EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT COMMERCIAL GENERAL LIABILITY INSURANCE COVERAGE BUT WERE AFRAID TO ASK

*By Richard A. Fogel**

I. INSURANCE GENERALLY

When you stop and think about it, outside of matrimonial law or estate practice virtually any other type of civil litigation revolves around insurance. Moreover, most types of corporate "deals" also involve insurance. Commercial insurance is the key to commerce, as it is the most important tool in managing the day-to-day risks of running a business. Notwithstanding its significance, most attorneys - be they litigators or corporate lawyers - lack even a fundamental understanding of insurance coverage law. Many make common assumptions that aren't correct. Even experienced personal injury litigators are often caught in the trap of just assuming the "carrier" will resolve the dispute without ever considering whether there is coverage for the dispute in the first place. Many businesses take insurance for granted and are deeply shocked when their commercial dispute is not covered by insurance.

This program is intended for people who are not coverage experts but who would gain from increased knowledge about coverage. The aim is that you will leave this course with a basic understanding of what is in an insurance contract, what the common issues are, how to read an insurance contract and how to find the answers to particular coverage questions. It is not intended to be an advanced course on any particular insurance topic. Indeed the outline is very broad and if I were to go into depth on any of these issues, this could easily become a year long course. However, you should leave this seminar with a much better understanding of the things to watch out for in coverage and how to better advise your clients on their insurance needs and their risks.

A. Five Minute History Lesson

It is useful to spend a few minutes discussing the history of insurance and how it evolved because it helps explain modern day concepts that are often debated by the parties. Like our common law and statutory law, the credit goes to Great Britain for generating what we now know as insurance and the basic concepts of insurance.

It's easy to forget today that a hundred years ago, if you were engaged in commerce, the way you transported your goods was by ship. Decent roads weren't available in most parts of the world and thus it's no accident that the great commercial centers of the world even today to a large extent are located on the waterways and near deep harbors. If you were a shipping magnate one hundred years ago, the biggest risk

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that you faced was the risk of the loss of your ship. You knew by experience that the more nautical miles you traveled and the more ships you possessed, the odds and the risks increased that sooner or later you were going to lose one of these ships, even if you hired the best captains and had the best seamen and the best maintained ships. Ships were regularly lost due to the elements, groundings, pirates, wars and sometimes just due to the old age of the ships.

Like any good businessman today, the ship owners realized that they needed to set aside a portion of their profits for capital expenditures to replace their ships and that the more shipping they did, the more they had to set aside. Obviously this put a big burden on the smaller companies in particular, because if you only owned one or two ships and you lost what you had, you were losing either 50% or 100% of your revenue until you were able to get a new ship back in business. Even when you got your ship back, it might take many months if not years to actually make a profit from that ship because you only made a profit when it came back and you were able to sell the goods. In the meantime, you had to advance quite a bit of money.

You are probably already aware that most modern civil laws evolved because of the necessities of conducting commerce. It should not surprise you that most modern day financing also originated because of the necessities of conducting commerce by ships and financing voyages. It is therefore natural to understand how clever businessmen eventually understood that if they could somehow spread the risk of loss of their ships, then they could conserve their very precious capital. A group of shipowners could get together and contribute to a common capital fund. The result would be that while more claims would be made against that fund in any given year because there were more ships, there would also be a lot more money, so the owners could smooth out the expected losses and contributions to capital to replace their ships. The amount of money each owner contributed to the fund would be based upon the number of ships or the number of nautical miles traveled, or possibly where the ships traveled (whether they went to continental destinations or to the New World), etc. Eventually the owners realized, based upon experience, that they could predict what their likely claims would be in the future.

This arrangement evolved into what we now call a mutual insurance company; that is, an insurance company owned by the insureds, each of whom contributes a premium. In a mutual insurance company, if the actual claims are less than expected based on the claims history, then the insureds should get a return of their excess premium. Indeed, that is the way it works even today in mutual insurance companies. However, if the claims are more than expected based on prior claims history, then the insureds may have to pay additional premiums. Shipowners would quickly realize that it benefited all if claims were minimized and that certain maintenance standards were required. Otherwise, they would not insure them. Thus, the whole idea evolved that a risk manager or engineer inspected the ships and made sure the ships met certain specifications and certain maintenance standards. This is indeed exactly what is done to this day for this type of insurance.

Note that the original concerns for ship owners were for property and not for people, injuries or loss of life. These first insurance contracts were for what is now called marine insurance. Those policies are not coverage for liability to others. Again, it is easy to forget that the risk of liability to others is a relatively recent phenomenon in business and in law. Liability risks only became the more dominant risks in the last fifty years or so. Prior to that, the biggest issues were property issues and therefore in most of the earlier cases, you will see that the insurance pertained to property losses such as fire insurance.

The original insurance organizations quickly realized that the losses must be accidental. If a ship owner could scuttle a ship and recover insurance, obviously the premium could never be charged high enough to cover a one hundred percent risk. The claims history had to based on accidental losses and there had to be some kind of fortuity in those losses.

It wasn't long before traditional financiers became involved and realized that insurance is a form of financing, of spreading the risk. Accordingly, financiers got involved as third parties in being the insurer, but two hundred years ago if you needed money there was no such thing as a local bank to lend you the money. If you didn't get an endowment from a king or a queen, you got it from a wealthy person, a duke, or a nobleman of some type. Just as these people financed your business or your ships they would also begin to finance insurance. As they became more sophisticated, they would not want to hold the risk individually for a whole group of ships. Instead a group of wealthy individuals would form a syndicate and they would "underwrite" a group of ships, once again the idea being to spread the risk. The amount of the premium paid was based on claims history. If the actuaries were wrong, the wealthy individual, the syndicate, and the people who stood behind it (eventually who became known as "names") would have to contribute money to the syndicate to pay off the losses. If the actuaries did their work properly, there would be a profit and the names would make money just as they did with lending money. Shipowners would make these arrangements with brokers at a coffee shop in London known as "Lloyds". The brokers there eventually began to limit their transactions to certain standard forms known as "Lloyd's policies of insurance". This system of course became what we now call the "London Market of Insurance" and it pretty much exists in that very form today. Eventually, insurance companies would evolve into stock companies and modern forms of corporations but even today in much of the world, the worst risks are carried by the London Market.

B. **Types of Insurance**

As I've already mentioned, the original focus of insurance was on losses to property and liability concerns are a relatively recent phenomenon. It is important to understand that there are very different types of insurance and to narrowly define what we are talking about for the rest of this seminar. In the universe that we call insurance, there are effectively two different galaxies; one is personal lines and one is commercial lines. There is some overlap between the two but it is relatively minor and nothing that

we are going to discuss. For all intents and purposes, we can consider these galaxies as totally separate; they have different rules, different policies, different companies, and different insureds. If you do not understand that, you will make a very significant mistake at some point. Like most of the other rules of modern day insurance, insurance evolved this way because of very basic marketing issues.

1. Personal Lines v. Commercial Lines

Personal lines insurance is geared to people. People have different needs when they buy insurance than businesses. It is generally understood that people are not going to read their policies, are not going to particularly understand their policies if they read them and that people don't want to spend a lot of time trying to figure out their insurance. Moreover, the amount of risk involved in a personal policy is of course far less significant than in a commercial policy. For all of these reasons, personal lines of insurance evolved to be much broader and inclusive than commercial lines of insurance. In most cases, when you read in law and in the newspaper about insurance, typically we are reading about personal insurance. Indeed, there are many CLE programs and seminars on auto insurance, homeowners insurance and many columns in various periodicals and insurance updates that invariably deal with personal lines of insurance. Personal insurance serves a very important need but that is not what we are going to discuss today.

The typical personal insurance policy that we are all quite familiar with is auto insurance. Auto insurance in most states is required to contain a liability portion to protect drivers and owners from liability to others. Most auto owners also understand that when their car is newer they should get what has come to be called "comprehensive coverage". What they are calling comprehensive coverage or "collision coverage" really is property coverage and that covers them for their own losses and not for liability to others. Accordingly, the auto insurance policy is effectively a hybrid policy of liability protection and first party property protection.

The other very common personal insurance policy is homeowners insurance. This almost universally will have liability coverage and property coverage that may be known as "fire coverage" in the parlance of personal lines. The idea is that the average consumer should just be able to go out and buy a homeowners policy and know he is covered pretty much for any typical claim that may come up that does not involve conducting a business. This same thing pertains to his auto insurance: any usual claim that will come up involving his car will be covered as long as it doesn't pertain to conducting a business.

The one thing to look out for with these type of claims is that many people conduct businesses out of their homes and out of their cars and insurers are going to disclaim on personal policies unless you have a specific endorsement including that type of coverage because that risk is not assessed and it is not considered a typical risk. That is one of the very few areas where commercial lines and property lines will cross but for the most part that doesn't come up very often.

Commercial lines are marketed differently than personal lines. The risks are much larger and therefore the premiums are much larger. Corporations are generally much more sophisticated users and have the resources to hire experts and brokerages and attorneys to review policies and review their needs. In addition, the types of businesses that are conducted are so diverse that the risks are vastly different. Accordingly, it doesn't make much sense to have a policy that is so overbroad that it could cover every conceivable risk of business that could come up. The premium would just be far too much. Businesses want to pick and choose what kind of coverage they want, and if they don't need it, if they don't need aircraft liability, they don't need watercraft liability, if they don't need auto liability, they don't want to pay for it. In addition, businesses, because they pay so much more money, are much more willing to shop around and buy a little piece of insurance from this company, a little piece of a different type of insurance from that company and get themselves the best possible deal. Accordingly, commercial lines of insurance, which is what we are going to talk about for the rest of this seminar, evolved differently from personal lines. The typical mistake made by small businessmen, who are generally less sophisticated, is that they buy a very basic commercial insurance policy and think they are covered for everything, but they are not. The reason is not because insurance companies are trying to be tricky. It is because that is the way the policies are marketed and that is what the target consumers, the businesses desire. We should note that personal lines as you might expect are far more regulated than commercial lines but commercial lines are heavily regulated as well.

2. Types of Commercial Lines

The most basic form of commercial insurance is known as the CGL policy (sometimes called in a backwards way GCL policy) "Comprehensive General Liability" insurance. Don't let that million dollar name fool you because the "comprehensive" really should be "basic" but for marketing reasons it has always been called "comprehensive". The basic policy covers liability to others. If you look at the materials, pages 8-58, you will see a typical CGL policy that was written for a large company whose name has been deleted. Think of the CGL policy as a building block. This is what you start with for most companies and then those companies will add and pick and choose various coverages that they need and they will get endorsements or separate policies. For example, if you look at page 8, there is a list of various endorsements that this insured could have purchased from this same company and made part of this policy, but it appears to have purchased, for some reason, only a "druggists liability" endorsement and an "elevator collision" insurance endorsement. Now that doesn't mean it didn't have other types of insurance. It just means it didn't purchase it from this particular insurer and it might well have had separate policies for other types of risk. If it wanted to, it could purchase commercial auto insurance liability coverage and could have made it part of this policy. You should be aware that businesses can pick and choose and that what may be produced as a CGL policy may be hundreds of pages or thousands of pages in a complex case, but the really significant portion may be a relatively small thirty or forty pages. You need to understand what you are looking at when you get this whole raft of documents.

Other types of insurance that businesses may buy in addition to a CGL will usually include some sort of auto policy to cover risks for autos that belong to the corporation. By law in most states, a business will have to purchase a workers' compensation or employers' liability policy. The other types of various coverages it could purchase are virtually limitless. It could buy boat insurance, plane insurance, war risk insurance or even environmental claims liability insurance. These policies may be wholly separate or they may be part of the CGL by endorsement. The important thing to note is that when your business client comes to you, if it has an auto claim, it is going to be very different from a slip and fall on his premises. You need to make sure you review the right insurance contract and purchase the right insurance for your client's needs. If your business client suddenly adds an operation and acquires a company that has a completely different risk such as tugboats and barges, it will need insurance for that risk. It will not be covered by its current CGL policy.

3. <u>Types of CGL Insurance</u>

a. <u>Primary Insurance</u>

On page 5 of the materials, there is a schematic diagram of the types of CGL coverage that is used for a typical business. What we've been referring to up to now as a CGL policy is what we call the "primary insurance". The policy on pages 8-58 is a primary CGL policy. If you think of insurance as a layer or layers that wraps itself around the business to protect it from risk, you can begin to understand how to build an insurance program for a business. The first layer, the most basic protection, is the primary layer and that is the layer that is primarily responsible for risk. The first dollar of coverage will come from that layer. If you are the business on the bottom of the page here, page five, in your primary layer you will typically have a CGL policy, an auto policy, an employers' liability or workers compensation policy, and a product liability or completed operations policy (if you are a manufacturer or you provide a service). You may have an owner's and landlord's policy if you are a landlord. These could all be added as endorsements to your CGL or they could be completely separate policies. There could be a lot more primary policies depending on the risks of the particular business.

Now, in all of these cases we are referring specifically to liability. Property is a different animal. When we talk about layers we talk about coverage for liability protection. As recently as the 1950's, most businesses didn't have large amounts of liability protection. They usually had their primary policy and maybe some of the bigger companies, the more sophisticated companies, had an umbrella or an excess policy above that. It's not uncommon for even an Fortune 500 company from that era to have only a million or two million dollars worth of coverage and certainly no more than say ten million dollars. As time passed and liability became a much more significant issue, businesses found that they needed to purchase a lot more protection. Also, the insurance companies became less willing to underwrite any given business a huge chunk of coverage so the policies began to insure smaller and smaller amounts, again with the idea of always of spreading the risk. If you are an insurer, you would rather have a small

chunk of risk on many, many companies in many different industries rather than have a large chunk of risk on one particular company or in one particular industry.

b. Umbrella Insurance

The first layer of coverage above the primary layer is called the "umbrella layer". It's called an umbrella because it is a liability policy that overlays many other types of liability policies. It will typically overlay the CGL policy as well as the auto liability policy, the employer's liability policy and whatever other liability policies are purchased by the business. There is an example of an umbrella policy on pages 59-116 of the materials. As you can see on page 5 from the schematic, the idea of the umbrella policy is that it will pick up liability coverage after the underlying policy limits are exhausted. For example, if your primary CGL policy is for a million dollars, then after that company pays out a million dollars the umbrella company will take over coverage.

The umbrella company is always one insurer. The umbrella policy is the one contract that sets forth the language, the terms, and conditions for all the other excess policies that may come after that umbrella policy. The umbrella policy typically has similar but not the same terms as the primary policy. By its very nature it must have different terms because it is more comprehensive. That is, it is an umbrella, it covers other liabilities that are not covered in the primary policy. Its wording is usually a little bit different, and the wording of an umbrella policy basically says that when the underlying policy limits as set forth in this particular set of declarations are exhausted, the umbrella policy will defend you and indemnify you. There are umbrella policies that do not include defense obligations. Some umbrella policies may have very materially different terms from the primary policy even excluding risks that were otherwise covered by the primary policy, so again you have to be careful that when you look at these policies that the risks they cover are the same as the primary contract.

c. Excess Insurance

On page 59 of the materials there is an umbrella policy that is very confusingly called an "excess liability" insurance policy. Generically, all liability insurance that is not primary is called "excess", so an umbrella policy is a type of excess liability insurance. However, the umbrella policy is the most important excess policy because it is the lowest level of the excess policies and it sets forth all the terms and conditions that will be followed. If the primary policy is one million dollars, the umbrella policy may be four million dollars for a total coverage of primary and umbrella of five million dollars. Typically, a business today wants a lot more coverage than five million dollars so it will have to buy coverage that is excess to the umbrella. A typical excess policy may be found on pages 117-134 of the materials. An excess policy almost certainly (except in the rarest circumstances) will state right in the policy that it follows the form of the umbrella policy that is named in the declarations. The reason is that if you're a business, you want to make sure that you are covered. You are not sure if you are covered if your primary policy says one thing and your umbrella policy says a second thing and your excess policies say different things all the way up. Business liability

insurance therefore evolved such that the umbrella usually (but not absolutely) has the same terms as the primary policy with the exception of liability limits and that the excess policy usually says little more than "it follows form to the umbrella policy". The example that I've included as an excess policy is the Dairyland contract from pages 117-134. It is a particularly good example of what to look for and we'll come back to this as we start to dissect what's actually in the guts of these policies but if you were to read through all these pages right after the first declarations page on page 117, you would find that it has all sorts of language that pretty much doesn't match precisely what the umbrella policy might say. It has all sorts of conditions and terms, etc., etc., so you go through all that thinking, "oh, well these are the terms and conditions". Then you come to page 134 and you will see an endorsement that says everything you just read is deleted with the exception of the liability limits and the contract follows form to the umbrella. And that is what an excess policy has to say somewhere because otherwise it would just be completely incomprehensible "gobbledy gook" to everybody.

C. Types of Insurance Companies

We already discussed a number of different forms of insurance companies. I will briefly define the ones we discussed and then we will go on to some of the other interesting types of significant companies that you will come across.

1. Corporations

Most insurance companies today that issue CGL policies are corporations. They are just like any other corporation except that they are regulated by the superintendent of insurance in any given state instead of the usual division of corporations.

2. Mutuals

As previously discussed, a mutual company is usually just that; a company like a regular incorporated company except that it is owned by the policy holders. In recent times, we have seen some interesting corporate transactions as the financial geniuses find ways to convert mutuals to corporations and thereby somehow make more money for a select group of people. The main thing to remember about a mutual is that they are in many ways similar to a non-profit. If there is too much premium charged, the insureds should get money back. If there is not enough premium charged, the insureds may be on the hook for additional premiums.

3. London Companies, London Market and Other Good Stuff

I have already spent a good deal of time explaining to you the London market, and how syndicates are formed using names. There is a third party entity that has a close relationship with these other companies called Lloyds of London and Lloyds is usually an entity that puts together syndicates. Lloyds and the London Market are not

necessarily the largest insurers in the world but they usually are found where the greatest risks are involved. Therefore, you may not be surprised to discover that, for example, Lloyds is the primary insurer for the space shuttle.

4. **Offshore Entities**

An offshore insurer is just like an offshore corporation. It generally refers to an insurance company found in one of the third world Caribbean nations such as Bermuda, which is the favorite. They go there not only for tax reasons but primarily to escape U.S. regulation. Therefore, if your client has offshore insurers, you should be suspicious. It usually means the insurer is not admitted or approved by the state in which your client operates and therefore if there is a problem, you may have a very difficult time trying to resolve it. Offshore companies are usually found in connection with the next set of companies which I will discuss.

5. **Captives**

Captives are insurance companies that are formed either by a particular industry or at times by a particular large company. Therefore, it is a captive of that industry or the large company. Captives are usually formed to save premium because the insurance risk is so large, the industry or that particular company has a hard time obtaining reasonable insurance. They also are formed because they are a natural offshoot of the self-insured retention which is something I will discuss a little bit later. Effectively the insured becomes its own insurer, usually again because of substantial risks. Captives are often offshore entities so they can be formed easily and escape the scrutiny of state regulators. The companies they insure don't really care that they are offshore or that they are captive because they are in effect an insurer as well as an insured. You will notice the similarity between a captive for an industry and between the old-fashioned mutuals that were the first insurance companies formed by the shipowners in London. Another very significant purpose of the captive is to create the "paper" that is necessary to get umbrella insurance and excess insurance and reinsurance. It is not unusual for a captive to be 100% reinsured, which brings us to the next couple of entities.

6. **Reinsurance, Facultative and Treaty**

Reinsurance is exactly what it sounds like. It is insurance for the insurer. This is a natural offshoot of spreading the risk. As long as we are spreading the risk linearly, there is no reason not to also spread it dimensionally. So for example, if you are an umbrella insurer with $5 million on the hook, you may reinsure $4 million of it and just keep a million dollars of risk. You will pay a premium but it will be a lesser premium than the insured paid to you, so you will make a profit. The reinsurers then insure you, so again it spreads the risk. The reinsurers may themselves be reinsured (and usually are) and in that way the risk is spread among even more entities. The idea is is that the further you are away from the insured and the risk, the less risk you have and also the less regulatory scrutiny you have.

Now there are two types of reinsurers that are commonly found: facultative and treaty. A facultative reinsurer is a type of reinsurer that is very similar to underlying insurance. The facultative reinsurer issues a policy and charges a premium just for this particular contract and covers just this particular insurance risk and none other.

The treaty reinsurer is a contract reinsurer. The insurance company that is being insured enters into a contract with a reinsurer to cover certain risks. The treaty reinsurer, for example, may agree to take a portion of all of the insurer's umbrella policies. He may agree to take a portion of all of the insurer's policies in a particular industry. The parties may agree to do whatever they want to do. The treaty says whatever it says. Other than that, this is basically an insurance policy. Going back to our example of an umbrella insurer with $5 million on the hook, of the $4 million that is reinsured, he may have a treaty to dispose of $1 million of that or ¼ of all his umbrella policies. The advantage of treaty reinsurance is that the transactional costs are very cheap and it guaranties both parties a certain amount of income and risk.

D. Agents, Producers and Other Creatures That Go Bump in the Night

In a commercial insurance program there are any number of middle men that might be involved in the transaction. Going back to our earlier example of auto insurance in personal lines, most of us understand that there are two ways we can purchase our auto insurance. We can go to a broker who usually is an agent for a particular insurance company such as State Farm or Allstate. He will get State Farm and Allstate to issue the policy. The other way is we can call up the insurer directly and have them issue the policy to us directly. For example GEICO works that way. The commercial world is more complex. The whole point of having commercial lines is being able to shop around and get only the coverages you need and pay the least possible. Commercial insurance is sold in many little bits and pieces. Therefore, whether you are a big company or a small company, you are likely to have an independent retail broker involved who is an expert on the latest developments in insurance and will shop around for you to get the best prices. He will also advise you on the types of insurance that you need. The more complex your business operations, the chances are the more different types of insurance that you will need.

Perhaps the most important advice you can tell your business clients is to get a good commercial broker and not their brother-in-law. There is a good chance that if they are in that stage where they are just going from a small business to a much more substantial business, that they are underinsured, underserved and that their insurance broker does not know what it is doing. While some of the personal lines companies do issue business policies that cover small businesses, in most cases their brokers are not really familiar with the commercial insurance market. All they know is that they sell a commercial policy. That may be perfectly adequate if you are running a pizza parlor or a shoe shine stand but if the business is a little more sophisticated, you need to find yourself a good commercial broker.

The insured's commercial broker will also deal with other middlemen. He will become the retail broker and effectively the insured's representative or theoretically its representative. He will deal with wholesale brokers who are known as producers. They may be independent or they may be effectively a representative of a particular insurance company.

An important thing to remember about all types of brokers, whether they are retail, wholesale or whatever they are, is that their loyalties, like agents of any type are very much divided. They are your agent, they are an agent of the insurance company and they are certainly an agent for themselves. Many mistakes in insurance are a result of agent error. It is not surprising that the larger a corporation, the more likely it is to employ its own insurance professionals to keep an eye on all these different agents and what they are doing. However, good agents can save a business, and that is why they are so important.

E. **<u>Insurance Programs</u>**

Page 5 of the materials provides an example of a simple insurance program for a business and page 6 is an example of a more complex program. An important thing that an insured should be advised to do is to review its insurance needs and programs at least annually. The people that should be involved in these reviews should be your commercial insurance broker, your attorneys and the executives of your business who know the various business risks with which the company is engaged. If the company has acquired new businesses, it should immediately advise its insurance professionals and its attorneys to make sure that the right coverages are being purchased. You will soon see that when businesses take a logical extension of the business, it doesn't necessarily mean that they are covered for that logical extension by their insurance.

The simple program on page 5 shows a basic CGL policy, an umbrella policy above that and excess layers above that until there is enough insurance to meet the business needs. You will notice on page 5 it says one or more insurers in the excess layers. Layering or how much risk each insurer accepts is normally designed by insurance professionals in order to obtain the best possible premiums. Again, most insurance companies only want to take a little piece. It is very common today for insurers to say "well, we'll take a million dollars of risk at the $20 million level and we will take a million dollars of risk at the $40 million level". Accordingly, if you structure a program which covers the business from $5 million to $10 million and also from $10 million to $15 million, that may logically make sense but it may not make any business sense as far as the insurance companies are concerned. They want it broken down into pieces. The insurance market has evolved in another way to spread the risk in the excess layers so that you won't have this building block approach even if you break it down to nice digestible pieces like $1 million, $1 million, $1 million. What companies will often do is say, "OK, the umbrella covers us up to $5 million, then we have a $5 million to $10 million layer" and they are going to find out who wants to take a piece of that layer. Of course, most companies may rather take the $9 to $10 million layer but don't really want the $5 to $6 million layer because that is triggered first. In order to get around that, the

brokers create one block and then the insurance companies will take a percentage of it. For example, the insurance company may take 20% of the $5 to $10 million layer or $1 million of that $5 to $10 million layer and there will be five insurers each taking 20% or maybe 10 companies each taking 5%. What that means is that if that layer is reached, there isn't one particular company that has to pay the first dollar. Every company in that layer has to pay the first dollar but only its percentage of it and it will work out that way up the ladder until the business gets whatever insurance it wants up to $100 million or whatever.

How this program may look appears on page 6 of the materials. For example, the 1982 primary policy is $500,000. CSL means combined single limit which means a combined single limit for property damage and bodily injury. This is in excess of the $100,000 SIR which is the self-insured retention.

A self-insured retention is an extension of the deductible. Fifty years ago most policies only had deductibles. The insurers covered you for everything above the deductible but your insurance company administered the deductible. They told you when the deductible was exhausted as long as you told them the amount of money you were spending to exhaust the deductible. As liability claims became more and more significant, the duty to defend became more and more significant, and it became very, very expensive to insure that first $10,000, first $50,000, first $100,000. The insurers weren't so worried about the $100,000 in indemnity; they were worried about all the defense costs they had to pay to all those attorneys for all those hundreds of slip and fall claims, for example, that you may get at your local store. So they said, "look we don't want to cover you for all these small nuisance claims and pay attorneys a fortune. I couldn't charge you enough of a premium for that so you will be self-insured until you spend $100,000 on that." The SIR is a little different from a deductible because a self-insured retention effectively makes the business its own insurer. Usually, the policies require that you put some money aside in reserve and that you have a third party administrator or "TPA". Some SIRS include defense costs and some don't. Usually, they do but you should double check your particular policy.

On page 5, in 1982, this insured has a $100,000 SIR. Once it is exhausted, it has a primary policy of $500,000. Once that is exhausted, it has an umbrella policy for an excess of $500,000 bringing its total coverage to $1,000,000, not including its $100,000 SIR. The next layer above $1 million has three companies in that layer. One company agreed to take only 20% or $200,000. The other company agreed to take 30% or $300,000 and the last company took 50% of $500,000. Therefore, you have these companies as $200,000 part of one million excess of $1 million or $300,000 part of one million excess of $1 million, etc. as listed there. And the schedule goes up and you can see how it works out. I can show you insurance charts like this one for Fortune 500 companies that would cover the wall. That's how complex it can get.

Keep in mind in addition to this vertical spreading of risk and the horizontal spreading of the risk over years, you also have a dimensional spreading of the risk because standing behind these insurers are reinsurers. In general, as we move over

the years from say the 1950's to the present time period, the coverage charts get far more complex. If you look over a coverage chart over many years you will see holes where people failed to get renewals or failed to get insurance when insurance was cancelled. You also see holes because of missing policies. All of these are very significant in a large coverage case.

II. PARTS OF AN INSURANCE CONTRACT

The parts of an insurance contract in general are the parts similar to the parts of any other contract. There is the declarations section, the basic agreement, conditions of coverage, exclusions, definitions and endorsements which change the usual form. Insurers have agreed on basic forms for the CGL policy as a matter of marketing although they have also been influenced by regulators. Generally, it would be a good idea if the insured had the same coverage no matter what state it is in. But in practice that doesn't work because insurance law is governed by state law and therefore the same contract could have very different meanings in different states. For example, there are very significant differences between the law in the State of New Jersey and the law in the State of New York regarding the exact same clauses.

A. Declarations

The declarations section of the contract contains the most basic information, name of the insured, effective dates of the contract, the indemnity limits, the name of the insurer, and the policy number. It will usually also tell you what other forms were used in this particular insurance contract. Often insurers and brokers will send only the declarations page and any endorsements to the insured or to the broker. The theory is that if the declarations listed all the forms, then the forms are in their computer or on file and the insurers could print them out anytime. That works fine as long as you are dealing with an insurance contract that is relatively recent, within the last five years. This is a problem in major coverage cases which often go back twenty, thirty, forty or fifty years or more. In many cases, those forms no longer exist. The parties usually assume that the standard forms that were applicable in that time period were used and the most commonly used forms for the last fifty or so years are known and available.

The rest of the insurance contract besides the declarations and the endorsements is called the "jacket" in insurance parlance. That's because originally, it was a form booklet or a jacket that was used and the endorsements and the declarations page was inserted into the jacket: The jacket would include all the basic and routine form language concerning the insuring agreement, the definitions, the standard exclusions and standard conditions. When a business receives its insurance policy from the insurers you might either see a few pages which are just declaration pages and endorsements or you may get the hundreds and hundreds of pages that really encompass the full contract.

The information on the declaration page is theoretically the most important. However, it is quite possible and indeed likely in the case of a more complex insurance program that virtually all of this information on the declarations page is

changed by virtue of endorsements. It is not unusual for example for endorsements to change the liability limits. It is not unusual to have endorsements which add or change the name insured, or even cancel the policy. Insurance companies rarely issue a whole new declarations page or a whole new policy. In most cases, they will simply issue an endorsement that amends the contract. Examples of declaration pages can be seen in the materials on pages 8-16 for the primary contract, on page 59 for the umbrella contract, and on page 117 for the excess contract.

B. Agreement

The agreement part of the jacket is the basic agreement that tells you what exactly is insured. In the materials, there are several agreements because this particular primary policy had more than just the basic CGL, but the basic CGL language is found on page 41. The language there is the standard language that has been in use for the last thirty or forty years. It states that the insurer agrees to pay all sums which the insured shall become legally obligated to pay as a result of bodily injury, which is a defined term, and property damage, which is a defined term, caused by an occurrence, which is also a defined term. Further, the insurance company has the right and duty to defend all such claims.

Notice here that there are two duties that are inherent in a CGL policy. There is a duty to defend and a duty to indemnify. We will come back to that to discuss it in more detail but this is where those duties are specified in the contract.

C. Conditions

The conditions part of the jacket is found in the materials on pages 69-73. The conditions typically include such provisions as the insured shall provide notice of any claims of occurrence, shall cooperate with the insurer, and shall not misrepresent any facts to the insurer. We will come back to the most important ones in a few minutes when we discuss the various coverage issues that typically arise.

D. Exclusions

The next part of the standard form jacket are the exclusions and these are standard form exclusions. The way to remember what is a standard exclusion from a CGL is that anything the insurer can sell you a separate policy for is going to be excluded from the basic policy. Therefore, without even looking at the exclusions you should expect to find an exclusion for auto coverage, for boats, for planes and for owned or leased property because there are separate policies for all of those things. There will also be an exclusion for workers compensation claims, for products liability and completed operations claims. There are also standard exclusions for pollution and depending on the date there might be exclusions for asbestos and for lead paint liability. We will discuss the most significant exclusions in a few minutes. The standard form exclusions are found

on page 41 of the primary policy of the materials and on pages 65-69 of the umbrella policy in the materials.

E. Definitions

The last part of the jacket are the definitions and these can be extremely important. It is here where you will find the definition of such things as property damage, bodily injury and occurrence. They tell you what the insurer has agreed to do. The definition section for the primary policy is on page 57 of the materials but you will notice it is not complete. As I stated, this policy is a very typical policy that could be produced by an insured and it is incomplete. We will go over the most significant definitions in a few minutes when we get to the coverage issues.

F. Endorsements

The endorsement are the last part of the contract and are often the most voluminous part of the contract. They contain all of the various things that the parties added to tailor this form agreement to the needs of this particular insured. Any term that is in the contract can be amended in the endorsements, so it is very important to review the endorsements. Endorsements themselves can be forms and may be listed in the declarations page as a form. There were certain endorsements that insurance companies would issue as a standard practice for an additional premium such as additional named insureds or amending the notice provision, etc. The endorsements could very much amend the entire agreement and include a whole new insurance agreement in them. Usually, the endorsements are easier to locate because that is one of the things that the insurance companies and the brokers almost always send out when the policy is issued.

Now you know the basic parts of a policy, you'll know when you get a big stack of papers what you should be looking for. A lot of these papers are going to be schedules and things that are very specific to this insured and are not going to be relevant to the particular claim that is at issue. In a typical case there may only be four or five pages of the insurance policy that are really important.

III. THE DUTY TO DEFEND VS. THE DUTY TO INDEMNIFY

Probably the most common mistake made by novice coverage counsel and by insureds is that they do not understand that there are two very significant duties in a commercial insurance contract and there are two standards of law interpreting them. In the primary insurance policy and even in the umbrella policy, the duty to defend is by far more significant obligation than the duty to indemnify. This was not always true, as I previously stated. Liability and attorney fees only became a real financial concern in the last fifty or so years. In any case, many insurers do not want to enter into primary insurance contracts and the main reason is not because of the indemnity limits but because of the defense obligation.

In virtually all CGL's, the liability limits pertain only to the duty to indemnify. Therefore a million dollar policy means that the insurer is obligated to pay out as damages or settlement no more than a million dollars. These limits do not apply to the duty to defend and therefore the attorney fees are theoretically unlimited. An insurer can win a case calling for say ten million dollars in damages and not incur a dollar against its indemnity limit and still spend three million dollars on attorney fees. There are a few cases in certain types of unique policies where the defense costs are included within the limits but these are unusual. You should always double check just to make sure you don't happen to have one of these unusual policies.

In virtually every state, courts have said that if there is even a possibility that a claim would come within coverage, then the insurer must defend the insured. It could reserve its right on indemnity but it has to come in and defend. Therefore, if an insurer issues a reservation of rights and refuses to defend, it may quickly find itself in hot water with the court. Most courts interpret the duty to indemnify much more narrowly. Usually the court says that the insurer is not obligated to indemnify unless the obligation is clear.

IV. PARTICULAR COVERAGE ISSUES (The Good Stuff)

A. Occurrence Issues

"Occurrence" is a defined term in the policy and is found in the definition section. The definition of "occurrence" is "an accident", including continuous or repeated exposure to substantially the same conditions, resulting in bodily injury (a defined term) or property damage (also a defined term) "that is neither expected nor intended from the standpoint of the insured".

The first part of that definition states that an occurrence is an accident, so why didn't they just leave it at that and say it's an accident? Well at one time that is exactly what the policies did say and if you are unfortunate enough to litigate cases with policies from the fifties or forties and sometimes even later, you will see accident based policies. Clever attorneys cast quite a bit of doubt as to what exactly an "accident" is. For example, consider the case of a man who jumps off a bridge a hundred feet into a body of water and kills himself. The insurer would disclaim saying, that it is not an accident because it was an intentional act. The attorney says, wait a minute, the jumper didn't think he was going to hurt himself and thought that he would survive and swim away and go have a nice meal with his girlfriend. Accordingly, he didn't expect to have an injury and therefore it's an accident. The courts came to agree with this reasoning and ruled that even if the act was intentional, if the damage was unexpected then it was a covered claim.

Ultimately, the insurers clarified the policy language to be consistent with this majority view of the courts and there was an increase in premiums. Thus was born the "occurrence" language. The occurrence language focuses on whether the damage or the injury was expected or intended, not whether the act itself was intentional. You may

recall in my original comments that there has to be fortuity for a liability insurer to cover the damages. There is some tension between the whole premise of fortuity and this definition. Moreover, if you look at the last part of the definition, the standard is a subjective standard. The language says from the standpoint of the insured. The problem with this is what if the subjective viewpoint is so ridiculous that it offends common sense.

This argument has come up, in particular, in environmental cases where the insured has been dumping toxic waste at a site for many, many years, as a routine part of its operations. The insured argues, "we didn't expect the damages, we expected that it would be all magically cleaned up, that it would be swallowed by the sand. We didn't know that it would end up in the groundwater and in somebody's drinking water supply". The insurers introduce evidence showing that it was common knowledge that this pollution would result in contaminating water supplies. Accordingly, many courts have now adopted an interpretation of occurrence that says, if the insured knew or should have known that the damage was likely to occur then it is not an "occurrence". The problem with that ruling is that it sounds very much like an objective test and the definition itself says it’s a subjective test. The tension here is that the court wants to give the insured the benefit of the doubt of a subjective test without offending common sense.

An important thing to note here is that whether there was an occurrence or not is almost always a question of fact that requires a great deal of discovery. In most cases, the courts have been unwilling to suspend their common sense in favor of a ridiculous subjective intent. Nonetheless, it is generally difficult for an insurer to win a case based on the occurrence language.

B. <u>Trigger</u>

I know that most attorneys and most people involved in insurance claims in one form or another are familiar with the term "trigger", and there are literally thousands of cases which claim to tell you exactly what is a "trigger" with respect to an insurance policy. I can tell you two things about "trigger" for sure: 1) it has nothing to do with a horse, and, 2) you can look through every policy that was ever written and you will never find a definition for a term called "trigger". In fact you will not find the word "trigger" used in any of these policies. Why then is the concept of trigger so important?

Trigger deals with the issue of when did the occurrence occur. Going back again to when times were a bit simpler and there was not the tremendous growth in liability that we have today, it was clear in most cases for the parties and the court to agree on which insurance policy is involved in any particular claim. The law in virtually every state says that there is an "occurrence" when actual injury occurs, and that could be actual injury to property or to a person. That is pretty clear, except when we start talking about latent manifestation injuries such as toxic tort claims, asbestos, etc. or environmental claims. Accordingly, in recent years, the last twenty years or so, the concept of "trigger" has greatly expanded and has been greatly explained and greatly misunderstood.

The seminal case that led to all this confusion is a 1981 case in the D.C. Circuit called *Keene Corp. vs. Insurance Company of North America* which was an asbestos coverage case and one of the very first. The problem with asbestos as with most toxic tort claims is that exposure to the hazardous substance, asbestos, may have occurred many, many years ago in the forties, the thirties, the twenties, the fifties, who knows? The injured party may not have learned he was sick until many years later, say in the sixties or seventies and he may not have learned that his exposure to asbestos caused the injury until years after that. The question then arises as to which insurance policy must respond to this bodily injury claim. For example, if you look at page 6 in the materials I have six policies over a span of time in the 1980's. Now if you could imagine that we had a schedule here from the forties and that there were many, many years of coverage just like the schematic on page 6, the question is which insurance company or which year has to respond to the claim?

It's all well and fine for the law to say the policy that is on the risk is when there was "actual injury". When is an asbestos victim actually injured? The insurers in the latter years of coverage of course argued that it's when the victim was exposed to the asbestos, and earlier asbestos cases ruled that way. This is probably the most favorable interpretation in general for the insurance industry because the further back in time you go, generally the lesser were the limits of the insurance policies. It was not uncommon for a Fortune 500 company to have less than ten million dollars of coverage going back to the fifties or forties. The insurers on the risk in those early years are certainly not that happy to give up their millions, and they argued "trigger" is when there was manifestation of the disease. You could almost guess what the insured argued. It said, "it's both" and everything in between because the asbestos was in residence then and it was continuing to cause further damage. This argument is helped along by expert testimony that states that when you inhale one asbestos fiber, it causes some damage and continues to cause damage as long as that asbestos fiber remains in the body and it remains in the body forever. The D.C. Circuit agreed with this theory and said it's a triple trigger: it's exposure, it's injury in residence and it's manifestation. A triple trigger is also known as the "continuous trigger" theory.

This raises a whole new problem. If you have fifty years of coverage triggered, which year or years has to pay and how much. Here the insurers are going to split. The excess carriers who tend not to issue primary or umbrella policies argue that all of the lower level policies have to be horizontally triggered over that fifty year period so that all of the primaries have to pay and then all of the umbrellas have to pay proportionately. When the lower level for all 50 years is exhausted, the trigger works its way up the ladder to the excess layers. This is fair because the excess carriers charged a lesser premium and they took on a lesser risk and the carriers who charged the bigger premiums and took on more of the risk should be the first to pay.

The primary and umbrella carriers of course disagreed with this horizontal trigger since they tend not to issue that many excess policies and this would trigger all of their policies: They argued "we have to pick one year and that one year pays, so the trigger goes up vertically". Alternatively, they argued that insurers should pay based on

their percentage of indemnity limits. Once again you could almost guess what the insured was going to say. It said, "pick one year but I get to pick the year and when that year's coverage is used up, I get to pick a second year and a third year until all the coverage is used up. In this way I can stack every year on another year". The insured, of course, is going to pick the years with the most coverage which are going to be the latter years. He is going to avoid the years where there are holes in his coverage. The justification the insured cites for this theory is that, the language of the agreement, says "all sums which the insured is legally obligated to pay". The insurers have to pay "all sums".

The court in *Keene* agreed with this theory and to this day some insureds make that same argument about stacking. However, unlike the continuous trigger theory, virtually no courts anywhere else have followed that theory and the vast majority have arrived at some sort of formula allocating the losses in more of a horizontal fashion. The reason for this is that latter courts became troubled by the fact that there were years in which the insured failed to get coverage or was otherwise underinsured. The stacking theory rewards an insured for failing to get adequate coverage and that's not good public policy. The courts reasoned that the insured should have to pay sums where it failed to get adequate insurance. Moreover, the courts were also generally sympathetic to the excess insurers' argument that they took the least amount of risk and therefore should be the last to pay.

The triple trigger has been modified somewhat as absolute asbestos exclusions and absolute pollution exclusions have come into policies. Those policies are not triggered because of those absolute exclusions which are upheld in most courts. It's relatively easy for a court to look at a coverage chart and spot the holes in coverage but it's hard to figure out what years the insured is simply underinsured. A number of courts have allowed testimony on the issue of what insurance was available historically for various claims, in order to try to make a determination of what is underinsured. The net result is that conflicting allocation theories currently exist which use some sort of horizontal trigger formula to share the burden in a continuous trigger case. These formulas have been used in asbestos cases and in environmental cases and other types latent toxic tort claims.

C. Known Loss

Known loss deals with the issue of fortuity and it has come up again in recent cases, mostly in the context of environmental claims. There are older cases that support the concept regardless of policy language, but some courts reject it because of the subjective standard in the "occurrence" definition. Other courts have said that known loss is really the same thing as the occurrence defense. In New York, for example, there was a federal court decision which dismissed the case based on "known loss" and a contrary state court decision that said there was no basis for the defense from the language of the insurance contract. However, other courts have adopted it, although it has not become a major defense. The leading case on it at this point is a case called *Central Quality Services* which is a perclorethylene case emanating out of Michigan in

the late eighties which eventually went up to the Sixth Circuit. There, the courts upheld the known loss defense.

D. **Property Damage**

Property damage is a defined term and the thing to remember about the definition is that it must be damage to tangible property. Therefore it can't be loss of reputation or loss of earnings, a business interruption or anything like that. It has to be physical damage to physical property. That really wasn't very controversial until we had the advent of environmental claims in the 1980's. The leading case is a case that came out of the Fourth Circuit called *Mraz v. Canadian Universal Insurance Co*. in which the court held environmental contamination cleanup costs is not a loss to tangible property but a government mandated cost of doing business like a tax. The argument comes up usually in the context of contamination in a landfill whose function was to accept waste. Is that property damage? There are a few mostly lower courts that have accepted this theory, but it has not been widely accepted and only rarely comes up today in the common law. It is still raised as a defense in most environmental coverage cases.

E. **Claim or Suit/The PRP Issue**

This is an issue that comes up with the respect to the duty to defend and again it seems to be straight forward except in the mystical world of environmental coverage. In an environmental claim under either the federal CERCLA law or most states laws, the claims are often initiated by what's called a "PRP" letter. That is, a letter sent from the state of federal agency that says, "you may be a potentially responsible party for the contamination at this site and if you don't cooperate with us and begin a cleanup you will not only be jointly and severally liable for the cleanup costs, but may be subject to treble damages and a hefty per day fine." Needless to say, the statutory coercion of huge financial penalties is a very strong incentive for insureds to cooperate with the state or federal government and undertake a cleanup of the site. The insured usually hires lawyers and goes to informational meetings and does all of the things that are required under the various environmental laws. The question then becomes are the attorney fees and expert fees incurred in this process "defense costs"?

Assuming there is coverage at all, the insurance companies argue that these costs are indemnity, if anything, and therefore should be charged against the indemnity limits. The businesses of course want to argue that they are defense costs and therefore are unlimited. The problem with that argument is if you call them a defense cost, then everything is a defense cost. It's easy when you have a lawsuit and you're paying a lawyer to defend you to say, that the attorneys' fees are defense costs. When the lawyer is responding to inquiries from the state, is that a defense cost? If he hires a public relations firm to appear for public meetings mandated by state law, is that a defense cost?

Most courts have said that, depending on the exact wording of the letter, if the letter has the kind of coerciveness that is similar to a lawsuit, and it "smells like a

lawsuit and looks like a lawsuit and walks like a lawsuit", then it's a lawsuit, within the meaning of an insurance contract. Therefore, hiring an attorney is a defense cost within reasonable bounds, as long as it is required to respond to the allegations. There is a lot more to this argument and the cases are factually intensive but there is a series of interesting cases emanating from the state courts in Michigan relating to an insured called *Gelman Sciences* which extensively discusses this whole issue about defense costs.

F. Owned or Leased Property Exclusion

As previously stated a liability policy covers you for liability to others and therefore it should not be surprising that it doesn't cover you for damage to your own property or property that you otherwise control. Once again, this seems particularly obvious and should not have been controversial except in the modern day world of environmental coverage disputes where there is contamination of soil and groundwater. Virtually every state has now adopted the rule that pollution of the soil that you own or the soil in which your factory lies or is leased is damage to owned or leased property and is not covered. However, if the contamination reaches the groundwater, then that contamination is covered because groundwater is owned by all people. Thus, it is possible to have coverage for groundwater cleanup but not for soil cleanup. Moreover, if the soil on your neighbor's property becomes contaminated because it originates from your soil, that contamination should be covered. However, under that factual scenario, you might have other coverage issues such as an occurrence defense or a known loss defense.

G. Pollution Exclusions, Standard and Absolute

The CGL contains a standard exclusion known as the pollution exclusion. The standard pollution exclusion was first used by virtually all insurance companies in 1972 and continued in its use until the late 80's, although it occasionally turns up in newly issued policies even today. You can view the exclusion in the materials in the primary policy on page 61. The standard exclusion states that "the insurance does not apply to any discharge or dispersal of a pollutant, contaminant or toxic substance, etc., etc., unless such discharge or release was sudden and accidental". The reason for the exclusion is that insurance companies and state authorities agreed they did not want insurance coverage for long term pollution because this was against public policy. There are, in fact, various state laws which may bar such coverage even if the policies don't have the standard exclusion. Interestingly, if you take the regulatory history of the standard pollution exclusion from the early 70's and compare it with the statutory history of the federal CERCLA law that came into being in 1980, and the various state statutes that complement CERCLA, you will see that there was much discussion by Congress and in the state legislatures about insurance. Clearly, there was an assumption by many legislators that insurance would indeed pay for the cleanup of hazardous waste sites.

In any case, the insurance industry argues that policies with the standard pollution exclusion do not cover long term industrial pollution. It will cover the insured if the contamination was caused by a "boom accident"; that is, if a tank explodes and

spreads oil all over the premises, that would be covered under the policy. However, the policy should not respond when the contamination was caused by a leaking tank that had been underground for years or seepage ponds or landfills or various other types of dumping activities that routinely occurred in the development of our industrialized society.

The focus of all of the litigation that primarily took place in the early 90's and late 80's is on the exception to the exclusion: "sudden and accidental". We've already briefly discussed how "accidental" was modified by the legal community and limited by the courts. The insurance industry argued that the word "sudden" requires a temporal element. Thus, the "boom" type of accident that we discussed. Attorneys for the insureds said wait a minute, if you look up the meaning of the word "sudden" in a dictionary, one of the secondary meanings is "unexpected". Therefore, as long as the damage was "unexpected" it should be covered. In other words, the pollution exclusion is merely a restatement of the "occurrence" definition. Now this is wrong clearly in at least in one respect. The occurrence definition focuses, as we've previously mentioned, on whether the damages or the injuries were expected or intended. The pollution exclusion focuses on the act: on the release, the discharge, dispersal and whether that was "sudden and accidental". Even if you are to use the word "sudden" as the equivalent of the word "unexpected", it would still be an unexpected release and in most cases these releases were not unexpected. The courts have pretty much gone all over the map on this one, with for example, New York saying "sudden" has a temporal element and New Jersey saying it doesn't and means "unexpected". The law is constantly evolving in this regard.

The insurance industry resolved the whole matter by issuing entirely new exclusions commencing around 1987, 1988 that are still in use today and which are called "absolute pollution exclusions". These exclusions are much more long winded and say, "this policy doesn't cover you for any environmental contamination, any cleanup, any response cost, any PRP notices etc. and we will not defend you and we will not indemnify you". It is pretty express and clear language and varies slightly from policy to policy. Virtually all courts have upheld the absolute pollution exclusion and have barred coverage for any kind of hazardous waste site.

The other issue where the pollution exclusion has come up is in various other types of modern day toxic tort issues, such as lead paint, asbestos, sick building syndrome, even latex gloves. In general, the courts have said that the pollution exclusion does not apply to these types of cases where the substance was intentionally put there as part of a building or as part of a product and was not thought to be hazardous or pollution or waste in any way. The courts generally limit the pollution exclusion to waste.

H. Late Notice

In the condition section of the policy, virtually all commercial insurance contracts have the same notice condition and this has been in use for at least fifty years. The late notice clause says that if the insured has any notice of a claim or occurrence, it

must notify the insurer as soon as practicable. If the insured receives service of process then it must notify the insurer immediately. The notice defense has been the source of a great deal of litigation, particularly in New York.

The first thing to note about the notice provision is that it applies to the insured. It is the insured who is obligated to provide notice to the insurer. Often times the insured will provide notice to its broker. The broker is not the one who is obligated under this contract to be notified. Remember this is a contract. Moreover, as a matter of law, a broker does not have the duty to notify the insurers on behalf of an insured, unless it assumes that duty. If the broker does assume that duty, you better make sure you get it in writing. Even if you do notify your broker, I would still put the insurers on notice directly just to make sure that it's done properly. If you do get a broker to assume the duty it will give you another party to sue.

The other thing to note is how the courts have interpreted the phrase "immediately" and "as soon as practicable". Generally there are two camps of thought: the "prejudice" states and the "no prejudice" states. States such as New Jersey require that in order for an insurer to argue that notice was late, it must show that there was prejudice by the late notice. Usually "prejudice" is defined so narrowly that it is virtually impossible for the insurer to argue that there was prejudice. In most cases prejudice is defined as "the insurer is no longer able to raise a defense and that defense was available in the underlying case". This is a very favorable ruling of law for the insureds. It has a particular impact on the duty to defend. In many prejudice states, the insureds will hire their attorneys, often very expensive attorneys, to carry out the defense and let the case go on for years and then at some point notify the insurers and ask for reimbursement of all defense costs. The insured will argue there is no prejudice because it had the best counsel available. The insurers will say wait a minute, we wouldn't have hired such expensive counsel. That is not a defense because that is not prejudice. Some prejudice states have cut back on that ruling and said that the insurer is only responsible for the defense costs once it is put on notice, even if notice is not late. It doesn't have to reimburse for defense costs incurred prior to the notice.

New York on the other hand is a "no prejudice" state. If notice is untimely, the insurer does not have to prove a thing. Most courts in New York have held that anything more than twenty to thirty days is untimely as a matter of law, unless the insured has a good reason for being that late. The good reason may be that it didn't know the identity of the insurer or how to contact them which is a common problem that occurs. Another more difficult argument is that the insured had a reasonable belief in non-liability. This particularly comes up in notice of occurrence situations. New York courts will usually hold that the reasonableness of that belief is a question of fact for the jury. In the non-prejudice States such as New York, there is usually also a duty on behalf of the insurer to respond on a timely basis to claims. That is, timely notice goes both ways.

Once the insurer is put on notice it must either accept coverage or deny coverage within a very short period. In New York, the common law is that anything

more than 20 days is unreasonable and the insurer will have been deemed to waive any defenses if it doesn't respond. As with the insured, the insurer can argue that it has a reasonable excuse for the delay in determining coverage, such as it needed more information from the insured, it cannot find the policy, etc. These types of excuses will also be strictly construed by the courts, but if they are reasonable they are upheld. For this reason, most insurers routinely include a request for information that is very broad when they acknowledge receipt of a complaint or a notice of occurrence. They also usually include a reservation of rights which states that the insurer reserves all rights to disclaim at a later date should information arise leading it to conclude that there is no coverage.

Some insurers are under the mistaken belief that a reservation of rights is a magic letter, but many states do not honor such reservations, including New York. There are many cases in New York which state, "I don't care what the insurer reserves, he still has to respond within twenty days". In general, the courts would be much more favorably disposed to an insurer who steps up and defends the insured under a reservation of rights and continues an investigation. However, even in that case, there are decisions where the court said that the insurer will have been deemed to have waived its rights by virtue of its act of defending the insured. These issues often are dramatically affected by what the insurer is disclaiming, whether they are disclaiming the duty to defend or the duty to indemnify. The duty to defend is much broader as I have previously stated. The courts usually strictly construe any kind of disclaimer on the duty to defend.

I. Missing Policies

With the advent of latent manifestation claims it became very common to have claims arising under policies that may have been ten, twenty, thirty, or more years old. Many businesses did not routinely retain these policies and the insurers did not retain them either. The brokers are usually not much better. This was exacerbated by the common practice of just sending out declarations pages and endorsements without the actual policy language.

Generally, the law in most states is that if the policy is missing, then it becomes a question of fact as to whether the policy exists and what its terms are and the burden is on the insured to go forward. However, the courts have generally accepted virtually anything as evidence of a standard form CGL, including most certainly a binder or certificate of insurance. This issue very closely affects what will happen in the allocation stage in a continuous trigger situation.

There is an example of a certificate of insurance on page 7 of the materials and an example of a binder on page 4. The certificate of insurance is what you want to request if you want to see if one of your vendors or one of your subcontractors, etc., is insured. Generally, you don't want to request a copy of the policy instead of a certificate, although it is always nice to have a copy of the policy as well as the certificate. The certificate says that some entity, usually a broker, certifies that a policy has been issued with the following terms. It further obligates the party certifying the insurance to put the

certificate holder on notice if anything changes in the coverage. This at least gives the certificate holder another target to go after if the correct insurance was not obtained. If you have a copy of the policy, that doesn't guarantee that the policy has not been changed by endorsement, declarations or even cancelled. Therefore, a copy of the policy itself it no assurance that the policy really exists.

A binder is a contract from a broker, although it could be from the insurer directly, that states he promises to issue a policy or that a policy will be issued with the following terms. It is not the same thing as a certificate. It is also not the same thing as getting insurance. A binder does not obligate the insurance company unless it is the insurance company issuing the binder. However, it does give the insured a target to go after. If you receive a binder, you should make sure you follow up and get a copy of the actual policy if you are the insured.

J. Other Clauses

There are numerous other clauses that have been litigated and come up from time to time in various coverage cases and these may be found in the endorsements, in the conditions section, or in the definition or agreement section. The issues I described above are generally the most popular ones to litigate and dispute, but anything can come up in insurance and these clauses are worth noting.

1. Named Insured

The named insured is listed in the declarations page. In the case of a large corporation, there is typically an endorsement or a schedule amending the declarations page which adds additional named insureds. All of these insureds are entitled to the benefits of the insurance in its entirety. They are usually alter egos, sister corporations, officers or partners and their existence and their risks have been taken into account by the insurance company in determining a premium.

One thing to note about the named insured, it is different from an additional insured. An additional insured is a third party that is entitled to some limited benefits under the policy. It is usually specified in an endorsement, although it can also be an agreement. For example, additional insured is typically a vendor, a general contractor, a customer, a landlord, a mortgagee or a bank. The additional insured endorsement states that these entities are entitled to benefits arising out of a particular risk, such as the named insured's work, the named insured's product, the named insured's land, property, etc. It should be fairly obvious that the additional insured in not covered for his own liabilities and risks that have nothing at all to do with the named insured. Thus, for example, if you’re a retailer, you will typically require a vendor's endorsement which makes you an additional insured on your vendor's insurance policy for any liability arising out of the vendor's products. However, that insurance does not cover the retailer for his general retail operations. He has to purchase his own insurance for that risk. In practice, the retailer's insurance should be broad enough to cover everything it does

including liability arising out of the products it sells. The additional insured endorsement gives it additional (and primary) coverage.

Another thing to note about named insureds: insurance contracts are very different from other contracts in a number of respects but in one in particular that corporate lawyers always seem to forget: an insurance contract cannot be assigned. Often times you will see a corporate deal that says, "all of our rights and ownership interest in this insurance policy are hereby assigned to the buyer", etc., but that is completely improper and will not be upheld. If you stop and think about it, it should be obvious that one company can't assign its insurance policy to another company. The contract is personal to the risks of the named insured and a premium has not been charged for the risks of anybody else. Therefore, a gas station can't assign its insurance contract to a dry cleaner because the risks are completely different and difference premiums are charged. We should distinguish this issue from a claim against an insurer which can be assigned but the insurance itself can never be assigned unless, of course, you obtain the permission of the insurer and then effectively you are getting a new policy issued and a new premium is going to be charged.

This issue has come up in at least one case of which I am aware in a lower New Jersey court where an insurance policy that was issued to the trust department of a bank received a claim on it from an heir of an estate that the bank was administering. In turns out that the property at issue had a hazardous waste problem and the heir didn't bother to purchase insurance before he accepted title to the property. Accordingly, he was liable under various state and federal laws for the cleanup of the site and he had no insurance, so he tried to get coverage through the bank's policy. The insurer moved for summary judgment arguing that an insurance policy cannot be assigned even though in that case the bank's trust department had actually drafted an agreement purporting to assign the insurance policy. The lower court ruled against the insurer and said the policy runs with the land, as if the insurance policy was a negative covenant on the property. That case was settled before it went to the appellate court, but that is an unbelievable ruling.

2. <u>Duty of Cooperation</u>

The conditions section contains a duty of cooperation which is found in every type of insurance policy. The CGL states the insured must cooperate with the insurer. Typically, cases arise where the insured fails to supply information to the insurer that is necessary for the defense or fails to show up for depositions or trial, etc. An insurer can disclaim under such circumstances even if it has already accepted coverage.

3. <u>Misrepresentations</u>

There is always a clause in every insurance contract that says the insured can not misrepresent the facts or the risks to the insurer, either in the application which is made part of the policy or the policy itself. If it is discovered that a material fact has been misrepresented, the insurer can disclaim even if the claim would be otherwise covered.

4. **"Other Insurance" Clause**

This clause has been the source of a tremendous amount of litigation particularly in construction cases where there are agreements from various parties to indemnify each other. The standard clause says that, "if any other insurance is applicable to this claim then this policy will be excess to such other insurance". The problem is obvious: if all the contracts contain the same clause, they all claim to be excess to each other. The resulting caselaw has generally been a mess and is always factually intensive. There are quite a few cases that just simply split the baby and make every one of the insurers pay an equal portion. The problem with that particular theory is you could end up with a windfall of multiple insurance limits, so instead of having a combined total, for example, of one million dollars per occurrence, with all the cross-indemnity provisions you could end up with ten million dollars per occurrence. That is not really a windfall so much to the injured party or the insured as it is to the excess insurers or umbrella carriers who should have had to kick in after the first million dollars is exhausted, for example.

5. **Miscellaneous Clauses**

There are other clauses concerning the right to sue, forum, etc. These rarely come up except in the largest of cases. Again, it is important to know that they exist and you should look through these clauses because you never know what is going to pertain to your particular case, especially if it is one of these very large, mega coverage cases.

V. **EXCESS ISSUES**

There are a number of issues that are unique to umbrella and other types of excess insurance policies.

A. **Exhaustion and Drop Down**

The basic agreement in an excess policy is that the policy only picks up coverage when the underlying policy has been exhausted: i.e., indemnity limits have been paid in full. In theory this should be a fairly straightforward calculation. The primary insurer either has or hasn't paid out the full amount of its indemnity limits. However, exhaustion issues arise in a number of contexts. For example, if the underlying policy is missing and the underlying company has gone bankrupt, the insureds have argued that the excess insurers should "drop down" to pick up the missing coverage. Virtually no courts have accepted this argument. Although it is unfortunate to the insured if the underlying company goes under, the umbrella carrier was paid a premium based only upon the existence of underlying policy. It is up to the insured to make sure that it is buying policies from highly rated insurance companies that are less likely to go bust and the risk is properly placed on the insured. Additionally, there is no "drop down" when the policy is simply missing. This should be the insured's responsibility and not the insurers.

Another type of exhaustion issue arises when the underlying liability appears probable and is likely to exceed the modest indemnity limits of the primary policy. For example, in a very significant wrongful death claim, liability may well exceed millions of dollars and the primary carrier only has a hundred thousand or two hundred thousand dollars worth of insurance. The underlying carrier may try to avoid the duty to defend by tendering his indemnity limits to the insured or to the umbrella carrier and then asking the umbrella carrier to defend. These cases have been hotly contested and tender has been accepted in some circumstances. This varies from jurisdiction to jurisdiction, so you would have to look at what the law is in your particular jurisdiction regarding these kinds of issues. In general, it simply makes sense for the umbrella carrier to take control of the defense where it is clear that the umbrella carrier has the most significant interest in the case. On the other hand, the cost to defend often vastly exceeds the cost of indemnity and this is the primary cost that goes into factoring the premiums paid for the primary policy. Therefore, to allow the primary insurer to avoid the costs of the duty to defend may be quite unfair as a matter of law and economics. The language of most umbrella policies permits them to associate with the defense if they so choose and if it's clear that the liability limits are likely to exceed the primary policy. Most umbrella carriers will appoint at least a monitoring counsel to keep an eye on things and make sure that the primary insurer is doing the proper job. Where it gets messy is if the primary insurer doesn't do the proper job.

B. <u>Following Form</u>

As I have previously explained, the excess policies normally state that they "follow the form" of the umbrella policy with the exception of indemnity limits. In some cases there are other exceptions and, in particular, the duty to defend. It wouldn't make much sense for an insurer to have various policies in the same policy year with differing language and agreements that conflict with each other.

Some of you may have heard the expression, "follow the fortunes". That is a different issue from following form. "Follow the fortunes" generally pertains to reinsurance and it refers to an axiom of law that says that the reinsurers can not begin to re-litigate the underlying claim. This does not stop the reinsurers from raising reinsurance coverage issues.

C. <u>Justiciability</u>

This has become an increasingly popular issue, in which excess carriers argue that the underlying claim is not likely to exhaust the indemnity limits of the policy underlying their excess policy and therefore the claim should be dismissed without prejudice because the claim is not yet "ripe" or justiciable. The language goes back to the uniform declaratory judgment act which is an unusual law in itself and what is important to remember about the declaratory act, in terms of justiciability, is that it does allow lawsuits to proceed even where there are not yet any damages. That sometimes can lead to many insurers being included in a suit where they really have no interest because their limits are not likely to be reached.

VI. Complex Case Management Issues

There are many simple coverage cases but more often than not, these cases become very complex because they involve a number of insurers and usually a number of insurers over a number of years. It is also not uncommon for there to be multiple underlying claims that give rise to the various coverage issues. As you might expect, the more money that is involved, the more people that are involved, the more claims that are involved and the more attorneys that are involved, the more complex the case becomes.

The effect is to magnify every little issue in the case to such a degree that the case slows to a halt, as every little issue is hotly contested. I wrote an article on management of such cases which appeared in Mealy's, an insurance coverage reporter, approximately ten years ago and has been cited by a number of legal scholars. If you are not familiar with these cases, you might find it useful.

A. Steering Committee

Typically, the cases are organized by a Steering Committee. The counsel that serve on the committee are usually the attorneys that represent the insurers with the most at risk in the case. They are willing to take a much more active role in the case because of their increased risk and typically these insurers have policies that are primary or umbrella or otherwise relatively low level. The insurers with less risk are generally quite happy to tell their attorneys to sit back and just monitor what the Steering Committee is doing.

B. Joint Defense Group/Fund

Usually the first thing a Steering Committee does is formalize a joint defense group which consists of all the insurers. The most important part of the formalization, besides a joint defense agreement, is deciding on the amounts to be contributed by each insurer to a joint defense fund or to pay for common defense issues. The common defense costs include such items as document copying, joint defense meetings, joint experts, services that computerize all the documents, court reporters, transcripts, etc. This is often the first big fight among the defendants in a complex coverage case. In general, the insurers will arrive at some sort of equitable formula in which the insurers with the most at risk will pay the highest percentage of the joint defense fund and the insurers with the least at risk will pay the least amount. Everybody ultimately agrees to it because it is in everyone's interest. The agreement then usually provides that any significant decisions will be made by a vote that is weighted by the amount of money that a particular party is contributing to the joint defense fund, so that the insurers that are paying the most money also have the most say in how it is spent. The agreement is good for the insurers with a lot a risk because if they were to go with it alone, they would have to incur all these expenses anyway and they get carriers with relatively small risk to chip in. The excess carriers don't want to spend a lot of money getting copies of documents and attending every deposition, etc. The joint defense fund

allows them to get copies of the documents and get access to joint defense work product for a fraction of what it would cost for them to do it on their own. While each excess carrier may only be paying a relatively small amount compared to the main insurer at risk, there are usually many more excess insurers and that amount, therefore, adds up to a significant contribution.

C. CMO, Protective Order, Discovery Plans and Other Good Stuff

Once the joint defense group is organized, usually the next task is to draft a case management order or "CMO". The law in virtually every jurisdiction allows the parties to stipulate to changes in the usual procedural law so that the case can be managed more effectively and efficiently. The first thing the CMO does is recognize the joint defense group and joint defense work product. Plaintiffs are very happy to allow the defendants to unify into one group because it allows them to deal with one set of discovery demands and one Steering Committee instead of hundreds of law firms with separate discovery demands. The court is very happy to consider it as well because it makes things much simpler for everybody and it only has to deal with one lead counsel. Typical things that may be included in the case management order, besides the joint defense group itself, will be time frames for completion of certain types of discovery and maybe some kind of discovery plan which organizes the process, and again, tries to minimize duplication and expense.

Discovery plans are crucial in a complex case. In talking about multiple personal injury plaintiffs such as in a latent toxic tort claim involving say asbestos or lead or latex gloves or whatever it is, you may be talking about thousands or hundreds of thousands of plaintiffs in multiple jurisdictions across the country involving all kinds of underlying counsel. If it is an environmental case you could be talking about hundreds of hazardous waste sites across the country. It will become a matter of necessity to pick a sampling of sites or a sampling of claims, but be aware that whatever legal rulings are achieved on these claims are going to apply to all claims. Accordingly, selection of claims is a very significant strategic issue. It will likely affect every other claim in the case and the law that is applied to them. In an environmental case, for example, the insured would be better served by picking sites where he is a so-called "offsite generator". These are typically landfills where the insured usually has done nothing to cause the contamination other than the fact that some of its wastes have ended up in a landfill. The insurers would be much better served by taking discovery on sites that the insured actually owns, as these are likely to be manufacturing facilities where dumping and long term pollution has gone on and where the facts would support numerous defenses. The location of the sites is important as well because it may affect the choice of law that is provided.

D. Legal Issues

In a complex coverage case every little legal issue becomes far more important because it could affect millions and millions of dollars that are at issue.

1. **Choice of Law**

Probably the most significant issue for insurance purposes is the choice of law. Insurance law is controlled by the state and may drastically differ from state to state. Most courts in most jurisdictions apply the modern theories of choice of law, which generally say that the laws of the location with the most significant contacts govern. There are a couple of things to remember about choice of law. In the vast majority of cases, the judge will apply the law of the jurisdiction in which he sits. No matter what the facts indicate, most judges will find a reason to apply their particular state's law. The second thing to remember is that they will rarely apply different law to different parts of the insurance contract. Finally, once a court chooses the law to apply it usually will find a reason to apply it to every other claim at issue in the case, even if they are in other jurisdictions. For all these reasons the choice of forum is as critical as the choice of law.

2. **Choice of Forum**

The choice of forum is often times the first battle in a complex coverage case because of its impact on the choice of law and because the law varies so much from state to state. The general rule is that the jurisdiction where the first coverage case was filed should retain the case, unless the second filed action is a more comprehensive and complete action and will afford, therefore, a more final and complete relief. Courts do not follow the first filed action religiously, particularly where the only difference is a difference by a few days. Recently in the *Mobil* case in New York Supreme Court, the lower court completely ignored that factor for that reason, and transferred the case to Texas.

Beyond the *conveniens* type analysis, there is a secondary argument which was raised successfully in a large coverage case involving *CPC International* in New Jersey, using the Uniform Declaratory Judgment Act as a basis to dismiss cases.

3. **Declaratory Judgment Act**

The Uniform Declaratory Judgement Act is an interesting statute because it is one of the very few statutes in all of American law that allows a lawsuit to be filed before there is damages. A claim is "ripe" under the declaratory judgment law as long as there is an actual case or controversy and all interested parties to the claim have been joined to the lawsuit. The second factor is particularly important, because the court wants to afford complete and final relief and does not want to entertain repetitive actions. Therefore, if there are parties with an interest in the outcome that are not joined, the court may grant dismissal. Thus, the Act can serve as alternative argument to a *forum non conveniens* argument.

An interested party is not the same thing as an "indispensable" party, although there are cases which suggest the two are equivalent. A party may be interested who is not otherwise indispensable. The most important interested party besides the insureds and the insurers is the underlying claimant. In the case of an environmental

claim, the underlying claimant may well be a state agency or a state government which can not be joined in another state. That argument was made in the *CPC* case in New Jersey which involved a single large hazardous waste site that was located in Michigan. The insurers successfully argued that the Michigan Department of Natural Resources was an interested party and should be joined and could only be joined in Michigan. The court dismissed the case and sent it to a state with much more favorable law to the insurers.

You may often want to join the various state or federal agencies into environmental coverage cases case to make sure they are bound by the determination. In another New Jersey case called *Continental Vanguard,* the state agency tried to avoid joinder saying it was, in essence, pre-action review under the federal CERCLA law which is otherwise barred. The court rejected the States argument when the State's attorney said that if the agency was not joined, it would not be bound by the determination of the coverage action.

4. Direct Actions

In *Continental Vanguard,* the court rejected the argument of pre-action review because it did not want the specter of repetitive actions and nonfinal relief. This is something you must be sensitive to in states such as New York and New Jersey where, depending upon the facts, the insured may have the right of a direct action against the insurer and will not otherwise be bound by the determination in the coverage action.

In New York, the parties must also be particularly sensitive to coverage cases involving personal injury. The insurer as a matter of statutory law must send a copy of the disclaimer to the injured party as well as the insured. If the insurer fails to do so, even if he has appropriate coverage defenses against the insured, the injured party will not be bound by it. Indeed, the law holds that coverage defenses will be waived if the injured party is not send a copy of the disclaimer, unless there is no coverage at all. That sounds confusing, but what it means is that if the insurer is disclaiming because the insured failed to meet a condition precedent such as notice, or the duty of cooperation, or because of an exclusion, the courts will generally hold that the insurer waived the defense by not sending a copy of the disclaimer to the injured party. If the claim is the type that is not even contemplated by the agreement then the failure to notify the injured party will not create coverage. Interestingly, there was a related case recently in New York, in which the Appellate Division held that an insurer's failure to disclaim completely for a breach of contract claim did not create coverage by waiver even though contract coverage was excluded by an exclusion. The courts seemed to understand that intentional conduct is not that kind of thing that is covered by an insurance contract, even if the language barring the coverage may be contained in an exclusion.

5. Defense Costs

We already touched on this issue previously when we talked about claims. The issue here is that if the insured is responding to the statutory liability it may be

responding to agency demands. The insured's obligations may well be outside the justiciable realm of a "defense cost".

CONCLUSION

This concludes my general survey and introduction to the comprehensive general liability (commercial) insurance policy. Again, let me emphasize that a detailed discussion of almost any of the issues that I have raised here could itself take weeks. I have given you the general rulings of courts but be advised that in many cases there are numerous minority opinions and it varies from jurisdiction to jurisdiction. You must always check the current law in the jurisdiction in which your claim arises, assuming that is the law that is going to be applied to the claim. Moreover, many of the current law arises out of lower court opinions, and therefore the law is always evolving. There are decisions coming out daily in slip opinions. The point of this course is to make you feel comfortable in at least reviewing insurance policies, knowing what to look for and knowing what the likely issues are. Should you have any questions please feel free to email me at *rfogel@mrbr.com*.