and holding, "If an insurance contract is ambiguous either party should be allowed to introduce evidence to disambiguate it. But if, all such evidence having been considered, the meaning of the contract is still uncertain, then the insured wins. In other words, the interpretative principle (favor the insured) is merely a tie-breaker").

38. See George Couch, *Couch on Insurance* 2d § 79:315 at 255 (Rhodes rev. ed. 1983).

39. See Farnsworth, *supra* note 2, at §§ 8.2, 8.3.

40. *Id.* at § 8.2. Because of the historical confusion attending the terms, the *Restatement (Second)* refers simply to "conditions" to describe conditions precedent. *Id.* at 569.

41. See, e.g., *Kalell v. Mutual Fire & Auto Ins. Co.*, 471 N.W.2d 865, 867 (Iowa 1991).

42. See, e.g., *New Castle Co. v. Hartford Accident & Indem. Co.*, 933 F.2d 1162, 1181-82 (3d Cir. 1991) (applying Delaware law); *Brammer v. Allied Mut. Ins. Co.*, 182 N.W.2d 169, 174 (Iowa 1970). But see *Northern Ins. Co. v. Aardvark Assocs., Inc.*, 942 F.2d 189, 195 (3d Cir. 1991) (applying Pennsylvania law and placing burden on policyholder to show that its pollution—an exclusion—was not subject to the exclusion because it was "sudden and accidental"—an exception).

43. See *New Castle Co. v. Hartford Accident and Indem. Co.*, 933 F.2d at 1181; *U.S. Fidelity & Guar. Co. v. Morrison Grain Co.*, 734 F. Supp. 437, 443 (D. Kan. 1990) (applying Kansas law).

44. See generally Stempel, *supra* note 3, § 31.3.

45. See *id.* § 31.4. See, e.g., *Weaver Bros., Inc. v. Chappel*, 684 P.2d 123 (Alaska 1984) (late notice six years after loss no bar to coverage because insurer could not demonstrate prejudice).

46. See, e.g., *Cooper v. Government Ins. Co.*, 51 N.J. 86, 237 A.2d 870 (1968) (insurer must show appreciable prejudice to prevail on late notice defense).

47. See, e.g., *Jennings v. Horace Mann Mut. Ins. Co.*, 549 F.2d 1364, 1367-68 (10th Cir. 1977) (applying Colorado law); *Gerrard Realty Corp. v. American States Ins. Co.*, 89 Wis. 2d 130, 277 N.W.2d 863 (1979).

48. See *Unigard Sec. Ins. Co., Inc. v. North River Ins. Co.*, 79 N.Y.2d 576, 594 N.E.2d 571, 584 N.Y.S.2d 290 (1992) (primary insurer need only show late notice to avoid coverage, but reinsurer must show prejudice when complaining about primary insurer's allegedly late notice).

49. See, e.g., *Jefferson-Pilot Fire & Cas. Co. v. Boothe, Prichard & Dudley*, 638 F.2d 670 (4th Cir. 1980) (applying Virginia law); *Ayres v. Harleysville Mut. Cas. Co.*, 172 Va. 383, 2 S.E.2d 303 (1939).

50. Robert E. Keeton, "Insurance Law Rights at Variance with Policy Provisions," 83 Harv. L. Rev. 961 (Part I) (1970) and 83 Harv. L. Rev. 1281 (Part II) (1970).

51. See Stempel, *supra* note 3, § 11.1; Barry R.

Ostrager & Thomas R. Newman, *Handbook of Insurance Coverage Disputes* § 1.03 (7th ed. 1994).

52. See, e.g., *Keene Corp. v. Aetna Casualty & Sur. Co.*, 667 F.2d 1034 (D.C. Cir. 1981), cert. denied, 455 U.S. 1007 (1982) (applying reasonable expectations approach where policyholder was large commercial entity to question of when asbestos injury "occurs" within the meaning of the policy); *Insurance Co. of N. Am. v. John J. Bordlee Constr.*, 543 F. Supp. 597, 602 (E.D. La. 1982) (reasonable expectations "apt when the insured is an innocent and naive party unfamiliar with the insurance field").

53. See Stempel, *supra* note 3, § 31.10.

54. See, e.g., *First S. Ins. Co. v. Jim Lynch Enter., Inc.*, 932 F.2d 717 (8th Cir. 1991) (applying Missouri law).

55. See, e.g., *Beckwith Mach. Co. v. Travelers Indem. Co.*, 638 F. Supp. 1179 (W.D. Pa. 1986), appeal dismissed, 815 F.2d 286 (3d Cir. 1987) (applying Pennsylvania law).

56. See *John Deere Ins. v. Shamrock Ind.*, 929 F.2d 413, 417 (8th Cir. 1991) (applying Minnesota law).

57. See, e.g., *Perkins v. Hartford Ins. Group*, 932 F.2d 1392, 1395 (11th Cir. 1991) (applying Alabama law). See Stempel, *supra* note 3, § 11.10.2.

58. See Stempel, *supra* note 3, § 31.11.

59. See, e.g., *Beck v. Farmer's Ins. Exch.*, 701 P.2d 795 (Utah 1985).

60. See, e.g., *Eureka Fed. Sav. & Loan Ass'n v. American Casualty Co.*, 873 F.2d 229 (9th Cir. 1989) (applying California law). Other states permit an award of punitive damages only if the tort of bad-faith breach is accompanied by an independent tort (e.g., fraud) that would itself support an award of punitive damages. See, e.g., *Lissman v. Hartford Fire Ins. Co.*, 848 F.2d 50, (4th Cir. 1988) (applying Virginia law). See generally Stempel, *supra* note 3, Ch. 19.

61. See, e.g., *Talley v. MFA Mut. Ins. Co.*, 273 Ark. 269, 620 S.W.2d 260 (1981). See Stempel, *supra* note 3, § 24.2.4.

62. See, e.g., *Farmers Ins. Co. v. Vagnozzi*, 138 Ariz.

443, 675 P.2d 703 (1983). See Stempel, *supra* note 3, § 24.2.1.

63. See, e.g., *Pachucki v. Republic Ins. Co.*, 89 Wis. 2d 703, 278 N.W.2d 898 (1979). See Stempel, *supra* note 3, § 24.2.2.

64. See, e.g., *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980) (applying Illinois and New Jersey law).

65. See, e.g., *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12 (1st Cir. 1982), cert. denied, 460 U.S. 1028 (1983) (applying Illinois and Ohio law). This is the same Illinois law that led to use of the exposure trigger in the 6th Circuit decision cited in the previous note. Ultimately, the real Illinois courts adopted a double trigger, ruling that either exposure or manifestation invoked the policy. See *Zurich Ins. Co. v. Raymark Indus.*, 118 Ill. 2d 23, 514 N.E.2d 150 (1987).

66. See, e.g., *American Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 748 F.2d 760 (2d Cir. 1984) (applying New York law).

67. See, e.g., *Keene Corp. v. Aetna Cas. & Sur. Co.*, 667 F.2d 1034 (D.C. Cir. 1981) (applying essentially generic or universal law).

68. See, e.g., *National Indem. Co. v. St. Paul Ins. Cos.*, 150 Ariz. 458, 724 P.2d 544 (1985).

69. See, e.g., *Northern States Power Co. v. Fidelity & Cas. Co.*, 517 N.W.2d 918 (Minn. 1984).

70. See, e.g., *Pacific Indem. Co. v. Linn*, 766 F.2d 754 (3d Cir. 1985) (applying Pennsylvania law).

71. See, e.g., *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1388 (E.D.N.Y. 1988) (applying New York law).

72. See, e.g., *Owens-Illinois Mfg. Co. v. Aetna Cas. & Sur. Co.*, 138 N.J. 437, 650 A.2d 974 (N.J. 1994) (embracing proration by limits as a basic guide but insisting that trial court on remand appoint a master and attempt to allocate losses among carriers according to actual injury determinable by modeling if particularized proof unavailable).

73. See, e.g., *Keene Corp.*, 667 F.2d 1034.

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