SYMPOSIUM—INSURANCE LAW FOR THE 1990s

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EDITOR'S PREFACE

This symposium on insurance law represents the first time that a business of any kind has sponsored an issue of the Northern Kentucky Law Review. Because of the foresight and generosity of National Underwriter, as well as the efforts of Mead Data Central, the law review is now well equipped to keep abreast of the many technological advances in publishing and in legal research.

The idea for an insurance issue was born in a committee meeting a year and a half ago, when I suggested that the law review would be foolish if it didn’t take advantage of the contacts and expertise of staff member Bruce Hillman. Bruce works for The Fire, Casualty and Surety Bulletins, in addition to meeting the demands of law school, and his phone calls and letters produced our outstanding lineup of authors who have wide-ranging backgrounds in insurance.

Once our authors were committed, Bruce suggested that perhaps the insurance theme could provide a springboard for replacing our outmoded and dilapidated computers and printers. He contacted his colleagues at Cincinnati-based National Underwriter, and they graciously agreed to donate new equipment and technical expertise. On behalf of all of us at the law review, I extend my deepest appreciation to Mr. Clarence Barnes, National Underwriter president; to Mr. Garry Baumgartner, a Chase alumnus and National Underwriter editorial director; and to Mr. E.F. Wolters, editor of The Fire, Casualty and Surety Bulletins. Their efforts will ensure that the law review has the modern tools it needs for publishing in the 1990s.

Finally, I would like to acknowledge the efforts of Ms. Greta K. Southard, a Cincinnati-based representative of Mead Data Central. Ms. Southard was the driving force in ensuring that the law review has the latest in computers, printers, and software to conduct its legal research. Our equipment overhaul would not have been complete without her perseverance.

— R. Stephen Burke
Editor-in-Chief
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DEDICATION:
L. STANLEY CHAUVIN, JR.

I am deeply honored and privileged to have the opportunity to draft a bit of dedicatory prose honoring an outstanding lawyer and humanitarian, L. Stanley Chauvin, Jr. For the last three years, Salmon P. Chase College of Law of Northern Kentucky University has been greatly benefited by having Stan Chauvin, the current President of the American Bar Association, as the Chairman of its Board of Visitors. His dedication to Chase, as well as all law schools, and the prominence he has given legal education issues during his leadership of the American Bar Association provide the impetus for dedicating this issue of the *Northern Kentucky Law Review* to Stan.

Stan Chauvin first extended a helping hand to the College of Law when it joined the Commonwealth of Kentucky legal education system in the fall of 1972. By assisting the American Bar Association in the reaccreditation of the school, he endeared himself to faculty and students alike while demonstrating a commitment that would continue until the present day. It is certainly no surprise than an intellectual of Stan's attainment would find friends on the faculty and student body of a law school; what is unusual is the beneficiary law school was neither his alma mater nor that of his children or close friends. Rather, he made a commitment of assistance to a law school striving to achieve academic excellence, and with his assistance, that goal has been reached. During the last 18 years, Stan has made countless visits to campus for every conceivable formal and informal purpose including providing addresses at commencement, at Awards Day, and at annual fund-raising dinners. All this has been accomplished while he has served as Chairman of the House of Delegates of the American Bar Association, as President of the American Judiciary Society, and on numerous civic organizations throughout the city of Louisville and the Commonwealth of Kentucky. His tenure as President of the American Bar Association has been proactive on behalf of legal education, and he has attempted to acquaint all with whom he has come in contact of the pressing needs of academe. All persons interested in or connected with first-degree professional legal education can take comfort in the fact that our load has been
lightened by Stan Chauvin. As we know that his presidency of the American Bar Association is but another predictable milestone in a brilliant legal career, we look forward to having the benefit of his intellect, insight, dedication, and gentle good humor for many years to come.

Thank you, Stan—from all of us.

—Henry L. Stephens, Jr.
Dean, Salmon P. Chase College of Law
This Foreword, as well as this symposium issue, addresses some of the most serious problems within the field of insurance. The insurance industry, both life and casualty companies, is under fire across the nation. The results of Proposition 103 in California indicate that consumers have the perception, rightly or wrongly, that their interests are being ignored by the insurance industry and by their state legislators. The industry needs to correct this public image — not by spending millions for institutional public relations but by listening to its customers, its policyholders.

There must be a change on the part of consumers and insurers — a change from an adversarial attitude to one of understanding. There are several ways to do this.

First, insurance companies should invest in and support alternative dispute resolution. They should utilize mediation and arbitration in handling disputes. Often, when these negotiating tools are used, the adversarial fire goes out of a complainant. Once complainants have had fair hearings and have had their points of view heard, their feelings of anger and hostility toward the insurance company diminish, even when the company prevails in the hearing.

Often the first contact that many consumers have with any insurance person, other than their agent, is when they have a claim and are face to face with what they consider to be an arbitrary insurance adjuster. Sometimes the complainant is correct and has been subjected to an adjuster who may have been over-enthusiastic in denying the claim. Often the adjuster is correct but lacks the skills to say “no” gracefully. Sometimes this creates an impasse. It is at this point that companies have

* George Fabe is Director of the Ohio Department of Insurance.
an opportunity to smooth out the rough spots. The use of a mediator can create a kinder and gentler system and still allow companies to deny claims without creating anger.

It's not enough for the industry to rail against sympathetic judges, soft-hearted juries, and bounty-hunting lawyers that hand out money to claimants as if they had won the lottery. The industry must get to the root causes of consumer unhappiness.

Second, insurance companies should hire consumer activists to work, in house, with company staffs. Companies should set up an ombudsman's office to address special dispute situations. The ombudsman's office would function in two ways. It would help train adjusters in ways to negotiate with complainants and would step into situations that have hit the impasse level.

The companies should do this, not in an effort to co-opt or "throw a bone" to consumers, but in good faith with an intent to help make the system function more smoothly. One of the early American retailers coined the business slogan, "The customer is always right." The industry should try a liberal dose of this maxim.

Certainly there will be attempts by some insureds to overreach in their dealings with insurance companies, but most people are honorable. Treat them fairly, give alternative dispute resolution and the ombudsman a chance, and you can change consumer attitudes. I think it will work better and be less costly.
Since the 1980 enactment of the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA, 42 U.S.C. § 9601, et seq.), the cleanup of environmental contamination has become a top concern across the country. CERCLA, and a spate of similar state laws, impose strict joint and several liability on individuals and businesses that have generated, transported or disposed of hazardous substances. Liability is for the costs of cleaning up facilities where those hazardous substances have escaped into the environment. Since such costs can be staggering, not surprisingly the liable parties are looking to their insurers for financial relief.

This article explores one aspect of the controversy surrounding the availability of insurance coverage for cleanup costs. Specifically, assuming there is coverage for this type of loss, and that a number of successive policies were in effect over the period of time the damage was taking place, will or should the insured be

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1. The Environmental Protection Agency (EPA) has estimated that the average cost in 1988 dollars to clean up a site listed on the National Priorities List (NPL) is approximately $19,020,000. See 54 Fed. Reg. 33,846-33,850 (Aug. 16, 1989). The NPL is a list of sites considered national priorities among the known or threatened releases of hazardous substances, contaminants or pollutants throughout the United States. There are presently 889 sites on the final NPL, with another 337 sites proposed for inclusion on the list, for a total of 1,226 NPL sites. Id. at 33,846. Thousands of other sites have been identified as priorities at regional and local levels.

2. Insurers have successfully argued that, under the facts existing in particular cases, coverage is absent for an environmental cleanup claim because (1) there is no "occurrence;" (2) there is no "bodily injury" or "property damage;" (3) cleanup liability does not constitute "damages;" and/or (4) the "pollution exclusion" negates coverage. These and other related coverage issues are addressed in a multitude of published opinions, as well as in the literature, and will not be dealt with in this article.

3. See discussion in Part I, infra.
entitled to recover the sum of the limits of all applicable policies? Judicial decisions on the issue are virtually nonexistent in the context of environmental liability coverage disputes, and to the extent decisions have been rendered in analogous cases, they are inconsistent and contradictory. The authors consider the various approaches to the problem, their underlying assumptions, and the possibility that a uniform resolution is possible.

I. INTRODUCTION: THE NATURE OF THE PROBLEM

Most liability policies are designed to respond to losses, such as automobile accidents, which occur instantaneously. Losses of this nature are relatively easy to identify because damages are both immediate and finite, and can be measured quite simply against the limits of the policy or policies in effect on the date of the accident.

On the other hand, losses where damage develops unrecognized over an extended period of time, such as bodily injury claims for toxic exposures and property damage claims for environmental contamination, are more difficult to pinpoint both in time and in degree. In these cases, correlating degrees of damage to particular points along the loss timeline may be virtually impossible. This has led to substantial uncertainty as to how responsibility for such losses should be allocated where multiple insurers have issued successive policies to the insured over the period of time the damage was developing.

Environmental cleanup liability is usually the result of waste disposal activities. Environmental claims generally share several characteristics. These include: (1) the damage arises from the insured's regular (and in most cases legal) activities at the facility during the ordinary course of its business; (2) the damage takes place over an extended period of time; (3) the damage remains unrecognized during most of that period of time; (4) the damage is cumulative; (5) multiple, successive policies of insurance were issued to the insured over the period of time the damage was developing; and (6) the amount of the claim exceeds the liability limits available under any single policy, and may exceed the limits of all policies combined. Because the costs of cleaning up a contaminated site are so substantial, both insureds and insurers are economically motivated to establish that cleanup liability should be borne by the other.
An insured's quest for coverage begins with a review of the applicable policy language. Because an insurance policy is simply a contract, the amount of coverage available for an environmental cleanup claim, as well as allocation of liability between any applicable policies, should be determined properly by focusing exclusively on the contractual provisions.

II. TRIGGER OF COVERAGE

Liability policies generally cover only losses that "occur" during the policy period. Thus, to establish coverage under a particular policy, an insured must demonstrate that damage "occurred" while the policy was in effect.

4. In the standard comprehensive general liability (CGL) insurance policy, the insurance company agrees to pay on behalf of the insured:

all sums which the insured shall become legally liable to pay as damages because of bodily injury or property damage to which this insurance applies caused by an occurrence, and the company shall have the right and duty to defend any suit against the insured seeking damages on account of such bodily injury or property damage, even if any of the allegations of the suit are groundless, false or fraudulent.

An "occurrence" is defined by the standard policy as:

an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.

Most standard policies also contain a provision that:

For the purpose of determining the limit of the company's liability, all bodily injury and property damage arising out of continuous or repeated exposure to substantially the same general conditions, shall be considered as arising out of one occurrence.

Likewise, the typical "other insurance" provision of a liability policy reads as follows:

When both this insurance and other insurance apply to the loss on the same basis, whether primary, excess or contingent, the company shall not be liable under this policy for a greater proportion of the loss than that stated in the applicable contribution provision below:

(a) Contribution by Equal Shares. If all of such other valid and collectible insurance provides for contribution by equal shares, the company shall not be liable for a greater proportion of such loss than would be payable if each insurer contributes an equal share until the share of each insurer equals the lowest applicable limit of liability under any one policy or the full amount of the loss is paid, and with respect to any amount of loss not so paid, the remaining insurers then continue to contribute equal shares of the remaining amount of the loss until each such insurer has paid its limit in full or the full amount of the loss is paid.

(b) Contribution by Limits. If any of such other insurance does not provide for contribution by equal shares, the company shall not be liable for a greater proportion of such loss than the applicable limit of liability under this policy for such loss bears to the total applicable limit of liability of all valid and collectible insurance against such loss.
If damage "occurs" at a single point in time, only a single policy will provide coverage if only a single policy was in effect on the date in question. In environmental contamination and toxic exposure cases, however, the damage usually cannot be traced to having "occurred" at a specific point in time because the damage began, developed and existed continuously, while remaining unrecognized, for several years before it was discovered. Theoretically, at least, damage has therefore "occurred" or been "triggered" along a continuous timeline during which several successive policies issued to the insured were in effect.

In the context of insurance coverage disputes arising from toxic exposure to asbestos, the courts have adopted at least four different trigger-of-coverage theories. The differences appear to arise from the courts' desire to maximize the coverage available to particular insureds, since different theories will provide more or less coverage depending upon the particular facts, and not from a disregard of the provisions of the insurance policies themselves. Indeed, the policies are silent on what triggers coverage in a progressive-injury situation.

One theory provides that injury or damage occurs during the years the individual is exposed to asbestos. This is known as the "exposure theory."  

A second theory provides that bodily injury occurs at the time an asbestos-related disease becomes reasonably capable of medical diagnosis. This is known as the "manifestation theory."  

The third theory provides that injury occurs continuously from first exposure to manifestation. This is known as the "triple trigger" or "continuous trigger" approach.

6. This ad hoc approach to insurance coverage served the courts well in dealing with personal lines insurance. Its use in big-dollar commercial insurance coverage litigation reveals its lack of logical and analytical underpinnings. In addition, its inherent lack of predictability has created a litigation bonanza for lawyers.
Finally, a fourth theory provides that only the coverage in effect when the injury in fact occurred, regardless of exposure or manifestation, is triggered. This is the "injury in fact" theory. 10

Only a few courts have addressed the "trigger of coverage" question in cases involving coverage for environmental contamination. The initial problem involves identification of the event which actually triggers coverage: the injury, its cause, or both. 11 There are clearly parallels between asbestos claims and hazardous wastes claims in this respect. As one observer has noted:

The dumping or discharge of the waste is akin to initial exposure to (i.e., inhalation of) asbestos; the leaching of the wastes into the ground and subsurface reservoirs is similar to exposure in residence; and the property damage ultimately discovered is analogous to the manifestation of asbestos-related diseases. 12

Most courts that have considered the trigger question in the hazardous waste context have adopted the coverage-maximizing "continuous" trigger. These courts generally hold that each exposure of the environment to a pollutant triggers coverage. 13

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11. The Third Circuit Court of Appeals offered the following observations on this question:

Exactly what event would, as a legal matter, trigger liability in a toxic waste case may be subject to some controversy. The district court and the parties to this case have not addressed this legal issue; that is, whether the dumping of the wastes is the "occurrence" upon which coverage would be based; or whether the leaching of these wastes is the "occurrence"; or whether the discovery of the pollution is the "occurrence."

Riehl v. Travelers Ins. Co., 772 F.2d 19, 23 (3d Cir. 1985). The record before the court was silent as to when any of these events took place. Thus, the court felt it could not resolve the legal issues until these disputed facts had been decided.

12. Howard, supra note 5, at 630. See also DiMugno, Insurance Coverage For Hazardous Waste Cleanup Costs, 1 INSURANCE LAW BRIEFINGS 89, 109 (Aug. 1988), observing that "[i]n hazardous waste cases, as in asbestos cases, the disease process occurs over time with damage occurring at each state of the process."

However, a number of courts have adopted an "injury in fact" trigger. Under this theory, all policies in effect when the property damage occurs are triggered. Since property damage usually occurs in the hazardous waste context almost continuously from dumping until discovery, an "injury in fact" trigger is not too different from a "continuous" trigger in the environmental coverage context.

Likewise, a few courts have adopted what essentially amounts to a "manifestation" trigger. These decisions hold that only the policy or policies in effect at the time the environmental damage is "discovered" are triggered.

Still, most courts appear inclined to adopt the trigger that will maximize the insurance available to cover the loss: The more policies triggered, the more likely the insured's losses will be covered, and the more coverage potentially available to indemnify the insured for its loss. Thus, "determination of the trigger of coverage sets the parameters for which policy periods will be considered."

III. NUMBER OF OCCURRENCES

After all triggered policies are identified, the next inquiry focuses upon determining how many "occurrences" comprise the loss. The number of occurrences will affect how much total coverage is available, when any particular policy's liability limits have been exhausted, and how often a policy's deductible or self-insured retention must be absorbed by the insured. Thus, determining the number of occurrences is central to determining whether the insured will be fully compensated for the loss.


16. Murphy & Caron, Insurance Coverage and Environmental Liability, FED'N. INS. & CORP. COUNS. Q. 353, 361 (Summer 1988). But see Howard, supra note 5, at 633 n.33 (observing that when the beneficiary of the insurance proceeds is an identified polluter, as opposed to an innocent asbestos victim, "the need to maximize coverage will be perceived with somewhat less conviction").
In insurance coverage cases, courts have developed two separate tests to determine the number of occurrences. The majority of jurisdictions employ the "cause" test, which focuses on the number of causes of the loss. Under this test, there is a single occurrence if there is a single proximate, uninterrupted, and continuing cause of the loss.17

A minority of jurisdictions adopt the "effect" test. This analysis focuses on the number of injuries, rather than upon the number of causes for the loss. Under this test, there will be as many occurrences as there are injuries.18

If the "cause" test is applied to an environmental coverage claim, characterization of the cause or causes of the environmental damage will be extremely important. From one viewpoint, the damage could be characterized as the result of a "single" cause — either the continuous exposure of the property to contaminants, the continuous leaching of contaminants from the ground surface, or the continuous operation of the facility. From another viewpoint, the same damage could be characterized as the result of multiple acts of disposing of waste on the premises, each separate act of disposal being considered a separate cause of the loss, and therefore a separate occurrence. From this same viewpoint, the leaching of the contaminants through the soils and the manifestation of injury or damage might also each qualify as a separate "occurrence" because each is a separate cause of the loss.19

Application of the "effect" test will depend on the number of claims or injuries that resulted from the insured's waste disposal activities. Since usually there will be only a single cleanup claim, a court applying the "effect" test should be constrained to find only a single occurrence.

Courts that have addressed the "number of occurrences" issue in environmental damage cases have been inconsistent. An early unpublished case, Township of Jackson v. American Home Assur-

17. Truck Ins. Exch. v. Rohde, 49 Wash. 2d 465, 303 P.2d 659 (1956) (where driver lost control of his vehicle and picked off three separate motorcyclists one after another, there was only a single occurrence because there was a single, continuous, and uninterrupted act of negligence).

18. Cf. Liberty Mut. Ins. Co. v. Rawls, 404 F.2d 880 (5th Cir. 1968) (per curiam) (while being pursued by police, insured hit first one car then a second car; court held there were two accidents for purposes of determining limits of liability).

19. Howard, supra note 5 at 635; DiMugno, supra note 12, at 104-105.
ance Co.,\textsuperscript{20} where several wells were contaminated by the insured's landfill, appeared to apply both the "cause" and the "effect" theories before concluding that several occurrences had taken place. The court found that the claimants' damages were the proximate result of a "multitude of causes," including negligent siting of the landfill, digging beneath the water table, providing inadequate cover, failing to inspect tank trucks, accepting improper and imprudent amounts of liquid, ignoring signs of contamination, failing to manage prudently the amount of waste accepted at the landfill, and permitting ponding or lagooning of liquids to occur. Accordingly, the court found that the contamination of 97 wells by seepage of toxic chemicals from the landfill constituted 97 separate occurrences.

In a more recent case, Headley v. St. Paul Fire & Marine Ins. Co.,\textsuperscript{21} the court appeared to apply the "cause" test, holding that there was a single occurrence where the discharge of pollutants caused property damage. The court observed that "all subsequent flows causing damage are but varying degrees of the original discharge."\textsuperscript{22}

Courts have found both single and multiple occurrences in other types of long-term exposure cases that are seemingly similar. For example, in Uniroyal, Inc. v. The Home Ins. Co.,\textsuperscript{23} the court applied a variation on the "effect" test and held that multiple deliveries of "Agent Orange" constituted a single occurrence because the deliveries were so "numerous, uniform, routinized and regularized, at such steady and frequent intervals, that they merged into one continuous and repeated event."\textsuperscript{24} Likewise, in cases involving property damage resulting from earth movement, courts often find a single occurrence because the damage is characterized as having resulted from a single condition of progressively worsening damage.\textsuperscript{25} By contrast, in Pittsburg Corning Corp. v. Travelers Indem. Co.,\textsuperscript{26} an asbestos case, the court

\textsuperscript{22} \textit{Id.} at 748.
\textsuperscript{24} \textit{Id.} at 1385.
\textsuperscript{26} No. 84-985, slip op. 1988 \textit{WESTLAW} 5299 (E.D. Pa. 1988).
found multiple occurrences because the cause of the injury was the exposure of each individual worker to asbestos.27

Environmental contamination claims are arguably distinguishable, in that the determination of the number-of-occurrences question may be significantly affected by two factors that are not generally present or relevant in other long-term exposure cases. First, in most environmental contamination cases there will be only a single claim against the insured: the government’s order that the contamination be cleaned up. Thus, application of the “effect” test will not necessarily maximize coverage, as is the case in the personal injury toxic exposure context, where multiple claims are the rule.

Second, the standard policy contains a provision that “all damages arising out of exposure to substantially the same general conditions shall be considered as arising out of one occurrence.” As noted above, usually environmental damage can be characterized as the result of a continuous exposure to pollutants, continuous leaching of pollutants, and/or continuous operation of a disposal facility; e.g., the result of a continuous exposure “to substantially the same general conditions.” Cases that have construed this policy language, albeit in non-identical factual contexts, suggest there is only a single occurrence where environmental damage is the result of a continuous operation of a facility over many years.28

In light of these considerations, a court considering coverage for a single costly cleanup claim should find that a single occurrence has taken place.

27. See also Asbestos Ins. Coverage Cases, Judicial Council Coordination Proceeding No. 1072 (Cal. Sup. Ct., San Francisco County, Dept. 9), Phase IV (August 29, 1988), where the court found that each claim for asbestos-related injury constituted a separate occurrence.

IV. ALLOCATION OF LIABILITY BETWEEN TRIGGERED POLICIES

The remainder of this article assumes the following: 29 (1) a continuous trigger has been adopted and therefore a number of successive policies have been triggered; and (2) there is a single occurrence under those policies. In this situation, is the insured entitled to collect the sum of the limits available under all the triggered policies? If not, to what coverage is the insured entitled, and how should it be allocated between the various triggered policies?

Scant case authority addresses these allocation questions in the context of environmental cleanup liability claims. Nor have the questions received much attention in the literature. Nevertheless, the answers to these questions will have a significant impact upon judicial resolution or private settlement of environmental liability coverage disputes.

To illustrate the various approaches that might be taken to resolve these questions, consider the following hypothetical scenario: For 15 years (1969-1984), the insured disposed of its industrial waste products in a lagoon at its manufacturing facility as a regular part of its business. In 1984, the insured's facility was identified as contaminated. The government ordered the insured to clean up the contamination. The insured did so, incurring $8 million in cleanup costs. The insured now seeks reimbursement of this sum from its liability insurance carriers.

The insured either had no liability insurance between 1969 and 1974, or is presently unable to identify its insurers. Between 1974 and 1979, the insured had $100,000 per occurrence limits under a succession of annual primary policies, and $1 million per occurrence and aggregate limits under corresponding excess policies. Between 1979 and 1984, the insured carried $500,000 per occurrence primary limits on an annual basis and $5 million per occurrence and aggregate limits under corresponding excess policies. The insured changed insurance carriers from time to time, so the various policies were issued by a number of different insurers.

All policies are triggered by the claim, which arose from a single occurrence — the insured's continuous disposal of wastes

29. The assumptions are based upon the authors' view of what appears to be the position taken by the majority of courts which have considered the questions.
during the 15-year period. If the above coverages could be totaled, there is potentially $3 million in primary limits available for the years 1974 through 1984, and $30 million in excess limits for the same years. No coverage is available for the first five years of the occurrence.

A. "Vertical" Allocation of Coverages

In the asbestos context, a number of courts have held that an insured is not entitled to the sum of the limits of successive policies triggered by a single occurrence. The seminal case to this effect is Keene Corp. v. Insurance Co. of North America. In Keene, the court held that each policy triggered was fully liable to the insured subject to the policy's limits and its "other insurance" provisions. However, the court also found that since there was but a single injury (occurrence), the insured could collect under only one of the policies, which the insured was entitled to select. Once the insured selected a policy, the insurer so selected would be entitled to obtain contribution from the other triggered policies pursuant to the various policies' "other insurance" provisions.

The key to the Keene court's decision was its conclusion that there was only a single occurrence. The court's concern was that the insurers' liability for a long-term exposure injury be the same as their obligations for other types of losses. This is a fundamental consideration if consistent results are to be achieved in the various contexts in which coverage issues can arise. For the insurance industry, consistency and predictability are crucial if risk, and therefore underwriting decisions, are to be accurately 30. 667 F.2d 1034 (D.C. Cir. 1981), cert. denied, 455 U.S. 1007 (1982). Other asbestos cases that follow the Keene approach include Owens-Illinois, Inc. v. Aetna Casualty & Sur. Co., 597 F. Supp. 1515 (D.D.C. 1984); ACandS, Inc. v. Aetna Casualty & Sur. Co., 674 F.2d 968 (3d Cir. 1985); and Lac D'Amiante du Quebec, Ltee. v. American Home Assurance Co., 613 F. Supp. 1549 (D.N.J. 1985). The approach has also been followed in a DES case. See Eli Lilly & Co. v. Home Ins. Co., 653 F. Supp. 1 (D.D.C. 1984).

31. Keene, 667 F.2d at 1049-50.

32. Id. at 1050. On remand, the district court held that allocation of the loss pursuant to the policies' "other insurance" clauses was to be done entirely among the insurance carriers, without any participation by the insured. Keene Corp. v. Insurance Co. of N. Am., No. 78-1011, slip op. (D.D.C. June 21, 1982, and May 13, 1983). For a discussion of the Keene trial court's decision following the appeal, see Kahn, The "Other Insurance" Clause, 19 FORUM 591, 612 (Summer 1984).

33. 667 F.2d at 1049. "Keene is entitled to nothing more."
assessed. Theoretically, the amount of coverage available for an instantaneous occurrence should be the same as for a long-term exposure occurrence, since both are but a single insurable event. Allowing an insured to recover the sum of the coverages provided by successive insurers of a continuing occurrence (a “horizontal” allocation of the risk) would lead to the inconsistent result of allowing a larger recovery than in the case of an instantaneous occurrence.

A “vertical” allocation of coverage,34 along the lines adopted by the Keene court, was also applied in a medical malpractice action, Chicago Ins. Co. v. Pacific Indem. Co.35 In this case, a dispute arose between a physician’s primary and excess malpractice carriers. A judgment had been entered against the physician for a claim of malpractice which spanned two successive annual policies that provided primary malpractice coverage. The physician’s excess insurer argued that each of the primary carriers should contribute their full policy limits before it would be required to contribute. The court rejected such an allocation for two fundamental reasons.

First, the court found that, although the physician’s alleged omissions in treatment spanned the two policy periods, there was only a single claim of malpractice because the claimant did not sustain separate injuries each time the physician failed to perform treatment. The physician was therefore entitled to only a “single claim” liability limit under the primary policy, which provided the highest limits. The court reasoned that if “stacking” were allowed, the insured would be given more than was bargained for.36 This reasoning is on target, in that allowing an insured to “stack” the limits of successive primaries in the case of a single, continuing occurrence presents a logical inconsistency. It would allow the insured to recover for a “new” occurrence under each policy (effectively, for multiple occurrences). Conceptually, there is not a new occurrence under each successive policy, but only a portion of the single continuing occurrence that falls within the policy period.

34. By “vertical” allocation, the authors refer to a formula along the lines of that adopted in Keene, where the insured may choose to recover under a single primary policy and, presumably, the excess policy directly above the chosen primary.
36. Id. at 957.
Second, the court relied on language contained in the excess policy which provided that the excess insurer would be liable only for payments in excess of the insured's retained limit, which corresponded to the policy limits provided by the underlying primary. The court felt that, if "stacking" of the underlying coverages were allowed, the excess insurer's exposure would be substantially decreased with each renewal of the primary even though the premiums paid to the excess insurer did not reflect any such change.

In addition to the reasons upon which the Chicago Ins. Co. decision rests, there is another reason why coverage should be allocated "vertically" between primary and excess policies where several successive policies are triggered by a single continuous occurrence. Allowing a "horizontal" allocation of coverages, or horizontal "stacking," would provide a negative incentive for insureds because it would reward insureds with greater coverage for not discovering continuing damage at an earlier date. Insureds should be encouraged to discover insurable damages or injuries at the earliest possible time. This objective would be defeated by allowing an insured to "stack" the limits of all policies in effect when damage remains latent, because the amount of available insurance would increase the longer the damage remains undiscovered.

In our hypothetical, a "vertical" allocation of coverages following the Keene approach would likely result in the insured choosing to collect the full limits of one of the $500,000 primary policies, and the full $5 million limits of the excess policy corresponding to that primary. This would yield total available limits of $5.5 million. The policies so chosen could then allocate liability to the other triggered policies at their respective layers of coverage pursuant to the policies' "other insurance" clauses or some other equitable method of apportionment. At the same time, the insured would bear the responsibility for the remaining $2.5 million of the loss itself.

We are not aware of any published appellate decision where, in the context of an environmental liability coverage claim, a court has allocated liability pursuant to the Keene formula.

B. "Horizontal" Allocation of Coverage

The counterpoint to a "vertical" allocation formula would be a scheme pursuant to which the insured is entitled to the sum of
all coverages triggered by the occurrence. Under this formula, the insured would first be required to exhaust the limits of all primary policies, after which the limits of the excess policies would be similarly available. We shall refer to this as a “horizontal” allocation of coverages.

A “horizontal” allocation of coverages was recently adopted in an asbestos coverage case. In *Air Products & Chems., Inc. v. Hartford Accident & Indem. Co.*, the court found that a single occurrence had triggered a number of successive policies. The court then discussed *Keene* and related cases. It rejected that line of authority and held that the insured could not designate coverage under a particular policy. Rather, the insurer whose policy was first activated must defend and indemnify the insured until the applicable limits of its liability were exhausted, at which point the next-in-time insurer would defend and indemnify until its limits were exhausted, and so on. At the same time, however, if not all limits were exhausted, the insurers could still allocate their respective liabilities for the loss between themselves pursuant to their “other insurance” clauses.

A “horizontal” allocation of coverages has apparently also been applied in earth-movement cases. For example, in *Gruol Constr. Co. v. Insurance Co. of North America*, the court found each of three successive primary carriers jointly and severally liable for the property damage that resulted from a single continuous occurrence of dry rot spanning all of their policy periods. The court also held that the burden of apportioning damages was on the carriers, not on the insured. Although the *Gruol* court did not have before it the issue whether the insured was entitled to recover the sum of its primary limits, since the amount of the claim was less than any single policy’s coverage, arguably it held implicitly that such a recovery would be permissible by imposing

no limitation on the insurers' joint and several obligation. 42

A "horizontal" allocation of coverages has also been sanctioned, albeit with no discussion, in a silicosis case. 43

A party wishing to effect a "horizontal" allocation of coverages could also argue that insurers would receive a windfall unless a horizontal allocation were allowed, since the insured paid a separate premium for each policy and so should be allowed to recover each policy's full limits. Such an argument might be persuasive to a court seeking to maximize the coverage available to the insured, particularly in a situation where a "vertical" allocation of coverages would result in the insured not being fully compensated for its loss.

Of course, a "horizontal" allocation of coverages is the general rule where, in a case involving an instantaneous injury, multiple coverages are available at the primary and excess levels. In this situation, it is clear that all primary insurance policies must be exhausted before the excess policies are required to contribute, and that if necessary to cover the full extent of the loss, the insured will be entitled to the full sum of all available limits. 44 However, this result obtains because it is mandated by the express terms of the policies "other insurance" provisions, which

42. On the other hand, imposition of joint and several liability upon successive insurers of a single continuing occurrence would be logically and legally inconsistent with a horizontal allocation of coverages. Since the liability of each insurer is subject to its policy's limits, no one insurer could be held jointly and severally liable for the insured's total recovery of the sum of all policy limits.

43. Associated Int'l Ins. Co. v. E.D. Bullard Co., No. 540754, slip op. (Cal. Super. Ct., Santa Clara County, March 21, 1988). Silicosis, like asbestosis, is an injury that develops slowly and insidiously following exposure to certain toxic substances. The trial court in this case held, upon the motion of an excess carrier, that the excess carrier was not required to provide any defense costs or coverage to the insured until coverage under all primary policies had been exhausted by payment of policy limits.


A secondary policy, by its own terms, does not apply to cover a loss until the underlying primary insurance has been exhausted. This principle holds true even where there is more underlying primary insurance than contemplated by the terms of the secondary policy. . . . Liability under a secondary policy will not attach until all primary insurance is exhausted, even if the total amount of primary insurance exceeds the amount contemplated by the secondary policy.

126 Cal. App. 3d at 600, 178 Cal. Rptr. at 912.
are not directly applicable in a case involving successively triggered policies.45

C. Proportionate Allocations of Coverage

A number of courts have approached the allocation question with an eye toward equity. Courts have adopted at least three proportionate allocation formulas that effect neither a pure vertical nor a pure horizontal allocation as described above.

Many courts prorate liability among all triggered carriers pursuant to a "time on the risk" formula. Under this approach, each triggered policy's liability is proportionate to the number of years it was on the risk relative to the total number of years of coverage that have been triggered.

45. The typical "other insurance" clause provides that it applies only when it and other insurance apply to the loss "on the same basis." It would appear, therefore, that the "other insurance" clause is only designed to resolve the multiple coverage situation where the triggered policies are concurrent, i.e., where the policies share an identity of the insured interest, an identity of the risk, and an identity of parties at the same time. See generally 16 COUCH ON INSURANCE 2d §§ 62:93-96, 62:112 (rev. ed. 1983). In the case of successive, non-concurrent policies, the policies arguably do not apply to the loss "on the same basis" since they do not apply to the risk at the same time. Cf COUCH § 62:112.

The "other insurance" clause limits a carrier's liability where another policy covers the same loss by apportioning the loss between all policies which apply "on the same basis." The apportionment is relatively simple if the amount of the claim is less than the limits of any particular policy. However, if the amount of the claim exceeds the limits of any particular policy, the loss will be allocated so the insured is fully compensated, thus effectively allowing the insured to collect the sum of all available coverages and, if necessary, exhaust all available coverages to achieve full compensation. All policies may be exhausted because all apply to the risk "on the same basis."

Where successive policies are triggered by a single continuing occurrence that spans the various policy periods, the situation is different. Although all policies are triggered, they do not all apply to the risk "on the same basis" because each is in effect for a different policy period. The difficulties arise from the fact that it is usually impossible to apportion separate elements of the loss or damage to the separate policy periods. If this could be done, each policy would be responsible only for that portion of the loss which occurred while it was in effect. The question of allocation pursuant to an "other insurance" provision should not even be reached until all policies applicable to the risk "on the same basis" are identified.

Courts that have relied upon the "other insurance" clause to arrive at the total limits provided by successively triggered policies have erred given the language and purpose of the clause. The clause should not be used to determine the total limits available to cover a loss; it should only be invoked once that limit is known and the loss requires proration. Determining the total limits available should be accomplished only by considering the number of occurrences that comprise the loss.
The seminal case adopting a “time on the risk” proration is Insurance Co. of North America v. Forty-Eight Insulations, Inc.,\textsuperscript{46} which involved asbestos claims. In that case, the court not only prorated liability between insurers according to their “time on the risk,” it also prorated liability to the insured for the periods of time it was uninsured, thus requiring the insured to absorb a portion of the loss itself. While the court’s opinion was limited to the duty to defend question, and did not directly address whether it would apply the same formula to the insurers’ duty to indemnify, the result would seem to follow, particularly in light of the court’s comment that “there is no truly satisfactory solution we can make” to “this impossible problem before us.”\textsuperscript{47}

In Fireman’s Fund Ins. Co. v. Ex-Cell-O Corp.,\textsuperscript{48} the court applied a “time on the risk” allocation of defense costs in a case involving coverage for environmental cleanup liability where the insured was liable for environmental contamination at 22 separate sites. The court relied upon Forty-Eight Insulations and found that each exposure of the environment to a pollutant constituted an occurrence\textsuperscript{49} that triggered coverage. The court also concluded that, in this situation, an insurer should bear liability in the proportion that the period it was on the risk bears to the total period of alleged exposure, with the insured bearing its own pro

\begin{footnotes}
\footnote{46. 633 F.2d 1212 (6th Cir. 1980). \textit{See also} Employers Reinsurance Corp. v. Phoenix Ins. Co., 186 Cal. App. 3d 545, 230 Cal. Rptr. 792 (1986).}

\footnote{47. 633 F.2d at 1226. The disarming candor of the court may not enhance its view, but it is certainly a refreshing change.}

\footnote{48. 662 F. Supp. 71 (E.D. Mich. 1987). \textit{See also} Isaacson Corp. v. Holland-America Ins. Co., No. 85-2:12843-5 (King County, Wash., Super. Ct. Dec. 22, 1987), where a trial court relied upon Forty-Eight Insulations when, addressing the duty to defend in a pollution coverage case, it imposed individual and proportionate liability upon insurers relative to the amount of time each was on the risk. In Isaacson, the court found that continuing pollution damage spanned a 45-year period. In many of these years, the insured either had no insurance coverage or was unable to prove coverage had existed. The court ruled that each insurer on the risk was responsible in proportion to the number of years it was on the risk relative to the total number of years during which damage occurred. Thus, for example, one insurer which was on the risk for a two-year period was held to have individual and proportionate liability for 2/45ths of the claim. Likewise, the insured was itself required to absorb liability proportionate to its uninsured periods.}

\footnote{49. 662 F. Supp. at 76. The court did not discuss whether there was a single occurrence or multiple occurrences at each site. Nonetheless, the fact that 22 different sites were at issue means that, at a minimum, there were 22 separate occurrences regardless whether the “cause” or “effect” test were applied. \textit{See} discussion in Part III, \textit{supra}. Logically, coverage and therefore allocation should have been considered separately as to each site. However, the court’s opinion does not reflect whether such separate consideration was given.}
\end{footnotes}
rata share for uninsured periods. Again, however, as in _Forty-Eight Insulations_, the court's ruling addressed only the duty to defend, and did not discuss whether it would reach the same result with respect to the duty to indemnify. 50

Applying a time-on-the-risk allocation to the hypothetical described earlier, there were 15 total years of ongoing damage, during five of which the insured had no insurance. Thus, the insured would bear 5/15ths, or $2,666,666, of the $8 million cost itself. Its insurers would allocate responsibility for the remaining $5,333,333 of the liability according to the time each was on the risk relative to the 10 year period policies were in effect. 51

Another allocation formula prorates coverage according to the proportion of injuries triggering each specific policy. This approach was adopted in _Uniroyal, Inc. v. Home Ins. Co._, 52 a case involving coverage for injuries stemming from the insured's manufacture of "Agent Orange." Before deciding how the loss should be allocated, the court observed that there were at least four methods of allocating a continuing loss between triggered policies. 53 As a proxy for determining the proportion of injuries triggering each policy, the court looked to the gallons of "Agent Orange" delivered during the period the policy was in effect. 54

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50. See discussion in Part V, section D, infra.
51. None of the courts adopting the "time on the risk" formula appear to have considered how the formula should be applied where both primary and excess coverages are in issue. Presumably, all primary coverages should be invaded first according to the allocation formula. Assuming all or some of the primaries are exhausted before satisfying their proportionate liability for the period of time in issue, the excess policy corresponding to the primary would then satisfy any remaining liability.
53. _Id._ at 1391. As the court observed:

Because one continuous occurrence spanning two policy periods has resulted in injuries in fact triggering both of those policies, an appropriate method for allocating the net losses among the two policies must be devised. The court is aware of four methods: "stacking" the policies, finding each policy to be jointly and severally liable for the entire loss, allowing the insured to choose the policy it prefers, and allocating the losses to each policy according to the proportion of injuries triggering that policy. Only the last method makes sense in this case.

As discussed throughout this article, we do not agree that the allocation methods adopted by courts in these cases are limited to the four described in _Uniroyal_. Specifically, we do not agree with Judge Weinstein's conclusion that a simple "joint and several" approach was adopted in _Keene._ _Id._ at 1392. See discussion in Part IV, section A, _supra._
54. 707 F. Supp. at 1393. The court used a two-step process: gallons as a proxy for exposure, and exposure as a proxy for injury. A court wishing to allocate liability in this fashion in an environmental liability coverage case might by comparison look to the volume of wastes released into the environment during the applicable policy period.
At the same time, the court noted that there was one continuous occurrence under each policy, and so applied each policy's per-occurrence deductible and maximum once to each occurrence. 55

Yet another proportional allocation scheme involves allocating liability among all triggered policies according to the applicable policy limits of each policy multiplied by the years of coverage. Such a "pro rata by limits" approach was adopted in the consolidated Asbestos Ins. Coverage Cases. 56 The court there held preliminarily that the insured was not entitled to "stack" coverages, relying on Keene and holding that instead the insured was to select the policy under which it was to be indemnified. 57 Presumably, the court's proportionate allocation by policy limits was accomplished only after the insured had selected the policy whose limits would apply to the claim. The court adopted this formula after rejecting a literal interpretation of the policies' "other insurance" clauses. It preferred instead to effect allocation among the insurers based solely upon equitable principles.

A Pennsylvania trial court has adopted a "pro rata by limits" allocation in a coverage dispute involving hazardous waste disposal. 58 In that case, the insured faced cleanup liability for 20 years of waste disposal activities at three different sites. When two carriers entered into a settlement agreement with the insured, the non-settling carriers moved to prevent dismissal of their cross-claims against the settling insurers. The court found that all of the insurers qualified as "coinsurers," 59 and that as

55. Id. The court also felt the "Other Insurance" clauses of the policies suggested a proportional allocation scheme. As the court observed, "[C]onceptually a series of indistinguishable injuries to indeterminate plaintiffs from a continuous occurrence over two policy periods, as here, approaches the notion implied in the ‘Other Insurance’ clause." Id. The authors do not agree that the "Other Insurance" clause provides an appropriate basis upon which to base an allocation of coverage for a continuing loss. See supra note 45.


57. Id. at 70.


59. The court's holding on this issue is clearly incorrect. "Coincurrence means a relative division of the risk between the insurer and the insured, dependent upon the relative amount of the policy and the actual value of the property insured thereby." 16 COUCH ON INSURANCE 2d § 62:124 (1983) (emphasis supplied). A coinsurance clause therefore reduces an insurer's liability "in terms of the percentage of coverage which the clause
such their liability was several but not joint, with each insurer's liability being fixed by the face of its policy. The court held that since any liability owed to the insured would be determined on a pro rata basis by the amount of insurance provided by the policy, less the applicable deductible divided by the total amount of insurance available for the loss, no right of contribution would arise. The insured's agreement to accept a specified amount of money as satisfaction for the settling carriers' proportionate shares of liability therefore had no impact on the liability of the non-settling defendants.

Finally, one commentator has suggested that a proportionate allocation that takes into account policy limits as well as time on the risk would be a "fair and efficient" method of apportioning liability in environmental liability coverage litigation. The authors are not aware of any court that has actually followed such an approach.

V. COMPLICATIONS AND OTHER CONSIDERATIONS IN ALLOCATING LIABILITY

A. Conflicts Between Primary and Excess Carriers

As the foregoing discussion reveals, the various allocation methods can be manipulated or selectively adapted to minimize or maximize the liability of the insured or individual carriers. As a general proposition, however, a "vertical" allocation of a multi-million-dollar environmental liability loss will minimize loss distribution among primary carriers, and maximize coverage across the excess layer. By contrast, a "horizontal" allocation will maximize distribution of the loss across the primary layer, and minimize distribution across the excess layer. A proportionate allocation, whether by limits, time on the risk or some other

requires the insured to maintain." Id. at § 62:125. Thus, coinsurance describes the relationship between an insurer and an insured, not the relationship between multiple insurers. Indeed, the cases cited by the Cooper court to support its holding are not on point.


61. The HARVARD LAW REVIEW article cites the decision in Keene, 667 F. 2d 1034, as adopting this approach. 99 HARV. L. REV. at 1584, n.67. This observation appears erroneous, since the approach adopted by Keene was quite different. See discussion in Part IV, section A supra.
method, will yield a more even loss distribution, with a possibility of the insured bearing some portion of the liability itself.

Faced with these realities, carriers that write primarily primary coverages will advocate a "vertical" coverage allocation, while carriers writing primarily excess coverage will advocate a "horizontal" stacking scheme. A carrier that writes similar amounts of primary and excess coverages will be impaled on the horns of a dilemma. As a general corporate policy, it will probably want to advocate a single theory to avoid bad-faith claims by insureds for inconsistent claims handling. This, in turn, could result in a carrier arguing for a proportionately greater share of liability in certain circumstances.

Because the various allocation theories impact differently situated insureds so variably, it may be difficult if not impossible for insurers to adopt a unified and consistent position in response to specific allocation claims by individual insureds. This could, in turn, undermine the insurers' ability to undertake a joint defense to the coverage issues raised in environmental liability cases.

B. Deductibles and Self-Insured Retentions

A court interested in maximizing coverage for an insured may be disinclined to adopt any of the allocation theories that require the insured to absorb large deductibles or self-insured retentions for each triggered policy. For example, if the court were to impose a "horizontal" stacking of coverages, the insured should be required to pay the deductible or self-insured retention under each policy that will make payment on the loss. If these amounts are large, the insured may end up absorbing a relatively large share of the loss itself. An insured with large deductibles or self-insured retentions may therefore prefer a vertical allocation, particularly if there will be enough insurance to cover the loss at the excess levels, because it would then only be required to pay a single deductible for the policy it selects to cover the loss. Likewise, because the insured may selectively choose the policy it wants, it

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62. There is a certain irony in the courts' demand for consistency by a carrier when the courts seem incapable of performing in a like manner.

63. By contrast, insurers often have succeeded in mounting a unified joint defense to the coverage issues that arise in environmental liability cases, thereby pooling their resources and increasing their likelihood of success.
may avoid the policies with the highest deductibles or self-insured retentions.

C. Settlement Expectations

The extreme uncertainty as to which allocation formula a court might follow substantially reduces the likelihood of successful settlement negotiations between an insured and its carriers. An insured may be hopeful, or may even presume, that a court will allow it to recover the sum of all available coverages and that, accordingly, it should negotiate toward obtaining full limits from all triggered policies up to the total amount of the loss. The carriers, on the other hand, may feel strongly that a court would not allow the insured to recover the sum of all its primary coverages, and so be disinclined to settle with the insured for or near policy limits.

With these uncertainties in mind, parties to a coverage dispute that is in litigation should consider asking the court for an early ruling on the allocation method that will be applied in the event coverage is found to exist. Such a preliminary ruling from the court would enhance the likelihood of settlement by giving the parties a baseline from which they can assess the maximum limits of their respective liabilities.64

D. Duty to Defend v. Duty to Indemnify

Nearly all of the cases that have discussed the allocation issue have done so in the context of a carrier's defense obligation.65 It could be argued that allocation with respect to the duty to indemnify should be treated differently, since the duty to defend

64. One must never lose sight of the importance of settlement. While learned appellate judges love to write eloquent and erudite opinions about esoteric topics, like the subject of this article, the trial court judge does not have that luxury. The longer he takes to untie the Gordian Knot, the longer his docket becomes. The shortest and quickest way to shorten that docket is settlement. The parties, and their lawyers, should also remember that a good settlement beats a bad trial every time.


66. "Duty to indemnify" is, of course, a misnomer in the context of comprehensive or commercial general liability policies. In those policies the company generally promises "to pay on behalf of the insured." The company does not promise to pay or indemnify the insured. Whether this is just a relic left from the days when insurance policies were policies of indemnity and not liability policies, or whether it sounds more refined than "duty to pay," is not clear.
is a separate, distinct, and generally broader obligation than the
duty to indemnify. Thus, while it may be appropriate to adopt an
allocation scheme that maximizes allocation of an insured's defense
costs, it may not be appropriate to adopt the same approach when
it comes to allocating the indemnification obligation.

In the asbestos context, at least one court has specifically held
that the duty to defend and the duty to indemnify cannot be
separated for purposes of determining allocation.\textsuperscript{67} On the other
hand, another court in an environmental liability case imposed a
simple per capita proration of the defense obligation between all
insurers, but refused to consider the question of allocating liability
because facts remained in dispute.\textsuperscript{68} It is likely that the question
whether defense and indemnity obligations should be allocated
differently will receive more attention as allocation questions
become the subject of more litigation.

E. Allocation of Proportionate Share to Insured
for Uninsured Periods

Because many environmental losses extend back several deca-
des, it often happens that an insured either was uninsured for a
portion of the time the "occurrence" was taking place, or is unable
to locate documentation to prove which carrier insured it when,
for what, and for how much. It is effectively uninsured.

As the discussion above indicates, uninsured periods are treated
differently depending upon the allocation theory adopted. A pro-
portionate allocation theory based upon time on the risk will likely
allocate liability to the insured proportionate to the period of time
it was uninsured.\textsuperscript{69}

\textsuperscript{67} ACandS, Inc. v. Aetna Casualty & Sur. Co., 764 F.2d 968, 975 (3d Cir. 1985)
(reversing the trial court's decision "in so far as it grants ACandS the power to bifurcate
the duty to defend from the duty to indemnify"). See also Insurance Co. of N. Am. v.
Forty-Eight Insulations, Inc., 633 F.2d 1212, 1224 (6th Cir. 1980) (suggesting that proration
of defense and liability obligations should not differ).

\textsuperscript{68} United States Fidelity & Guar. Co. v. Thomas Solvent Co., 683 F. Supp. 1139, 1173
(W.D. Mich. 1988), which found the reasoning set forth in Forty-Eight Insulations to be
"inappropriate."

1978), aff'd, 633 F.2d 1212 (6th Cir. 1980). See also Isaacson Corp. v. Holland-America Ins.
On the other hand, courts that adopt a “vertical” allocation of coverage generally reject any attempt to impose liability on the insured for self-insured or uninsured periods of time.\(^{70}\)

An insured having large periods of uninsured exposure should therefore carefully consider the various allocation formulas, and seek to avoid imposition of any theory of allocation that would require it to absorb a portion of the liability itself.

F. Is This Really “Joint and Several” Liability?

When allocating coverage, many courts comment that the liability they are imposing upon the insurers is “joint and several,” regardless what allocation formula they are adopting.\(^{71}\) Other courts have described the liability of successive insurers as “several but not joint,”\(^{72}\) and yet others have termed it “individual and proportionate.”\(^{73}\)

One commentator has observed that the rule of joint and several liability, as applied to a loss that triggers successive policies, is not part of the trigger theory at all but rather is a rule designed to achieve administrative convenience and to afford protection to

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\(^{73}\) Isaacson Corp. v. Holland-America Ins. Co., No. 85-212843-5 (King County, Wash., Super. Ct. Dec. 22, 1987). The Isaacson court’s observation that liability was “individual and proportionate” related to the indemnification obligation. At the same time, however, the court held that liability for defense costs was joint and several, presumably because there is no upper limit on the insurer’s defense obligation as there is with its indemnification duty.
the insureds.74 This commentator also feels that the imposition of a joint and several liability rule could eliminate the need for a court to address questions of apportionment, this being "perhaps its greatest attraction from the judicial perspective."75 Unfortunately, it has been judicial inability or refusal to squarely face the allocation problem, compounded by attempts to avoid the problem by pretending to impose joint and several liability, which has led to the substantial confusion presently surrounding the allocation question. Courts should refrain from describing the results they reach as having any relation to "joint and several" liability when, in fact, no such relationship exists.

VI. CONCLUSION

The authors agree with those who have observed that the proliferation of different theories for allocating coverage for long-term exposure losses can best be explained as the implementation of a judicially adopted public policy of maximizing coverage for insureds.76 Unfortunately, the primary result of this judicial tinkering is that the insurance industry is presented with a changing target, which varies depending upon a particular judge's plan for a particular case. Insureds are free to advocate different formulas depending upon which will provide the most coverage in a given circumstance. However, if insurers were to adopt a similar outcome-determinative approach, they would run the risk of being presented with allegations of bad faith for inconsistent claims handling.

The confusion and inconsistencies that have resulted from this "impossible problem"77 will not be resolved until courts face the allocation issues squarely by reading the policy language, by following the policy language, and by disregarding extrinsic public policy objectives such as the maximization of coverage.78 After all,

74. Howard, supra note 5, at 626.
75. Id.
76. Id. See also Murphy & Caron, supra note 16.
78. "Neither abstract justice nor any rule of construction can create an insurance contract for the parties which they did not make for themselves." Vandivort Constr. Co. v. Seattle Tennis Club, 11 Wash. App. 303, 310, 522 P.2d 198, 202 (1974), review denied, 84 Wash. 2d 1014. A commendable rule, unfortunately more observed in the breach than in the application.
the question of coverage is, in both the beginning and in the end, purely a question of contract. Only when courts recognize this will they see that the various theories they have devised to allocate coverage largely ignore the express terms of policies, and as such ignore the intent and expectations of the contracting parties.
THE SUIT LIMITATION DEFENSE TO A PROPERTY INSURANCE POLLUTION CLAIM: WILL INSUREDS' LATE DISCOVERY ARGUMENTS SUCCEED?

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I. INTRODUCTION

Should an insured have the right to file suit under a property insurance policy for a pollution damage claim when problems in ascertaining the damage or the right to make claim have resulted in filing after expiration of the contractual limitation period specified in the policy? The answer to this question may vary depending on the nature of the problems encountered by the insured in discovering the loss or claim and on the nature of the problems the late suit presents for the insurer.

This issue is of concern because insureds are under federal pressure to correct environmental problems on their property.¹ Other sources of compensation, such as environmental impairment insurance and liability insurance, are largely unavailable.² Not only are these sources unavailable, but many property insurance policies currently issued have been amended so as to provide limited coverage for pollution damage.³ Thus, some claims are

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2. See Hamilton & Routman, Cleaning Up America: Superfund and Its Impact on the Insurance Industry, September 1988 CPCU JOURNAL 172. The article indicates that general liability insurance, although available, is inconsistently interpreted by courts insofar as pollution coverage is concerned.

3. See T. Mallin, POLLUTION AND CONTAMINATION: HOW WILL PROPERTY INSURERS RESPOND? (monograph published by the Tort and Insurance Practice Section, American Bar Association). Coverage issues under both previous and present forms are discussed thoroughly in the monograph. As can be seen from that discussion, there was controversy over the existence and extent of coverage under previous forms, and the forms were amended as a point of clarification. The instant paper does not reach the coverage issues under either set of forms but deals only with the suit limitation issue.
being filed under older policies for damage that occurred as far back as 20 years ago.

These claims present several problems for insurers. First of all, because they involve late discovery of a loss, they automatically involve late notice of that loss. Most policies require immediate notice or notice as soon as practicable. Second, due to the circumstances surrounding the late discovery, there may be problems in the insurer's completing other pre-suit requirements, such as filing of a sworn proof of loss stating the time, cause, and extent of the loss. Third, there are frequently coverage difficulties involved, in part because most policies contain contamination exclusions of some type. Finally, there is a problem with the policy suit limitation period, in that, counting from the commencement of the loss, that period has already expired. This paper will focus on the last of these difficulties: The effect of late discovery of the loss on the running of the suit limitation period.

Insureds are likely to raise two basic arguments to support an extension of the suit limitation period in late discovery situations. First, with respect to a typical suit limitation provision providing that the insured must file suit “within twelve months next after inception of the loss,” an insured may attempt to read “inception of the loss” to mean the time of discovery of that loss or claim. A variation on this argument would be to say that “inception of the loss” means the time the insured's cause of action accrues, and that the cause of action accrues at the time of discovery.

A second approach insureds may suggest is to adopt the discovery rule, which had its origins in medical malpractice cases. The statutory limitation on a tort or general contract action runs from the time of accrual of the cause of action. The time of

4. Some suit limit provisions vary this language, referring, for example, to “the date of loss” or “the occurrence of loss.” This paper does not distinguish between these phrases for purposes of analyzing potential judicial reactions to the arguments presented. Further, some provisions specify a two or three year period, instead of a 12-month period, for filing suit.
5. See, e.g., cases discussed infra text accompanying notes 48-53.
8. Id. at —, 260 Cal. Rptr. at 96.
accrual is generally the date the plaintiff was injured by the
defendant. According to the discovery rule, however, the cause
of action accrues when the plaintiff discovers, or in the exercise
of due care should have discovered, his injury.

Insurers are likely to respond to these arguments by contend-
ing that a contractual suit limitation period that is either man-
dated or allowed by the legislature reflects a balancing of the
insured's interest in having a fair opportunity to present a claim
with the insurer's interest in having a fair opportunity to inves-
tigate the merits of the claim and in reaching some point of
administrative repose. Further, the difficulties surrounding
fraudulent claims are more prevalent for insurance claims than
for general contract claims, and therefore, a shortened limitation
period is needed for insurance contracts. Consequently, this line
of argument concludes, the limitation period should not be ex-
tended merely because of an insured's late discovery of a loss or
claim.

In the minority of jurisdictions that apply a general contract
statute of limitation to insurance contracts, insurers will argue
that the more lengthy period should be extended no further.

The insurer-insured conflict outlined above will be explored by
way of reference to a series of hypothetical situations. In Sep-
tember of 1988, the Environmental Protection Agency published
its regulations concerning underground storage tanks. Existing
tanks are being phased into compliance during a five-year pe-

9. Id.
10. Id. Another argument that might be raised by insureds under a suit limitation
provision referring to the “date” or “occurrence” of loss, rather than the “inception” of
loss, is that the “date” or “occurrence” might be the final, rather than the first day of
the loss, and that as to a continuous loss, therefore, the limitation period never runs.
This literal interpretation would allow an insured with a continuous loss to watch the
loss as it occurs, biding his time until he chose to notify his insurer and subsequently, if
necessary, file suit. As will be discussed here, courts have consistently resisted the notion
that a loss, for purposes of the running of the suit limitation period, be left to the whimsy
of the insured.
J., dissenting).
12. Id.
13. See, e.g., ALA. CODE § 6-2-34 (1975) (requiring that actions on contracts generally be
commenced within six years).
14. EPA Technical Standards and Corrective Action Requirements for Owners and
Operators of Underground Storage Tanks, 40 C.F.R. § 280 (1988). See Regulation of
Tank owners will, among other requirements, have to monitor their tanks for leaks and take corrective action with respect to any leaks detected.\(^{16}\)

Several insurance scenarios may result. Some tank owners who suspected their tanks were leaking will confirm the existence of those leaks and will carefully analyze possible avenues of insurance recovery. Some tank owners, on the other hand, will discover leaks they had never suspected. Some will discover problems of fairly recent origin, and some, problems which date back 20 or more years through the policy periods of three or more insurers. It is around these and similar possibilities that the relevant suit limitation cases have been grouped in order to explore the scope of the extant holdings.

II. INSURED UNAWARE OF CLAIM

A. Insured Misinterprets Contract

The insured filling station owner now wants to clean up soil contamination he discovered a couple of years back. He files a property insurance claim. In response to the insurer's suit limitation defense, he argues that when he discovered his loss he did not believe his insurance contract provided coverage.

However, after recently learning in a conversation with the station owner across the street that he might have such coverage, he filed suit immediately. Will the suit limit defense prevail?

A similar argument was advanced by the insured in Lawrence v. Western Mut. Ins. Co.\(^{17}\) After heavy rains, part of the insured house settled, with the foundation tilting significantly. A laboratory report obtained by the insured indicated that the part of the home that settled was built on improperly compacted fill. The insured read his all-risk homeowners policy and concluded that damages caused by earth movement were excluded. Two and one-half years later, in a conversation with his attorney on unrelated matters, the attorney advised him that if the cause of the settling was indeed negligent compaction of fill, then the loss would be covered under the policy. At that point, he brought suit, arguing that "the inception of the loss" should be the date

\(^{15}\) 40 C.F.R. § 280.40(c) (1988).

\(^{16}\) 40 C.F.R. § 280.40(a) & (b) (1988).

\(^{17}\) 204 Cal. App. 3d 565, 251 Cal. Rptr. 319 (1988).
on which he discovered from his attorney that he might have a covered loss. The court responded:

If the argument ... were accepted, the practical effect would be to nullify the contractual one-year commencement of suit provisions. Any plaintiff could simply allege ignorance of his or her legal rights against a particular defendant. This is not difficult. Most people do not know the legal answers to questions arising from certain circumstances.18

Lawrence appears to represent the general rule on this issue.

The insured in Lawrence raised another argument. He stated that the insurer should be estopped from asserting the suit limitation period because the insurance policy did not advise the policyholder that if the negligence of a third party was a concurrent proximate cause of the damage along with earth movement, the loss might be covered under the all-risk policy, as indicated by settled case law on the matter. The court noted that it did not need to resolve that issue because the insured did not adequately allege that he read his policy in time to have relied on its wording in refraining from initiating a timely suit. However, in a footnote the court commented that it might be advisable for an insurer to explain directly which risks are covered in light of a theory of concurrent proximate cause.19

Since the decision in Lawrence, the California Supreme Court held, in Garvey v. State Farm Fire & Casualty Co.,20 that the doctrine of concurrent causation does not apply to property insurance. Thus, arguments concerning the incorporation into insurance forms of information about the effect of complex interpretive doctrines might be accordingly silenced. The insurance policy is a complex legal document and an insured who makes assumptions concerning its interpretation without consulting an attorney is doing so at his own risk. Such is the import of the case law.

B. Insurer Misinterprets Contract

The insured filling station owner did submit a claim to clean up his soil when he discovered the contamination a couple of years

19. Id. at 574, 251 Cal. Rptr. at 323 n.4.
back. His agent carefully explained that his policy provided him no coverage for that situation. Respecting his agent's professionalism, the insured did not file suit. Now, the insured was informed at a local trade association meeting that property policies are possible sources of coverage for soil contamination. He immediately filed suit. Will the circumstances surrounding his late filing overcome the insurer's suit limitation defense?

In Matsumoto v. Republic Ins. Co.,21 the insureds contacted their agent with a claim for dwelling damage caused by earth movement and were advised the loss was not covered. Over four years later, insurers began paying benefits to similarly situated neighbors where third-party negligence had caused the earth movement. The insureds determined that third-party negligence was the cause of their loss and filed suit at that point. The court held that their suit was barred by the four-year statute of limitations on contracts generally, not reaching the one-year suit limitation period. The court observed that a discovery rule had been applied only in cases where the factual predicate for plaintiff's injuries was misrepresented by a defendant. Contrasting the situation at hand with one involving misrepresentation of facts by an insurer and noting that no such factual misrepresentation had been alleged, the court reasoned that an insurer's incorrect interpretation of its policy terms cannot delay the running of a statute of limitations because otherwise, "'no insurer could deny liability without indefinitely suspending the running of the statute of limitations.'"22 As to this point of reasoning, there would appear to be no distinction between a statute of limitations and a contractual suit limitation period.

C. Insured Unaware of Cause of Loss

The insured filling station owner did not submit a claim when he discovered his contamination a couple of years ago because, upon discovering the problem, he entered into extensive investiga-

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21. 792 F.2d 869 (9th Cir. 1986).
22. Id. at 872 (quoting Neff v. New York Life Ins. Co., 30 Cal. 2d 165, 180 P.2d 900 (1947)). Recently, a maverick court distinguished Neff and refused to apply a suit limitation defense where insurers failed to inform insureds at the time of claim denial that there was a possibility of coverage if third-party negligence was a concurrent proximate cause of their losses. Davis v. State Farm Ins. Co., 262 Cal. Rptr. 595 (1989), decertified No. S012829 (Dec. 14, 1989).
tion of its cause, which included negotiations with the manufacturer and the installer of the tank. After the negotiations fell through, he filed a claim with his property insurer.

Will the negotiations with the installer and manufacturer provide a successful excuse so as to overcome the insurer's suit limit defense?

In Zurn Engineers v. Eagle Star Ins. Co., the insured general contractor of a waste water treatment plant entered into discussions with the city to determine who was responsible for the damage in question. The insured argued that the damage was caused by a design defect in the pipeline, for which the insured should not be held responsible. Seventeen months after the loss, the city denied responsibility. The policy excluded loss caused by defect in design and required that the insured submit a proof of loss specifying the cause of loss. Relying on cases equating "inception of the loss" with accrual of a cause of action against the insurer, the insured argued that its suit was timely.

The court held:

[T]he phrase "inception of the loss" must be construed in light of the other provisions of the policy, and that so construed in the context of the policy and factual situation which is here involved, the phrase does not mean the time at which the physical event causing damage to property occurred. Rather, it must be construed as occurring no earlier than the point at which the insured's reasonable belief of the third party's responsibility for the loss by reason of an uninsured cause is countered by the third party's assertion that it is not responsible.24

The court reasoned that as long as the insurer is not prejudiced, there is no reason to encourage the filing of unnecessary lawsuits.

On the other hand, in J.N. Futia Co. v. National Surety Corp. the insured electrical contractor delayed 20 months in filing suit after tests disclosed that cable it had installed for a state agency failed to meet contract specifications. It replaced the cable, asserting that defects in the pre-existing conduit system had caused

the damage and that the state agency was responsible. The agency took the position that part of the damage was caused by the contractor's rough handling of the cable when drawing it though the conduit. The insured brought suit within a year after the certificate of completion was issued by the State and the State declined to make full payment.

The court held:

It seems too clear to require extended discussion that the insurance contract in suit is one of indemnity and that the "peril" insured against, being "the physical loss of or damage to the property . . . from any external cause" (emphasis supplied) was just that; it became a debt immediately due from the insurer directly and was not a contingent liability for the monetary damage recoverable, or not, in a suit against a third party allegedly causing the physical loss or damage. 26

Failure to discover the cause of loss can be advanced by an insured as justification for the late filing of a suit in circumstances other than those involving a dispute with a third party. These circumstances can be varied, and, although there is a division of authority here as there is with respect to disputes with third parties, this division of authority appears to occur on the basis of the type of facts presented rather than along purely theoretical lines. The following four cases are examples:

In Olson Marine Supplies v. Fidelity-Phenix Fire Ins. Co., 27 an insured aircraft was reported missing within 48 hours of takeoff. The plane was missing approximately two months before it was located. Suit was filed within a year from the date the wreckage was located but not within a year from takeoff.

The court noted that the policy required filing of a proof of loss stating time, place, and cause of loss. It reasoned that obviously the insured could not comply with the condition before the wreckage was located. It further reasoned, therefore, that although the loss clearly occurred shortly after the plane took off, the suit limitation provision would be construed to mean that

26. Id. at 990, 294 N.Y.S.2d at 76. See also Donald M. Clement, Contractor, Inc. v. Southeastern Indus. Contracting, Inc., 425 So. 2d 1005 (1983); State Farm Fire & Casualty Co. v. Superior Court (Bolek), 210 Cal. App. 3d 604, 258 Cal. Rptr. 413 (1989) (refusing to toll the limitation provision pending the outcome of a coverage dispute with another insurance carrier).

an action must be brought within 12 months from the time the right to maintain an action accrued. The court stated:

[This is a reasonable rule to apply, especially under the circumstances of this case. It is not too remote a hypothesis for a loss such as this to be undiscovered within the entire period of the limitation in the policy. A rule as sought for by the [insurer] would have the effect of barring a suit before a claimant could take a step under the policy.28

Another case where an inability to detect cause amounted virtually to an inability to ascertain the fact of loss itself was Nationwide Mut. Fire Ins. Co. v. Tomlin.29 In Tomlin, the insureds discovered and reported to their insurer cracks in the exterior walls of their home. An adjuster informed the insureds that the cracks were due to the excluded cause of settling. At the insureds’ request, an engineer came out. He reported to the insurer that there might be a decaying tree under the foundation, but no one informed the insureds. Two months after the engineer’s visit and five months after the loss, the insureds dug under their home and discovered rotting logs and debris beneath a cold joint. Within a year of their discovery, but 14 months after first reporting the cracks, the insureds filed suit.

The court first held that a covered collapse had occurred, defining collapse “as having occurred when there is a reasonably detectable serious impairment of structural integrity.”30 On the suit limitation issue, the court held, “the inception of the loss began when it was detectable .... [T]he true cause was not determined until ... an excavation revealed the decaying timbers under a cold joint.”31

A decision where a court was unmoved by an insured’s pleas of inability to discover cause was Matsumoto, discussed above for its holding that an insurer’s legally incorrect claim denial does not postpone the running of a statute of limitations. The insureds in that case also presented an argument that their cause of action did not accrue until they knew the cause of their loss and that they were hindered in seeking such cause because of the misinformation received from their insurer. The court re-

28. Id. at 728.
30. Id. at 415, 352 S.E.2d at 615.
31. Id. at 417, 352 S.E.2d at 616.
jected the argument, stating: "To rule otherwise would be to equate date of injury with the date on which every factual controversy is resolved."32

Another case with a similar holding is *Naghten v. Maryland Casualty Co.*33 Here, the insured's rear bedroom became unusable due to a misshapen floor and cracked and distorted walls. The insured repaired the floor approximately five months afterward and discovered that the loss was caused by the pressure of underground water. His suit was filed within 12 months after he discovered the cause of the loss but 17 months after the room became unusable. He argued that for purposes of the suit limitation provision a loss cannot be considered to have occurred until the insured knows the extent of his loss in relation to the policy terms. The court held:

[The insured] allowed this condition to exist for over five months without caring to discover whether the damage was covered and not even attempting to fix it .... The usual method of dealing with a loss situation is through estimates on the damage and immediate notice to the insurance company where there is any possibility of loss. Where the condition does not appear at all to be within the bounds of the policy, it does not seem particularly burdensome to expect that the work will be done soon after the occurrence of the damage, so that in the event a possible liability may arise, a suit might still be brought within "twelve months next after inception of the loss."34

### III. INSURED UNAWARE OF LOSS

#### A. Effects of Known Occurrence Undiscovered

Two years ago, a semi-trailer backed into a pump at the insured filling station and knocked over the pump. The pump was repaired, but the station owner was unaware that the accident jarred underground piping, causing it to rupture. After soil monitoring disclosed contamination and the rupture was subsequently discovered, the insured filed suit. Will the insured's failure to discover the rupture after the initial occurrence excuse his noncompliance with the limitation period?

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34. *Id.* at 79, 197 N.E.2d at 491.
In *Thames Realty Corp. v. Massachusetts Fire & Marine Ins. Co.*[^35] the insured building owner was paid by its insurer for damage caused by explosion. It subsequently discovered additional damage. Suit was filed within 12 months of that discovery but more than 12 months after the explosion. The court held that the time of the discovery was “immaterial,”[^36] that the words “inception of the loss” mean “the occurrence of the event insured against.”[^37]

In *Harris v. Hanover Fire Ins. Co.*[^38] a severe rain and hailstorm occurred. The insured discovered that the upper layers of grain stored in a warehouse had suffered water damage. These layers were stored to a depth of 35 to 40 feet. The water-soaked grain was removed, dried and restored. No notice or proof of loss was filed with the insurer. More than four years later, all the grain was removed from the warehouse. At that time, the insured discovered that water seepage had damaged the grain at the bottom of the storage facility. Subsequently, the insured filed suit to recover for that damage.

The insured argued that the two-year contractual suit limitation period and the four-year general contract statute of limitations were both “inapplicable, that he suffered a concealed loss which was unknown to him and which could not have been ascertained with due diligence prior to removal of the bottom layers of grain because of the depth of the storage facility.”[^39] The court rejected the argument, noting that the authorities cited for the argument were based on tort concepts or on the existence of fraud perpetrated against the injured party by the defendant.

The policy was nonstandard in that it limited the period for suit to be commenced to two years and one day “next after discovery by the assured of the occurrence which gives rise to the claim.”[^40] The court noted that suit was filed too late after the “occurrence, the hailstorm.”[^41] There was no need to consider whether the water damage to the bottom layers of grain might

[^36]: Id. at 748, 184 N.Y.S.2d at 171.
[^37]: Id.
[^38]: 425 F.2d 1168 (5th Cir. 1970).
[^39]: Id. at 1169.
[^40]: Id.
[^41]: Id.
have occurred more recently, as there arguably would have been
had the operative word been “loss” as opposed to “occurrence.”

In Marshburn v. Associated Indem. Corp., the insured’s home
was struck by lightning. There was smoke damage, scorched
walls, and damage to the heating system and television. Addi-
tionally, there were cracked and loosened bricks on a rear win-
dowsill. The loss was adjusted.

Three years later, the insured noticed cracks along the mortar
joints and through some of the bricks immediately below the
windowsill. He contacted the insurer and was requested to dig a
trench down to the concrete footings. After inspection by an
engineer, the insurer denied the claim on the basis that the
cracks in the footings were a result of water intrusion at the
foundation and drainage problems which rendered the soil unsta-
ble. After a contrary report by the insured’s engineer and a
confirmed denial by the insurer, the insured filed suit five and
one-half years after the original lightning strike and two and one-
half years after the cracking of mortar joints was noticed. The
North Carolina standard fire policy contains a three-year suit
limitation period.

With respect to the contractual suit limitation period, the court
stated that “inception of the loss” means that the “policy limi-
tation period runs from the date of the occurrence of the event
out of which the claim for recovery arose....” Therefore, “the
insured’s failure or inability to discover damage resulting from
the insured against casualty until after the contractual limitations
period has run is immaterial and does not operate to toll or
restart the limitations period.”

The insureds also contended that the statutory standard fire
policy, G.S. 58-176, as incorporated by the insurance policy, did
not govern their claim because of the nature of their loss. They
asserted that their claim was instead governed by G.S. 1-52(12)
and G.S. 1-52(16). G.S. 1-52(12) prescribes a three-year period for
the commencement of an action “upon a claim for loss covered
by an insurance policy which is subject to the three-year limita-
tion contained in lines 158 through 161 of the Standard Fire
Insurance Policy for North Carolina, G.S. 58-176(c).”

43. Id. at 370, 353 S.E.2d at 126.
44. Id.
Another part of the same statute, G.S. 1-52(16), provides:

Unless otherwise provided by statute, for personal injury or physical damage to claimant's property, the cause of action, except in causes of actions referred to in G.S. 1-15(c), shall not accrue until bodily harm to the claimant or physical damage to his property become apparent or ought reasonably to have become apparent to the claimant, whichever event first occurs. Provided that no cause of action shall accrue more than 10 years from the last act or omission of the defendant giving rise to the cause of action.\(^45\)

The insureds asserted that the purpose for including the standard fire policy provision in the G.S. 1-52 scheme was so that the accrual provisions of 1-52(16) would apply to the standard fire policy as well as other causes of action.

This argument was rejected. The court held that G.S. 1-52(12) merely provides a cross reference between the general statutory period of limitation in G.S. 1-52 and the specific standard fire policy provision in G.S. 58-176. Furthermore, it observed that G.S. 1-52(16) provides by its own terms that it applies "unless otherwise provided by statute," and the standard fire policy contains a limitation period "otherwise provided by statute."\(^46\)

Thus, the court declined an invitation to make a statutory discovery rule applicable to the standard fire policy.

Taken as a whole, the cases addressed in this subsection indicate that once an insured has experienced a loss to his property, he is expected to ascertain the full extent of that loss in making claim to his insurer. If he fails to do so and discovers aspects of the loss at a later date, the running of the period for filing suit will not be postponed in light of this later discovery.

**B. Loss Itself Undiscovered**

The insured is the owner of a tenant-operated filling station. After monitoring by the tenant revealed soil contamination, an on-site inspection by the owner uncovered other pollution losses which the tenant had discovered but not reported. The owner filed claim for these other losses. Will his late discovery of the losses which were previously known to his tenant be an adequate excuse to

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\(^45\) Id. at 371, 353 S.E.2d at 127 (construing N.C. Gen. Stat. § 58-176(c) & 1-52(12) & (16) (1988)).

\(^46\) Id. at 372, 353 S.E.2d at 127-28.
overcome the insurer's suit limit defense with respect to those losses?

In *Sager Glove Corp. v. Aetna*, the insured corporation brought an action against 22 insurance companies to recover for vandalism and malicious mischief losses. Sager alleged that acts of vandalism occurred over a period of two years before the losses were discovered. Upon discovery, the losses were reported immediately. However, suit was not filed for approximately another year. The court held that suit could be brought only with respect to those acts of vandalism alleged to have occurred within one year of the filing of suit. Thus, suit could be brought only with respect to acts which occurred on three days. The court held that it was the insured's burden to show exactly what losses occurred on those three days and that because the insured failed in that burden, a grant of summary judgment for the insurer was proper.

Interpreting the phrase "twelve months next after the inception of the loss," the court reasoned that the phrase "has nothing to do with the state of mind of the insured. It deals with an objective fact which in the context of this case is a specific act of vandalism or malicious mischief. The loss occurs and has its 'inception' whether or not the insured knows of it."48

This emphatic language was relied on by the court in *General State Auth. v. Planet Ins. Co.*49 The Authority gave the insurer notice of a fire two years and four months after it occurred, immediately after being informed of the fire by an official of the Department of Public Welfare, which was leasing the building in question. The Authority argued that it should be excused from compliance with the 12-month limitation because of the context of governmental relationships, because it was so occupied with its primary task of current construction administration that it was unable to keep completed projects under constant surveillance. The court adopted the *Sager* holding with the caveat that if conduct on the part of the insurer is responsible for the insured's failure to comply with time limitations, injustice is avoided by resort to traditional principles of waiver and estoppel.

47. 317 F.2d 439 (7th Cir.), cert. denied, 375 U.S. 921 (1963).
The Sager holding was also quoted and relied on in Wilson v. Indiana Ins. Co. In Wilson, while the insured was away from her home for four days, a hot water pipe in the crawl space burst. The insured did not become aware of the problem until 10 months later, when she observed cracks in walls and separations between cabinets and walls. During the interim period, insulation had absorbed moisture, which caused joints, beams, and flooring to decay. The decay, in turn, reduced the strength and load carrying capacity of the floor system. The weakened floor system gave way to the cracks which the insured subsequently observed.

The insured filed suit 20 months after the pipe burst, but nine months after discovery of the damage. The insured asked the court to "establish a rule that if the loss is discovered within a reasonable time, the time of discovery be deemed to be the time of 'inception.'" Relying on and quoting Sager, the court declined to adopt a "discovery rule."

These cases suggest that an insured's ignorance of conditions on his property, which ignorance is due to the insured's failure to police the property, will serve as no excuse for late filing of an insurance claim.

C. Latent Loss Undiscovered But Due to Insured's Negligence

Soil monitoring at the insured filling station suggests contamination. The station's inventory records, starting back a couple of years ago, reveal that a slight but significant and consistent discrepancy between gasoline received and gasoline sold began to appear at that time. The insured did nothing at that time to investigate the discrepancy. Will his suit now be barred by the insurer's suit limit defense?

In Stinson v. Home Ins. Co., the insureds purchased their home, noted that it had been damaged by settling and cracking, and watched those problems worsen during their first years of ownership. Fourteen years after purchase, the insureds decided the damage was more than mere wear and tear and submitted a

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51. Id. at 672, 502 N.E.2d at 71.
52. Id.
claim to the two insurers who had provided them coverage during that time. The second carrier settled the claim, and the insureds and the second carrier sued the first carrier.

The insureds argued that their awareness of a claim and consequent opportunity to submit a claim starts the limitation period running. They relied heavily on Zurn, discussed above.

The court distinguished Zurn on the basis that there, the insured could not submit a claim until the city denied liability for the damage. In this case there was no evidence that anything prevented the insureds from bringing a claim within 12 months of the first policy's termination.54

Similarly, in Lawrence, discussed above, the court stated that even if it were to accept the liberal Zurn construction that the inception of the loss means the accrual of a cause of action against the insurer, the insured's cause of action accrued no later than when he received a laboratory report approximately a year after the loss, when he "knew or should have known"55 that his lot had been improperly compacted. Suit was filed roughly two and one-half years after the loss was discovered.

Just how strictly a court will enforce the should-have-discovered standard is illustrated in the case of Fire Ins. Exch. v. Superior Court (Johnson),56 officially uncitable pending review by the California Supreme Court, but useful nonetheless as an example of possible judicial reaction to the hypothetical posed. In Johnson, an insured was working on the repair of her roof when she discovered that the rafters in the attic had separated from the bridgeboard by three to four inches. Over the next few months, she became aware of other cracks in the house and realized the problems were related. She filed a claim with her current insurance carrier. That carrier investigated, reported that her loss was due to soil subsidence, denied the claim, and referred the insured to her previous carriers, including the one involved in Johnson. Subsequently, the insured filed claim against the previous carriers and, after denial of the claims, filed suit. The suit against the carrier in question in Johnson was filed

54. Id. at 885.
approximately two and one half years after discovery of the problem in the attic. The court held:

Applying a reasonableness standard to these facts, we conclude the December 1984 damage was unusual and severe enough to start the contractual limitations period. Johnson's observation of this damage gave her the specialized knowledge she needed to place her under a duty to investigate her rights under the policy. These objective facts, not her receipt in October 1985 of the Fireman's Fund rejection of her claim and reference to soil subsidence as the cause of the distress, control the application of the limitations period to her claim. 57

In Johnson, the insured was aware that she had a loss and filed claim against her current insurer. However, she was not aware that she had suffered a loss during a previous policy period and, therefore, did not file claim or suit against her prior insurers. The court's holding demands of an insured not only that she investigate to ascertain if she has a loss and an insurance claim but that she ascertain just when that loss began.

One final case where the insureds did not investigate their loss with due diligence was Elsey v. Hastings Mut. Ins. Co. 58 Elsey involved a settling/collapse situation. Suit was filed approximately four and one-half years after the insureds first noticed a hairline crack in their fireplace. The insureds argued that inception of the loss meant the time at which the insureds had knowledge of the cause of loss and could bring suit. They argued that they had no knowledge until they received an engineer's report immediately prior to bringing suit. The court reasoned that even accepting the insureds' legal argument, such knowledge could have occurred no later than a year after a contractor evaluated the home and told them to have it re-measured a year later. The court spoke of a "duty" 59 on the part of the insureds to have the house re-measured.

The court also reasoned, in response to what it perceived to be a discovery of loss argument on the part of the insureds, that the discovery argument failed because, through the exercise of

57. Id. at ___, 260 Cal. Rptr. at 304.
59. Id. at 488, 411 N.W.2d at 462. For a case illustrating the duty of an absentee landlord in this regard, see Abari v. State Farm Fire & Casualty Co., 205 Cal. App. 3d 530, 252 Cal. Rptr. 565 (1988).
reasonable diligence, the insureds should have discovered their loss when one of them told an attorney co-worker the house was collapsing, prior to the contractor's initial visit.

Another way of articulating the concept addressed in these cases is that plaintiffs cannot fail to investigate when the need for investigation is naturally suggested by the circumstances known to them. Without such a rule, insureds would have latitude to discover losses or file claims at their whimsy.

D. Latent Loss Undiscovered Despite Nonnegligent Insured

Soil monitoring at the insured filling station suggests contamination. The station's inventory records, starting back two years ago, reveal that a slight discrepancy between gasoline received and gasoline sold began to appear at that time. However, the insured established that such a slight discrepancy normally indicates a problem with a gauge and would not be considered cause for further investigation. Under these circumstances, will the insured's discovery now that a leak began two years ago justify his late filing so as to overcome the insurer's suit limit defense?

Many of the cases discussed above bear on the answer to this hypothetical, and there are two additional cases to be discussed. First, let us consider cases the broad language and sweeping approach of which arguably indicate that the suit here would be barred. On the other hand, it should be noted that these cases might be distinguished on the basis that they did not involve both a latent occurrence and a latent loss, as does the hypothetical here.

First, let us review Wilson, where a pipe in a crawl space leaked for ten months. The Wilson court did not consider whether an insured in the exercise of due care would be aware of the sound of water dripping from a pipe or would periodically check his or her crawl space for potential problems. It simply rejected application of a discovery rule. Thus, it appears that even had the insured in Wilson been seen to have exercised due care, her suit would have been barred. Similar reasoning might be applied to Planet and Sager.

In Marshburn, the court pronounced that the insured's "failure or inability" to discover the loss was immaterial. Although in

Marshburn, the insured was on notice of the initial occurrence of lightning, the subsequent cracking of footings was a latent damage in that an ordinary insured in the exercise of due care would arguably not sustain the expense and inconvenience of excavation to expose the footings of his home until specifically alerted to the possibility of damage there.

In Harris, the court explicitly rejected application of a discovery rule on the basis that it was confined to situations involving limitations on actions in tort or where there had been fraud on the part of the defendant. The court did not bother to entertain the insured's argument that in the exercise of due care he could not have discovered damage to the grain at the bottom of the warehouse until he removed all the grain. Arguably, that damage was also latent in that the insured in the exercise of ordinary care would not have undergone the expense of emptying an entire warehouse after reaching a layer of grain which appeared to be dry.

With respect to Stinson, Lawrence, and Elsey, it should be noted that those courts did not reach the issue presented by the hypothetical here. Each of those courts assumed, for the sake of argument, that a discovery rule was applicable and then held that it afforded no relief under the circumstances involved. Therefore, none of those courts needed to address, nor did they address, the issue of whether a discovery rule would actually apply given an insured not negligent in discovering his claim. The court in Johnson, however, did adopt a discovery rule before rejecting its application to the facts before it.

Two of the cases previously considered lend support to the insured's argument here. In Olson, where the missing plane was undiscovered for roughly two years, it appears the insured was non-negligent in discovering the plane. The court held the insured's delay in filing suit was justifiable. The court referred to the possibility that the entire one-year suit period might elapse before an insured discovered a loss.

In Tomlin, where the insureds excavated and discovered a decaying tree trunk under their home, it appears that the insureds were not negligent in discovering their loss. The court commented that the "loss began when it was detectable." 61 It is somewhat

disturbing that the court did not better articulate this standard, and in failing to do so left open the question of what would have happened had the insureds waited another year to dig under the foundation. It should also be noted that the result might be explained in terms of the insurer's failure to divulge the engineer's speculations about the possibility of decay under the home. Nonetheless, the case may be cited for the rule that an insured has a year to file suit from the time his loss becomes detectable.

In two cases yet to be discussed, courts have formally announced that they would apply a discovery rule in a suit limitation context. Although these announcements were dicta, since they did not need to be made given the facts before the courts, they were nevertheless meant to state the law of the jurisdiction.

In Prete v. Royal Globe Ins. Co., the insureds discovered cracks in a corner of their apartment building. The cracks were repaired but reappeared in the same place. Almost four years after the initial cracks were discovered, the insureds were repairing the building and discovered a separated P-trap, which they alleged caused the damage to their apartment. They filed suit approximately 15 months after discovering the separated P-trap.

The federal district court summarily opined that the West Virginia Supreme Court would take the discovery rule which it had applied in legal and medical malpractice situations and apply it as well to the contractual suit limitation period. Observing that West Virginia commences the period running after the insured has had 60 days to file proof of loss, the court held that the suit was barred because it was brought more than one year and 60 days after discovery of the loss. Although the court stated that the discovery rule starts the time running when an insured actually learned or by the exercise of reasonable diligence should have learned of the damage to his property, the court did not have to consider whether the insureds exercised due care, since their filing was barred even in light of the date of actual discovery.

The second case, Prudential-LMI Commercial Ins. v. Superior Court (Lundberg), is officially uncitable pending review by the California Supreme Court, but is useful as an example of possible

judicial reaction to this hypothetical and to the next hypothetical posed. Lundberg adopted a discovery rule like that adopted in Prete. Lundberg is discussed with respect to the next hypothetical.

E. Latent Loss, No Negligence, Several Insurers

Soil monitoring at the insured filling station suggests contamination. The insured consults an expert who informs him that he has a massive contamination and that it is likely his tank has been leaking for upward of 15 years. The insured sues the four carriers who have been on the risk since the tank was installed 20 years ago.

A slight inventory discrepancy, which existed since tank installation, was not suspected by the owner to indicate a leak nor would such a discrepancy have indicated a leak to most station owners. Will a suit limit defense be valid for any of the four carriers?

In Prudential-LMI Commercial Ins. v. Superior Court (Lundberg), the insureds were replacing floor covering in one of the apartment units when they discovered an extensive crack in the foundation and slab floor of the building. Investigation revealed the cause of the crack was expansive soil, which caused stress, rupturing the foundation. The insureds filed suit against the four insurers who had been on the risk consecutively since the insureds built the apartment house 15 years before the discovery in question. Although notice was prompt, suit was filed more than one and one-half years after the damage was discovered. Thus, the court ultimately concluded that their action was barred.

However, in a lengthy opinion, the court announced that it would consider “the issues of whether an insured is required to comply with an internal policy notice of claims provision and one-year suit limitations period when the claimed loss could not reasonably have been discovered within the policy period.” In light of the facts of the case before it, the court narrowed the issue to consideration:

[Of whether a progressive property damage loss such as, but not limited to, land subsidence is qualitatively different from other forms of property damage compensable under a property damage

64. Id.
65. Id. at ___, 260 Cal. Rptr. at 86.
policy, such that the usual rules for determining timeliness of a claim and action thereon should be altered .... As will be shown, gradually incurred loss may be found to have caused an effect ... even when no person was there to perceive it. ....

The court reviewed California law regarding differences and similarities between property and liability insurance. It then reviewed some of the suit limitation authority regarding the time for filing suit in instances where damage is immediately observable.

Stating that, as a matter of policy, it would seek to interpret the notice and suit limitation requirements so as to avoid forfeiture on procedural grounds, the court embarked on a consideration of the pre-manifestation authority in the field of liability insurance. Since previous property insurance law had not, in the opinion of the court, addressed itself to progressively incurred damage, analogy to this authority was necessary.

The court observed that this authority focused on "the equities of holding pre-manifestation carriers jointly and severally liable where the claimed damage progressively developed over a long period of time, and thus no bright-line date of injury could be identified. Instead, in those cases, an exposure period and a manifestation of injury date marked the time the damage began to be incurred and the time it could be recognized as such." 67 The court analogized between gradually incurred disease and gradually incurred damage to a building structure. It stated that "[s]uch a fact pattern is distinguishable from the usual situation in which damage is eventually incurred when a specific negligently caused event later results in loss after a period of dormancy." 68

The court then observed that a loss could be fortuitous as to a subsequent carrier although the damage began before the start of that carrier's policy period. Since the loss was undetectable prior to the start of the subsequent carrier's policy period, the possibility of loss was a mere contingency or risk from the point of view of the parties at the time they contracted. The court then concluded that "apportionment of damages between those insurers whose policy periods were in effect during the ongoing

66. Id. at —, 260 Cal. Rptr. at 88.
67. Id. at —, 260 Cal. Rptr. at 93.
68. Id. at —, 260 Cal. Rptr. at 94.
development of the injury would be an equitable result." 69

From this entire line of thinking, the court concluded that progressive property damage is different from the type of damage for which notice and suit limit provisions were designed. With respect to progressive damage, the notice and time for suit provisions should logically start to run the date appreciable damage is detected. Otherwise, the merits of these disputes could never be litigated.

Having come to this conclusion, the court embarked upon an attempt to reconcile delayed discovery principles previously applicable only to statutory limitation periods with the contractual notice of claim and one-year suit provisions in question here. The court enunciated the rule: A cause of action accrues when the plaintiff discovers or should have discovered all facts essential to his cause of action. It noted that the rule had been extended from tort actions to a breach of contract cause of action in a case where a defendant secretly erased tapes in which the plaintiff had an interest. That extension was justified by the following considerations: (1) The injury and or the act causing the injury were difficult to detect. (2) The defendant was in a superior position to comprehend the injury and knew the plaintiff remained ignorant of the harm.

The Lundberg court took note of the fact that the plaintiff's action was not against the contractor who constructed the building but against a first-party insurer. It nevertheless analogized between the two situations on the basis that, in each, the plaintiff was "‘blamelessly ignorant’" 70 of his cause of action.

Having attempted to bridge the gap between a situation involving a harm created by a party to a contract and a harm unknown to both parties to a contract, the court sought to consider the analogy between a general contract statute of limitations and a suit limitation period. The court quoted several sources to support its conclusion that there is no meaningful reason to distinguish between the two for purposes of applying delayed discovery principles.

The court then set forth two procedural safeguards against unmeritorious claims. First, the plaintiff must establish "‘that he

69. Id. at ___, 260 Cal. Rptr. at 96.
70. Id. at ___, 260 Cal. Rptr. at 97 (paraphrasing April Enterprises v. KTTV, 147 Cal. App. 3d 805, 195 Cal. Rptr. 421 (1983)).
had no actual or presumptive knowledge of facts sufficient to put him on inquiry .... [w]hether the plaintiff exercised reasonable diligence is a question of fact...."71

Second, insurers may assert prejudice from the lateness of the claim and action. Lateness will not result in a presumption of prejudice, however, and the insurer must show "it suffered actual prejudice, in the form of inability to conduct an adequate investigation or otherwise defend the claim."72

IV. Analysis

The difficult continuous loss situation for suit limitation purposes involves the insured who is genuinely and reasonably surprised by his loss although it has been occurring for years. When should the period for filing suit begin to run for him? Should he be able to sue previous as well as current carriers? How would jurisdictions which have not considered these questions evaluate them in light of the existing precedent?

A. Pro and Con Delayed Discovery Standard

First of all, how would a court, new to the issue, respond to an insured's urging that it adopt a delayed discovery standard in a latent loss situation?

It may be useful to categorize jurisdictions as follows: (1) jurisdictions which hold that inception of the loss, insofar as it is the trigger for the limitation period, is said to be the time the loss occurs;73 (2) jurisdictions which hold that inception of the loss for that purpose is said to be the time the cause of action accrues.74 The Lundberg court noted in a footnote that it had an accrual decision in its jurisdiction.75 It is conceivable that some

71. Id., 260 Cal. Rptr. at 99 (quoting April Enterprises, 147 Cal. App. 3d at 833, 195 Cal. Rptr. at 437).
72. Id. at ——, 260 Cal. Rptr. at 99 (citing Northwestern Title Sec. Co. v. Flack, 6 Cal. App. 3d 134, 142-43, 85 Cal. Rptr. 693, 697-98 (1970)).
73. See, e.g., Brunner v. United Fire & Casualty Co., 338 N.W.2d 151 (Iowa 1983) (time began to run from date of fire rather than date of denial of claim).
other "accrual" states would do likewise in moving from an accrual to a discovery position.

It should be noted, however, that most accrual states hold that the time of accrual is the time the insurer denies the claim.76 Such holdings were a simplified method of giving an insured a full year to file suit and did not concern a potentially lengthy extension of the limitation period.77

Another factor to be considered with respect to adoption of a delayed discovery standard is whether a jurisdiction applies a discovery rule to contract actions in general or whether it limits the application of the rule to tort actions and actions involving fraud.78 One jurisdiction has extended the discovery rule to all actions.79

Even if a jurisdiction applies a discovery rule to a breach of contract action, it may not be willing to extend the rule to an action on a property insurance contract. To make the leap from a breach of contract action to an action on an insurance contract, the Lundberg court examined the reasons for applying the rule in the breach of contract action, namely, that the injury was difficult to detect and that in most instances the defendant was in a superior position to comprehend the injury and knew the plaintiff remained ignorant of the harm. Acknowledging that the only similarity in the insurance case was that the injury was difficult to detect and that the plaintiff, therefore, was blamelessly ignorant, the court nevertheless held the discovery rule applicable in the insurance case, while conditioning its adoption of the rule on the insurer's opportunity to show itself prejudiced thereby.

Some jurisdictions might find fault with this approach. First, some might not be willing to make the leap to applying a discovery rule to a property insurance contract where the insurer had no knowledge of the loss and in no way concealed anything from the plaintiff.80

76. See, e.g., Sand Lake Lounge, 514 P.2d 223.
77. Id.
Even the insurer's opportunity to show prejudice might not suffice for such a court. One justice has stated that a showing of prejudice by an insurer would require a full trial on the merits.\textsuperscript{81}

Some jurisdictions, in considering whether to extend a discovery rule from the tort sphere to cases involving implied warranty, have employed a balancing approach in that they have considered the type of prejudice likely to result to the class of defendant against whom the plaintiff was asserting a discovery rule.\textsuperscript{82} In implied warranty cases, courts have noted that the burden of proving a prima facie case is on the plaintiff.\textsuperscript{83} In insurance cases, property insurers have significant burdens of proof with respect to policy exclusions, and it might be argued that the inherent prejudice is to be presumed greater than in implied warranty cases.

Furthermore, there is a difference between a general contract statute of limitations and a suit limitation period of a property insurance policy. One court observed that the theory behind the conclusive effect of any limitation period is that "'the right to be free of stale claims in time comes to prevail over the right to prosecute them.'"\textsuperscript{84} That court observed further that the statutorily mandated one year contractual limitation period before it was "'the result of long insistence by insurance companies that they have additional protection against fraudulent proofs, which they could not meet if claims could be sued upon within four years as in the case of actions on other written instruments....'"\textsuperscript{85}

It might also be considered that the doctrines of waiver and estoppel are for property insurance law what the discovery rule is for general tort and contract law. The doctrines of waiver and estoppel apply to prevent an insurer from raising a suit limit

\textsuperscript{3}d 1131, 260 Cal. Rptr. 85, 97 (1989), \textit{review granted}, September 21, 1989 (acknowledging this discrepancy). \textit{See also} Matsumoto v. Republic Ins. Co., 792 F.2d 869 (9th Cir. 1986).


\textsuperscript{82} \textit{See}, \textit{e.g.}, City of Aurora v. Bechtel Corp., 599 F.2d 382 (10th Cir. 1979).

\textsuperscript{83} \textit{Id.} at 388.


\textsuperscript{85} \textit{Id.}
defense when that insurer has led the insured to believe that his claim would be paid and the insured, therefore, had no reason to file suit. In other words, when the insurer has knowledge of its intended denial of the claim but conceals that fact from the insured, the suit limitation period is extended accordingly. Similarly, the discovery rule applies in situations where the tort or breach of contract is known only to the defendant. To apply the discovery rule to a loss under an insurance contract is not comfortably analogous to applying the same rule to a breach of a construction or other contract. An insurance contract is not a warranty.

Notwithstanding all of these distinctions to be drawn between a statute of limitations as applied to a breach of contract and a suit limitation clause as applied to a loss under an insurance policy, some jurisdictions may agree with the Lundberg analogy that in neither situation has the plaintiff slept on his rights and in neither should he be prevented from bringing a claim for a loss which, due to no fault of his own, he did not discover earlier.

B. Delayed Discovery Safeguards

Jurisdictions that would adopt a delayed discovery rule would also stress that the Lundberg safeguards are sufficient to protect an insurer from unfairness while simultaneously protecting an insured's right to litigate his claim on the merits. These safeguards are two: (1) the insured has the burden to show that he exercised due diligence in discovering his loss, and (2) the insurer has the opportunity to show that it would suffer actual prejudice were the late suit to be allowed.

The first safeguard restates the definition of the delayed discovery standard. It stresses that the time period begins to run when the insured discovered or should have discovered his loss. What it adds is that it is the insured's burden to prove that he discovered his loss as soon as it would have been reasonably observable to him in the exercise of due care about his property.

Courts have been strict in applying this safeguard. For example, in Stinson, Lawrence, Johnson, and Elsey, the courts found

that the insureds should have discovered their losses earlier in the exercise of due care and that their suits were consequently barred. No case has been located in which the insured succeeded in carrying this burden of proof.

The reported cases have all involved some type of earth movement and some visible change in the insureds’ property. In our pollution hypotheticals, the change in the property is underground. Thus, the indicators of possible loss would not be visible changes in the property itself, but would consist of an inventory discrepancy not easily explained except by the possibility of a leaking tank. Despite this difference between the two types of situations, it appears that a court would be as strict in interpreting an insured’s burden under a delayed discovery standard in a pollution scenario as it would be in an earth movement case. Although the insured discovering a pollution loss might argue that his loss would not have been reasonably observable to him earlier because there was no change in his property, as there would have been in an earth movement loss, the indications provided by his inventory discrepancy would probably be considered by a court as the equivalent for him of the changes in property for the insured with an earth movement loss.

If an insured did sustain its burden under a delayed discovery standard, an insurer would have the opportunity to prove that it would be prejudiced were the late suit allowed. The *Lundberg* court stressed that, for it, prejudice would not be presumed by the passage of time. Rather, an insurer would have to show that it suffered “actual prejudice, in the form of inability to conduct an adequate investigation or otherwise defend the claim.”

Proving prejudice may involve a full trial on the merits of the claim, as mentioned previously. In effect, an insurer would have to present its case on the merits and demonstrate at what points evidence was missing which would not have been missing had the claim been timely filed. Although the case would not be sent to the jury on its merits, the question of prejudice — inability to flesh out the merits — would be sent to the jury.


Two other areas where an insurer might suffer prejudice are subrogation and correction of the loss. If an insurer's potential suit against a party which may be responsible for a loss is barred by a statute of limitations governing that claim, some courts might consider that insurer prejudiced by the insured's late filing. 89

With respect to correction of the loss, it might be argued that an insurer was prejudiced by late filing because, due to the delayed discovery, there was no opportunity either for the insured to mitigate the loss or for the company to make timely remedial measures to stop the continuous loss. 90

It should be noted that the Prete court made no mention of an insurer's right to establish that it would be prejudiced if late suit were allowed. It appears that adoption of a prejudice safeguard is essential to any delayed discovery rule and that its omission in Prete was probably an oversight due to the brevity of that opinion. Without a prejudice safeguard, insureds discovering their losses after an excusable delay might have a better chance of pressing claims against insurers than would insureds discovering their claims promptly.

C. Prior Carriers

For coverage purposes, should a loss be said to have occurred during a previous carrier's policy period when the loss was not reasonably observable by the insured at that time? The Lundberg court recognized that this issue presented a substantive determination. Although it set out to confine itself to the suit limitation issue, it expressed an opinion on this substantive question as well. It stated that apportionment of damages between insurers whose policy periods were in effect during the development of the injury would be an equitable result. How sound is the Lundberg reasoning and result on this issue?

89. See Katofsky, Subsiding Away: Can California Homeowners Recover From Their Insurer for Subsidence Damages to Their Homes?, 20 PAC. L.J. 783, 806 (1989); and Hook, Multiple Policy Period Losses and Liability Under First-Party Policies, 21 TORT & INS. L.J. 393, 402 (1985) [hereinafter Hook].

With respect to the factor of subrogation, late filing of suit is prejudicial when accompanied by late notice, which is often the case in delayed discovery situations. 90. See Hook, supra note 89, at 402. As with loss of subrogation rights, loss of opportunity to correct a problem occurs with late filing of suit when late filing is accompanied by late notice.
The Lundberg court relied primarily on case law involving liability insurance for bodily injury and property damage. It reasoned that "in some respects, a building undergoing soil subsidence distress or other progressive, continuous deterioration can in some respects be likened to a 'sick' or decaying structure."\(^{91}\)

There are several problems with the court's reliance on a property/liability analogy. First, the court stated in an overview of its own prior decision in *Home Ins. Co. v. Landmark Ins. Co.*,\(^{92}\) that in *Home*, it distinguished between asbestos bodily injury cases and cases, both liability and property, involving continuous property damage, on the ground that in asbestos bodily injury cases "'injury is immediate, cumulative and exacerbated by repeated exposure.'"\(^{93}\) Thus, in *Home*, the court grouped together property insurance cases and liability insurance cases involving property damage and distinguished liability insurance cases involving bodily injury. In *Lundberg*, the court grouped together all three, relying, for a property insurance decision, primarily on asbestos bodily injury cases, although it did also mention a liability insurance property damage case.

Another problem with the property/liability analogy is the way it squares with the other case the court discussed as background to its opinion — the decision of the California Supreme Court in *Garvey v. State Farm Fire & Casualty Co.*\(^{94}\) As the *Lundberg* court noted, the *Garvey* court expressly distinguished between property insurance and liability insurance. It reasoned that the "'cause' of loss in the context of a property insurance contract is totally different from that in a liability policy."\(^{95}\)

The *Lundberg* court did not attempt to distinguish *Garvey*, but instead stated that it must look to the definition of "property damage" in the liability section of the homeowners policy in the absence of a definition of loss in the property section. It reasoned that property damage is defined as "physical injury or destruction of tangible property which occurs during the policy period."\(^{96}\)

\(^{95}\) Id. at 406, 770 P.2d at 710, 257 Cal. Rptr. at 298.
\(^{96}\) 211 Cal. App. 3d at ----, 260 Cal. Rptr. at 95 (italics deleted).
Thus, it framed the issue as whether ongoing damage may qualify as "‘occurring’"\(^97\) during the policy period.

In addition to ignoring the thrust of Garvey, this line of reasoning is oblivious to the presence of the word "loss" in more than one place in the homeowners policy. The property section of a homeowners policy commonly provides that an insured must bring suit within 12 months of the "inception of the loss." The same policies provide: "This policy applies only to loss under Section I or bodily injury or property damage under Section II, which occurs during the policy term."\(^98\) Even in the absence of such an explicit policy provision, it is difficult to imagine property insurance coverage aside from that which indemnifies for a loss which occurs during the policy period.

If a court holds that a suit limitation period that runs from "inception of the loss" does not, in fact, start to run until that loss becomes reasonably observable, that court is redefining the concept of loss. Whereas "loss" might ordinarily refer to a physical actuality, "loss" now includes the concept of an insured's awareness. If a court so revises the definition for suit limitation purposes, should it not, in fairness, also revise the definition for purposes of evaluating whether a loss occurred within a given policy period?\(^99\)

The logic of this argument may be illustrated by examining a hypothetical loss situation involving a fire at a cabin in the mountains: The insured discovers a fire loss while Carrier B is on the risk, but the loss occurred during the policy period of Carrier A. According to traditional property insurance concepts, Carrier A will respond for the loss because it was on the risk at

\(^{97}\) Id.

\(^{98}\) See standard forms issued by the Insurance Services Office (ISO) (emphasis added).

\(^{99}\) Of course, it can always be argued that the word "loss" in a non-negotiated policy must be interpreted to favor the insured, even if that interpretation is inconsistent with the interpretation of the same word in a related policy provision.

This article stresses the conceptual difficulties in resolving the property insurance issues considered here by relying on analogy to liability insurance cases. It should be noted, however, that jurisdictions have solved the prior carrier issue with respect to liability coverages by using at least six different approaches.

See Howard, "Continuous Trigger" Liability: Application to Toxic Waste Cases and Impact on the Number of "Occurrences," TOTT & INS. L.J., Vol. XXII, No. 4 (1987). If a court considering a property insurance situation were to draw analogy to the manifestation approach, for example, it would presumably find prior property carriers not liable for continuous losses.
the time of the physical event insured against. Analogizing from that traditional situation to the situation involving a continuous loss, proponents of apportionment among prior and current carriers argue that all carriers on the risk during the development of the physical event insured against should respond for the loss.

The problem with their argument is that it assumes a court faced with the hypothetical would apply a delayed discovery standard in measuring compliance with the suit limitation period. However, based on the cases examined in this paper, that assumption does not appear to be valid. Courts have consistently suggested that insureds have a duty to police their property. The insured in the cabin hypothetical would probably be expected to have a system for keeping watch on his cabin, be that a resident of the general area or a mechanical alarm. Correspondingly, since a court would be likely to treat the cabin fire for suit limitation purposes as having occurred at the actual commencement of the fire, it makes sense that a court would treat the same loss as having occurred at that same time for purposes of determining which carrier was on the risk when the loss occurred.

Returning to Lundberg, the court rationalized the result of its property/liability analogy by noting that a continuous loss which is not reasonably observable to an insured is fortuitous as to each carrier which comes on the risk before the loss becomes reasonably observable. Thus, reasoned the court, it is appropriate for a continuous loss to be apportioned among all such carriers.

One of the cases mentioned by the court in this regard was the California Supreme Court decision in Snapp v. State Farm Fire & Casualty Co.100 However, the Snapp holding was that a carrier cannot terminate its liability during the occurrence of a peril insured against. The purpose of the Snapp rule is apparently to protect an insured once a peril, like the landslide in Snapp, has been set in motion. A subsequent insurer would not be likely to underwrite a risk knowing of a peril in motion. Further, if it did write a policy in ignorance of the circumstances but while the insured was aware of them, the continuing loss would not be considered fortuitous as to that carrier.101

100. 206 Cal. App. 2d 827, 24 Cal. Rptr. 44 (1962).
In a continuous loss situation, but one involving a latent loss, as *Snapp* did not, there is no reason to prevent the first carrier from cancelling its policy or terminating liability while the loss is in progress. So long as the loss has not become reasonably observable to the insured, the property may be insured up to its entire value by any subsequent insurer. Thus, it can be seen that the doctrine of fortuity works in favor of allowing each carrier's potential liability to terminate when a subsequent carrier's policy period begins. Assuming an insured has maintained insurance in force during the entire development of a continuous loss, the carrier on the loss when it became reasonably observable to the insured would respond for that loss.

Notwithstanding problems with the *Lundberg* reasoning, some property claimspeople favor the *Lundberg* result of apportioning liability among carriers which were on the risk until a loss became reasonably observable. They argue that each carrier was paid a premium for a policy period in which loss did actually occur.

One response to this line of thinking, which stresses premiums received, is that premiums received by an insurer in 1970, for example, bear little value resemblance to today's currency. If a carrier who was on a risk in 1970 must pay for a loss discovered in 1990, how will that carrier evaluate the cost of repair — in the current dollars required for actual repair or in the 1970 dollars in which the premiums were paid? A similar problem arises in commercial property policies with respect to establishing the value of property to determine if an insured has complied with coinsurance requirements. Can an insured be expected to have carried in 1970 the required 80 percent, for example, of the value of his property, if that value is measured in today's terms? But if that value is not measured in today's terms, is it reasonable to expect an insurer to pay for the loss in today's dollars?

At the end of each fiscal year, insurers set aside reserves on the basis of claims submitted and anticipated for each line of insurance they write. Property insurance policies have traditionally been underwritten on the basis that insurers promise to pay for losses which occur and are discoverable within the policy term and which are also discovered within the policy term or shortly thereafter. The longer the gap between a loss and a

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102. See Hook, supra note 89, at 405.
notice of claim and subsequent suit, if one is filed, the greater
the tension between the underwriting intentions and the insurer's
potential liability and the greater the possibility of insurer in-
solvency.\footnote{See 2 Webb, Launie, Rokes, Baglini, II Insurance Company Operations 272
(American Institute for Property and Liability Underwriters, Inc. 1984).} How is it that insurers have a potential exposure for
losses which are decades old?

When property insurers discovered that some previous stan-
dard forms might be interpreted to afford coverage for cleanup
of pollution losses, they revised many forms, especially those
insuring commercial property.\footnote{See T. Mallin, Pollution and Contamination: How Will Property Insurers Respond? (Tort and Insurance Practice Section, American Bar Association).} Thus, because many standard
forms afford limited coverage for these losses, insureds are
seeking coverage under the prior forms. In search of coverage,
some courts will be inclined to allow the suits against the prior
carriers, despite the conceptual and practical difficulties involved.
In essence, such a decision robs an insurer of its right to alter
a form insofar as the alteration may affect coverage for a latent
loss. Do insureds, themselves, really expect prior property insur-
ance policies to respond for losses which could not reasonably
have been discovered until years subsequent?

In Garvey, the California Supreme Court was protective of the
all-risk form. It rejected the doctrine of concurrent causation\footnote{The most commonly cited version of the doctrine states that where there are
multiple causes of a loss, so long as one of the causes is covered under the policy in
question, the policy provides coverage for the loss. This rule is frequently applied
regardless of the relative prominence of the several perils in causing the loss and
regardless of specific policy language to the contrary.} because the doctrine had the potential to obliterate policy exclu-
sions. It reasoned that insureds would expect an exclusion to be
operative if an excluded peril was the predominant cause of a
loss. The Garvey court concluded its holding: "Indeed, if we were
to approve of the trial court's directed verdict, we would be
requiring ordinary insureds to bear the expense of increased
premiums necessitated by the erroneous expansion of their in-
surer's potential liabilities."\footnote{Garvey v. State Farm Fire & Casualty Co., 48 Cal. 3d 395, 408, 770 P.2d 704, 711,
257 Cal. Rptr. 292, 299 (1989). In its newest commercial forms, e.g., CP 00 10 07 88, the
Insurance Services Office has clarified that coverage for removal of debris from a leaking
underground storage tank would not extend to prior carriers: "The expenses will be paid
only if they are reported to us within 180 days of the earlier of: a. The date of direct
physical loss or damage; or b. The end of the policy period."}
D. Alternatives

It has been observed that 50 percent of all money paid by insurers for environmental claims has gone for legal fees. It has, therefore, been proposed that all current commercial property insureds pay a minimal fee based on a percentage of annual premiums to finance EPA mandated cleanups. The fees would be collected by insurers and placed in an environmental trust fund, the proceeds of which would pay to clean up all sites for which the EPA has mandated cleanup. One proviso would be that the contamination discovered at the site did not violate regulations which were in force at the time the contamination occurred. This type of proposal would ease the burden on individuals responsible for enormous cleanup costs through no fault of their own, while respecting the integrity of the property insurance industry.

For courts which do decide to apportion liability among prior carriers, will insureds be entitled to sue carriers whose policy periods ended as far back as 30 years ago? Should there be no period of final repose?

For example, in a state with a statutorily mandated one-year contractual limitation period and a four-year statute of limitations on general contract claims, a court might hold that an insured has four years from the date of loss to file a claim, presuming the insurer does not show prejudice, but that after four years the suit is barred altogether. Or, a court might wish to apply a discovery rule to extend the four-year statute itself and give the insured eight years before suit would be barred.

Statutorily codified discovery rules often involve a date of final repose. For example, one state provides that a cause of action for personal injury or physical damage to a claimant’s property shall not accrue until harm becomes apparent or ought to have become apparent, “[p]rovided that no cause of action shall accrue more than ten years from the last act or omission of the defendant giving rise to the cause of action.”

108. Id.
V. CONCLUSION

It is submitted that achieving a balance between the needs of an insured to file suit on a loss which he could not reasonably have discovered earlier, against carriers on the risk at the time of discovery and while the loss progressed, and the needs of an insurer to promptly investigate a loss and to keep administrative records and financial projections in order, is no small task. It is hoped that as these difficult cases arise the needs of both insureds and insurers will be given full and fair consideration and that each state will develop a balance reflecting its own prioritizing of the competing values involved.
"DROP DOWN" LIABILITY OF THE EXCESS INSURER: CONSUMERISM V. COMMERCIAL REALITY

Jeffrey T. Kraus*

I. INTRODUCTION

Excess insurance is designed to protect against catastrophic losses resulting in large damage awards. As such, an excess insurer's defense and indemnity obligations normally attach only after losses exceed a predetermined amount of primary or "first dollar" coverage.1 Excess insurance is therefore the "layer" or "level" of coverage above the primary or "underlying" policy.2

Primary insurer insolvencies have given rise to demands by insureds that excess insurers "drop down" and fill the defense and indemnity voids left by the defunct underlying carrier. Excess insurers have consistently refused to provide such first dollar coverage. The resulting impasse has led to a significant body of case law on the drop down issue.

This article will analyze how two competing factors - the commercial realities of excess insurance and the consumer-oriented desire to protect policyholders from the unfortunate results of insurer insolvency - have impacted this developing area of jurisprudence.3

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3. This article deals solely with cases where an insurer is requested to provide indemnification and/or a defense when an underlying insurer becomes insolvent. Cases in which an excess carrier is requested to provide coverage when underlying insurance is not available for reasons other than insolvency are not discussed. See, e.g., Fried v. North River Ins. Co., 710 F.2d 1022 (4th Cir. 1983); Truehart v. Blandon, 884 F.2d 223 (5th Cir. 1989); Garmany v. Mission Ins. Co., 765 F.2d 941 (11th Cir. 1985); United States Fire Ins. Co. v. Charter Fin. Group, Inc., 851 F.2d 957 (7th Cir. 1988); Wright v. Newman, 767 F.2d 353
II. A General Overview

Cases involving insurance coverage disputes are first and foremost an exercise in contract construction. In drop down litigation, the standard judicial approach consists of a review of the excess policy wording to determine whether the parties intended for the excess insurer to step into the shoes of the insolvent underlying carrier. Unless a policy explicitly addresses the insolvency contingency, such a review becomes a semantic tug-of-war over the proper meaning of contract terms which were not drafted in anticipation of the primary insurer's insolvency.4

In general, true excess policies5 that reference the level of protection provided to a fixed amount of identifiable underlying coverage — such as "the limits of the underlying insurance as set out in the attached schedule" — have been held to not provide drop down coverage. This is because most courts have determined that such policies provide coverage which is contingent only on a stated level of loss being exceeded, thus making the ability of the underlying insurer to pay a claim irrelevant.


4. In the past, insurer insolvencies were rare and excess policies did not specifically address such a contingency. However, in response to the ever increasing incidence of insolvency in the insurance industry, excess insurers have begun to specifically disclaim drop down coverage in their policies. At least two such policies have become the subject of judicial interpretation, with predictable results. In Gibson v. Kreths, 538 So. 2d 1057 (La. Ct. App. 1989) (applying Louisiana law) the policy provided that:

In the event there is no recovery available to the insured as a result of the bankruptcy or insolvency of the underlying insurer, the coverage hereunder shall apply in excess of the applicable limit of liability specified in Schedule A.

Id. at 1059.

The court held that "unquestionably, by [this] paragraph ... [the insurer] indicated its coverage does not drop down in the event of primary insurer insolvency." Id. at 1060. See also Lamb Bros. Lumber Co. v. South Carolina Ins. Co., 186 Ga. App. 51, 366 S.E.2d 388 (1988) (applying Georgia Law) where the court denied drop down coverage in light of an identical policy provision, and stated that excess coverage "is what the parties bargained for; this is what they should get." Id. at , 366 S.E.2d at 390.

5. True excess policies are those which, by design, provide only secondary coverage. Excess coverage can also arise by "coincidence," such as when two primary policies apply to the same occurrence and an "other insurance" clause renders one policy excess. Marick, supra note 2. This article reviews the impact of the drop down demand on true excess policies.
On the other hand, excess policies which reference the level of protection to an amount of "recoverable," "collectible," "applicable," "reduced" or "exhausted" underlying insurance have at times been held to impose a drop down obligation. Drop down liability has been justified on the grounds that such policies are at least ambiguous because they can be interpreted as providing a level of coverage that varies depending on the financial withal of the underlying insurer.

There has not been a uniform construction, however, of "variable limit" policies, for many courts have declined to impose drop down coverage when confronted with references to "recoverable," "collectible," "applicable," "reduced" or "exhausted" underlying insurance. The differing constructions given these terms depend on divergent grammatical interpretations which are often filtered through the prism of "consumerism" or, alternatively, "commercial reality."

The "consumerism" perspective is that insureds — the innocent victims of insurer insolvency — should as a policy matter be provided with drop down coverage to avoid a potentially bankrupting coverage gap. The "commercial reality" perspective is that the imposition of drop down liability would frustrate the basic purpose of excess insurance — to provide low-cost coverage for a very limited type of catastrophic loss — and would transform excess insurers into guarantors of the solvency of primary insurers.

The impact these conflicting arguments have had in drop down litigation has not been uniform. In several cases where drop down coverage has been imposed, the court appeared to reject all extra-contractual arguments, reasoning that such considerations cannot change the intent of the parties as expressed in their contract. In a few cases where the insured prevailed, a consumerism argument supported the decision. In still other cases where the insured won, strained contract interpretations indicate that an unstated disposition to protect the insured was influential. And in a significant number of cases where the excess insurer was successful, a commercial reality analysis supported a finding that the excess policy was not intended to provide drop down coverage.

III. PARTICULAR DROP DOWN CASES

A. THE "AMOUNT RECOVERABLE" CASES

Policies which reference the level of excess coverage to the "amount recoverable" under an underlying policy have been the subject of frequent judicial review. This phrase has created a contractual ambiguity that doomed the excess insurer in a number of cases. In other cases, however, an opposite result was reached.

1. Drop Down Coverage Imposed

One of the leading cases in the drop down area is Reserve Ins. Co. v. Piscotta. In Reserve, the following policy provision was at issue.

The Company shall only be liable for the ultimate net loss in excess of either: ... 1. the amount recoverable under the underlying insurance as set out in the schedule of underlying insurance ....

The court found the term "amount recoverable" ambiguous because it was subject to two reasonable interpretations, one of which was that such an amount was zero when the primary insurer becomes insolvent. The policy was therefore construed in favor of the insured to "include [ ] the risk of [the underlying insurer's] insolvency within the scope of its coverage."

The Reserve court apparently rejected extra-contractual considerations and based its ruling solely on the contract language before it. Several courts have followed the Reserve approach, with similar results.

8. Id. at 812, 640 P.2d at 770, 180 Cal. Rptr. at 634 (emphasis added).
9. Id. at 815, 640 P.2d at 772, 180 Cal. Rptr. at 636.
10. The court rejected an earlier California case, McConnel v. Underwriters at Lloyds of London, 56 Cal. 2d 637, 365 P.2d 418, 16 Cal. Rptr. 362 (1961), which appeared to impose drop down coverage without regard to the terms of the excess policy, because it is "axiomatic that absent a violation of public policy, a statute, or a constitutional provision, the parties to a private contract may allocate risks in any manner they choose." 30 Cal. 3d 814, 640 P.2d at 772, 180 Cal. Rptr. at 636.
11. In McNeal, Inc. v. Interstate Fire & Cas. Co., 132 Ill. App. 3d 564, 569, 477 N.E.2d 1322, 1326 (1985) (applying Illinois law) the insurer's argument that the reduced premium it charged was indicative of its intent to not bear the risk of an underlying insolvency was rejected because the contract's "[amount recoverable] language admitting ... liability
2. No Drop Down Liability

Courts which have held that "amount recoverable" policies do not impose drop down liability rely not only on policy provisions that were not discussed in Reserve and its progeny but also on considerations of commercial reality.

Radiator Specialty Co. v. First State Ins. Co.\(^\text{12}\) appears to be the first case to take Reserve head on.\(^\text{13}\) There, the policy stated:

The limit of the company's liability shall be as stated herein, subject to all the terms of this policy having reference thereto. 1. $5,000,000 single limit any one occurrence . . . in excess of:

A. The amount recoverable under the underlying insurance as set in Schedule A attached . . . .\(^\text{14}\)

The Radiator court did not stop at the "amount recoverable" language because the limit of liability clause referenced "all the terms of this policy." In examining other policy terms, the "Underlying Limit-Retained Limit" provision proved crucial. This

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controls, . . . not the amount . . . charge[d] . . . for excess insurance." In McGuire v. Davis Trucking Services, Inc., 518 So. 2d 1171 (La. Ct. App. 1988), writ denied, 528 So. 2d 791 (applying Louisiana law) the court rejected the insurer's argument that the imposition of drop down coverage would be tantamount to forcing excess carriers to guaranty the solvency of underlying insurers and imposed drop down coverage based on the policy's "amount recoverable" clause. In Lechner v. Scharrer, 145 Wis. 2d 667, 429 N.W.2d 491 (Ct. App. 1988) (applying Wisconsin law), the court - based "on the peculiar language in [the] insurance contract, not on public policy basis" - again held an "amount recoverable" policy ambiguous and the insurer liable for drop down coverage.


13. One "amount recoverable" case preceded both Radiator Specialty and Reserve. In Golden Isles Hosp., Inc. v. Continental Cas. Co., 327 So. 2d 789 (Fla. Dist. Ct. App. 1976) (applying Florida law), the excess insurer "insured the HOSPITAL for losses (up to $1,000,000) in excess of the 'amount recoverable' for primary insurance." The primary insurer was solvent at the time of the occurrence, but was insolvent at the time judgment was entered against the insured. The insured wanted the "amount recoverable" under the excess policy to be measured as of the time of judgment, since at that time the amount was arguably zero. The court held that the primary insurer's coverage should be measured at the time of the occurrence. This holding was based, in part, on the policy argument that the McGuire court found unavailing:

[T]he apparent fault in [the insured's] argument is that it proposes that the court change the terms of the policy so that the excess insurer would be made the guarantor of the solvency of the primary insurer chosen by the policyholder.

Id. at 790.

In Golden Isles the court implicitly acknowledged that the term amount recoverable is at least ambiguous, but skirted that problem by focusing on a timing issue. Other courts have not engaged in this type of analysis.

14. 651 F. Supp. at 441 (emphasis in opinion).
“fixed limit” provision confined the ultimate net loss to the excess of:

an amount equal to the limits of liability indicated beside the underlying insurance listed in Schedule A of underlying insurance, plus the applicable limits of any other underlying insurance collectible by the INSURED . . . .15

After stating that this clause “does not say ‘recoverable underlying insurance listed in Schedule A of underlying insurance . . . .’” the court held that the policy language as a whole was not ambiguous and imposed no drop down obligation on the excess carrier.16

Moreover, in contrast to Reserve and its progeny, the court was receptive to the insured’s argument that excess insurance is predicated on a smaller risk of exposure than primary insurance. According to the court:

It would make no sense to hold that an “excess” insurer would be liable as a primary insurer. This would impose a liability on the “excess” insurer which is not bargained for in its premium that is based on the lesser risk which an excess carrier agrees to assume. . . . To . . . hold [in favor of the insured] would in effect mean that the [excess insurer] insures the solvency of the underlying insurer . . . .17

Other courts have followed Radiator Specialty and rejected the Reserve line of cases. In many of these cases, a consideration of the purpose of excess insurance played a role in the court’s analysis. For example, in Morbark Industries v. Western Employers Ins. Co. 18 the court noted that

the purpose of the umbrella coverage [is] to provide, at a relatively low premium, extended coverage up to high limits, over and above primary insurance coverage. . . . No one has seriously contended that such inexpensive excess coverage was intended by the parties to provide primary insurance, as well, in the event of the insolvency of the primary carrier.19

15. Provisions similar to this have themselves been the subject of varying interpretations focusing on the term “collectible.” See cases discussed at § III(B), infra.
16. 651 F. Supp. at 441 (emphasis in opinion). A finding of ambiguity “would completely ignore all of the definitions and Terms and Conditions of the Policy . . . .” Id.
17. Id. at 442.
19. Id. at 609, 429 N.W.2d at 216. The court criticized Reserve for “finding an ambiguity
And in Rapid City Regional Hospital, Inc. v. South Dakota Insurance Guaranty Assoc., the court declined to require drop down coverage, in part, because it was not willing to judicially impose "drop down" liability on excess insurers who do not contract for such liability. Such imposition of a theory of "drop down" liability would "fundamentally alter the risk an excess coverage provider is obligated to provide by agreeing to issue excess ... insurance...."

3. A Comment

It is not clear whether Reserve and its progeny dealt with policies which truly differed from the policies at issue in the Radiator Specialty line of cases. If different wordings were in fact at issue, the conflicting decisions are distinguishable on that basis alone.

It appears, however, that such a distinction is unwarranted, since Reserve has been consistently criticized for focusing on a single policy provision to the exclusion of all other policy terms. If in fact Reserve and its progeny engaged in a selective policy analysis, the decisions in those cases may have been guided, at least in part, by an unstated inclination to assist the insured. In contrast, the antithetic consideration — that the purpose of excess insurance mitigates against drop down coverage — influenced Radiator Specialty and the other cases which have followed its lead.

from the declarations language alone without attempting to construe the contract as a whole ... " Id. at 615, 429 N.W.2d at 219. After noting that "one may not simply pick particular language from the contract to claim either a reasonable expectation of coverage or ambiguity," the court found that the policy as a whole unambiguously did not require drop down coverage.


21. Id. at 567 (citation omitted). Again, the approach taken in Reserve and its progeny was criticized. The court stated that "to focus on a single reference to the 'amount recoverable' under the underlying insurance to the exclusion of the balance of the contract is 'distorted and legally inappropriate' (citation omitted). A review of the entire policy and attachments is vital to arrive at a sound judgment in determining the contracting intent of the parties." Id. at 567. See also Werner Industries, Inc. v. First State Ins. Co., 112 N.J. 30, 548 A.2d 188 (1988) (applying New Jersey law) (where the New Jersey Supreme Court criticized the Reserve approach of focusing on a single policy provision or sentence to the exclusion of the rest of the contract, analyzed the entire contract, and found that it plainly did not provide drop-down coverage); accord McNeal v. First State Ins. Co., 1986 WESTLAW 4477 (E.D. Pa. April 10, 1986) (applying Pennsylvania law).
B. The “Applicable,” “Inapplicable,” “Collectible,” “Reduced,” and “Exhausted” Cases

As with “amount recoverable” policies, insureds commonly argue that policies which reference “applicable,” “inapplicable,” “collectible,” “reduced,” or “exhausted” underlying limits of liability are at least ambiguous, since it is possible to interpret these policies to mean that underlying insurance either is no longer applicable or collectible or has been reduced or exhausted as a result of insolvency. This argument has found a few champions, but the vast majority of courts construing true excess policies with such language have rejected the analysis. 22

1. Drop Down Coverage Imposed

In Poirrier v. Cajun Insulation, Inc., 23 the excess policy stated that:

[L]iability shall be only for the ultimate net loss in excess of the Insured's retained limit defined as the greater of:
(a) an amount equal to the limits of liability indicated beside the underlying insurance listed in Schedule A hereof, plus the applicable limits of any other underlying insurance collectible by the Insured; or . . . . 24

22. The meaning of the term “collectible” has also come up in cases dealing with primary policies which are excess by “coincidence.” See supra note 4. In these cases, the policies at issue contained “other insurance” clauses referencing other “valid and collectible” insurance. Most courts construing such primary policies have found that first dollar coverage must be provided when the other primary coverage is unavailable due to insolvency. For example, in Gros v. Houston Fire & Casualty Ins. Co., 195 So. 2d 674 (La. Ct. App. 1967), a primary policy's “other insurance” clause provided that the policy was excess over any other “valid and collectible” insurance with respect to a “non-owned automobile.” Id. at 676. When the primary insurer of a non-owned automobile was declared insolvent, the court simply concluded that there was no other “collectible” insurance and imposed drop down coverage. See also Beauregard v. Salmon, 211 So. 2d 732 (La. Ct. App. 1968); Nasello v. Transit Casualty Co., 530 So. 2d 1114 (La. Ct. App. 1988); Gladstone v. D.W. Ritter Co., 508 N.Y.S.2d 880 (Sup. Ct. 1986). But see State Farm Mut. Ins. Co. v. Vines, 193 So. 2d 180 (Fla. Dist. Ct. App. 1966) (since primary policy for non-owned automobile was collectible at the time of occurrence, driver's primary policy did not provide first dollar coverage even though other primary insurer insolvent at the time of judgment). These decisions are distinguishable from cases construing true excess policies, which are intended to “always remain[ ] excess over and above all other applicable forms of contract, except as to specific risks upon which it may elect to carry the primary burden.” Washington Ins. Guar. Assoc. v. Guaranty Nat'l Ins. Co., 685 F. Supp. 1160 (W.D. Wash. 1988) (citing APPLEMAN, supra note 8, at § 4906).


24. Id. at 806 (emphasis in opinion).
The insurer claimed that the word “collectible” related to underlying coverage other than the listed primary insurance. A majority of the court disagreed and imposed drop down coverage.25

Deisch & Marion, P.C. v. International Ins. Co. 26 dealt with a demand for a defense, based on the following policy provision:27

With respect to any occurrence not covered, as agreed, by the underlying policies listed in Schedule A hereof or not covered by any other underlying insurance collectible by the insured, but covered by the terms and conditions of this policy except for the amount of retained limit specified in ... the declarations, the company shall:
(a) defend any suit against the insured ... 28

The court ruled against the excess carrier, both on quantum meruit grounds and because, under the terms of the excess policy the underlying (primary) insurance coverage was not “collectible by the insured” ... at least for the purposes of defense costs. Thus, by its very terms, the insurance contract provides that the [excess insurer] had a duty to defend.29

In Gulezian v. Lincoln Ins. Co.,30 the terms “applicable” and “collectible” surfaced in a number of provisions of an excess policy. In one clause, “applicable” underlying insurance was re-

25. The majority held that “the use of the phrase ‘any other’ in reference to ‘underlying collectible insurance’ means that [the listed primary insurance] along with any other underlying insurance retained by [the insured] must be collectible.” Id. at 807-808 (emphasis added); accord Alabama Ins. Guar. Assoc. v. Magic City Trucking Service, Inc., 547 So. 2d 849 (Ala. 1989) (applying Alabama law); Harrison v. General Marine Catering, 1986 WESTLAW 12689 (E.D. La. Oct. 31, 1986). This conclusion is at least questionable, since, as the dissent points out, the use of a comma between “hereof” and “plus” strongly suggests that “collectible” was not intended to modify the listed underlying insurance. Id. at 809.
27. The demand in Deisch & Marion was a little unusual in that the law firm retained by the primary insurer to defend the insured demanded that the excess carrier drop down and pay for the defense costs when the primary insurer went insolvent.
28. 771 P.2d at 20 (emphasis added).
29. Id. (citation omitted). This conclusion regarding the meaning of the contract is not accompanied by any analysis, so it is difficult to determine why the court thought that the term “collectible” modified the listed underlying policy when the quoted language indicates that it only modified unlisted underlying insurance. Cf. U.S. Fire Ins. Co. v. Capital Ford Truck Sales, Inc., 257 Ga. 77, 355 S.E.2d 428 (1987), where the court noted that an almost identical clause “requires other underlying insurance to be ‘collectible,’ but does not so specify with respect to the underlying policy.”
ferenced to post-occurrence coverage defenses. In another, "collectible" modified underlying insurance generally. And in another, "applicable" modified the listed underlying insurer's limit of liability. These terms eventually led a majority of the court to hold that the policy was ambiguous. As part of its holding, the majority stated that it would be "unconscionable" to interpret one of the troublesome policy provisions in a way that would require the insured to pay the underlying limit before it could obtain the benefit of excess coverage. Partly to avoid this result, the excess insurer had to provide first dollar coverage.

31. This clause stated:

[Section III.] The Company shall be liable only for Ultimate Net Loss . . . in excess of . . . (a) the total of the applicable limits of liability of the Underlying Insurance as stated in the Schedule of Underlying Insurance and the applicable limits of any other Underlying Insurance collectible by the Insured . . . . The limits of liability of any Underlying Insurance Policy shall be deemed applicable irrespective of any defense which the underlying insurer may assert because of the insured's failure to comply with any condition of the Policy subsequent to an occurrence. Id. at 608, 506 N.E.2d at 124 n.2 (emphasis added).

32. This provision stated:

[Condition 9.] The insurance afforded by this Policy shall be excess insurance over any other valid and collectible insurance available to the Insured whether or not described in the Schedule of Underlying Insurance . . . . and applicable to any part of the Ultimate Net Loss. Id. at 611, 506 N.E.2d at 126 (emphasis in opinion).

33. This clause stated:

[Condition 7.] The company's liability . . . shall not attach until the amount of the applicable Underlying Limit has been paid by or on behalf of the Insured . . . .

Id. (emphasis in opinion).

34. The majority first concluded that by referencing "applicable" underlying insurance to post-occurrence situations, the insured could conclude "that the applicability can be determined by postoccurrence events, including the uncollectibility of the primary insurance." Id. Second, the use of the term "collectible" in one policy section to modify all of the insured's underlying insurance implied that "coverage is excess only of collectible insurance, including the primary insurance listed in the schedule of underlying insurance." Id. Finally, the term "applicable" with reference to the listed underlying insurer's coverage could mean "the recoverable or collectible underlying limit." Id. at 612, 506 N.E.2d at 126. The court did not accept all of the insured's contract analysis, however. The contention that the phrase "applicable limits" could mean recoverable limits was rejected. Id. at 125. Also, the court declined to hold that the term "collectible" in Section III modified the listed primary insurance, citing the dissent in Porrier for the proposition that such a construction was "debatable." Id.

35. Id. The dissent criticized the majority's contract analysis on a number of grounds. Among other things, the dissent took issue with the majority's "unconscionability" concern, stating that "a provision requiring that the amount of the underlying insurance actually be paid by or on behalf of the insured before the excess insurer's liability will attach is not unconscionable." It simply promotes the purpose of excess coverage. Id. at 616, 506
On the same day it decided Gulezian, the Supreme Judicial Court of Massachusetts also decided Massachusetts Insurers Insolvency Fund v. Continental Casualty Co. There the policy provided that

with respect to [excess liability indemnity], if the applicable limit of liability of the underlying insurance is less than as stated in the schedule of underlying insurance because the aggregate limit of liability of the underlying insurance has been reduced this policy becomes excess of such reduced limit of liability.

While the insurer argued that the underlying insurance could only be “reduced” by the payment of losses, the majority thought that an insolvency also could “reduce” the underlying insurance, since the quoted provision did not reference “reduced” to payment of losses.

In addition to a traditional contract analysis, the majority reviewed the policy with a view toward “a hypothetical insured’s reasonable expectations,” and concluded that:

If a reasonable policyholder thought about the subject at all, it probably would have assumed that the excess insurer would step into the void whenever, for whatever reason, the primary insurance could not or would not meet its policy obligations.

2. No Drop Down Coverage

In more than 20 decisions, courts have determined that policies with terms similar to those discussed above do not require drop down coverage. Although not every one of these cases considers the commercial realities of excess insurance, a significant number do.

N.E.2d at 128 (emphasis in opinion). In addition, the dissent felt that equating the term “applicable” with “collectible” was improper. Since “applicable” modified “limits of liability” and “limits of liability cannot be gathered or received as can money,” the dissent concluded that “limits of liability are not collectible.” Id. at 614, 506 N.E.2d at 127.


37. Id. at 600. 506 N.E.2d at 120, n.3 (emphasis in opinion).

38. The dissent took issue with this interpretation because:

[an underlying insurer's aggregate limit of liability cannot be reduced except by a prior payment. **** The one fact that is critical to the resolution of this case is that the aggregate limit of liability of an insurer cannot be reduced by insolvency.

Id. at 603, 506 N.E.2d at 121 (emphasis in opinion).

39. Id. at 600-601, 506 N.E.2d at 120. While the majority disclaimed reliance on the “reasonable expectation” concept, a fair reading of the opinion shows that the concept was utilized.
Continental Marble & Granite v. Canal Ins. Co. presents perhaps the most explicit example of a decision influenced by a court's consideration of the nature of excess insurance. The policy provision at issue there stated:

The company shall be liable only for ultimate net loss resulting from any one occurrence in excess of ... if the insurance afforded by such underlying insurance is inapplicable to the occurrence, the amount stated in the declarations as the retained limit.

The insured argued that its primary insurer's insolvency rendered the underlying insurance "inapplicable" so that the coverage was excess of a minimal retained limit. The court disagreed, and stated:

Imposing the duty of indemnification on [the excess insurer] would, in effect, transmogrify the policy into one guaranteeing the solvency of whatever primary insurer the insured might chose. An excess liability insurer obviously does not anticipate this heavy onus: Excess or secondary coverage is coverage whereby, under the terms of the policy, liability attaches only after a predetermined amount of primary coverage has been exhausted. A second insurer thus greatly reduces his risk of loss. This reduced risk is reflected in the cost of the policy. [The insured's] proposed rule would require insurance companies to scrutinize one another's financial wellbeing before issuing secondary policies. The insurance world is complex enough; to impose this additional burden on companies ... would only further our legal system's lamentable trend of complicating commercial relationships and transactions.

Thus, even though the court acknowledged that the contract wording was "awkward," it still ruled that the policy did not drop down. The rationale adopted in Continental Marble has been widely influential.

40. 785 F.2d 1258 (5th Cir. 1986) (applicable law unclear).
41. Id. at 1259 (ellipse in original) (emphasis added).
42. Id. (citations omitted).
43. See, e.g., Ambassador Assoc. v. Corcoran, 541 N.Y.S.2d 715 (Sup. Ct. 1989) (applying New York law), where the court noted that "[w]ere the courts to impose upon excess insurers the risk of an underlying insurer's insolvency, it would, in effect "transmogrify the policy into one guaranteeing the solvency of [the] primary insurer." Id. at 717 (citing Continental Marble); McGlynn v. Salen Protexa Drilling Co., 1988 U.S. Dist. LEXIS 6301 (E.D. La. 1988) (applying federal maritime law), where the court - citing Continental Marble - felt that "[f]rom a practical business point of view, the theory which [the insured] exposes would wreak havoc within the insurance industry"; Harville v. Twin
In *Steve D. Thompson Trucking, Inc. v. Twin City Fire Ins. Co.*, the excess policy included an “Other Insurance” clause that stated:

The insurance afforded by this policy shall be excess insurance over any other valid and *collectible* insurance . . . available to the insured . . . .

The “Coverage” section of the policy, however, stated that indemnification is provided for losses in excess of the “underlying limit” and the “underlying limit” was defined as:

the amounts of the applicable limits of liability of the underlying insurance as stated in the Schedule of Underlying Insurance Policies less the amount, if any, by which any aggregate limit of such insurance has been reduced by payment of loss.

The court held that the policy could not be read to impose drop down coverage, in part because:

[There are] important reasons for maintaining a distinction between primary and excess insurance policies. The excess insurer’s risk of loss is based on the assumption that a predetermined amount of primary coverage will be exhausted before the excess insurer must pay. Excess insurers are not required to scrutinize primary insurers, financial stability before issuing policies or to guarantee that the insured’s choice of primary carriers will always be sound.

Similar concerns also played a role in *Wurth v. Ideal Mutual Ins. Co.* As the court saw it:

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44. 832 F.2d 309 (5th Cir. 1987) (applying Louisiana law).
45. Id. at 310 (emphasis added).
46. Id.

47. Id. at 311. See also *TXO Prod. Corp. v. Twin City Fire Ins. Co.*, 685 F. Supp. 156 (E.D. Tex. 1988) (applying Texas law). In *TXO*, the court construed a policy similar to the one at issue in *Thompson Trucking*, relied on the *Thompson* court’s analysis, and rejected the insured’s drop down claim.

To [impose drop down liability] would effectively impose on excess
coverage providers the burden of scrutinizing the financial stability
of every other primary provider and place the risk of loss for
securing an insolvent insurer not on the insurance purchaser... but on the excess coverage provider, who never contracted to
cover such a contingency. To this court such a state of affairs
would constitute not only an unjust shifting of the risk of insol-
vency, but a rewriting of an excess insurer's general contractual
undertaking simply to fulfill "notions of abstract justice."

It seems to us, by definition and longstanding principle, that an
excess insurer is not generally liable for any part of the loss or
damage which is covered by other insurance (be it collectible or
uncollectible), but is liable only for the amount of loss or damage
in excess of the coverage provided by all other applicable insurance
policies. To adopt, due to public policy, a theory of "drop down"
liability would fundamentally alter the risk an excess coverage
provider is obligated to provide by agreeing to issue excess liability
insurance protection. Therefore, we hold "drop down" liability
protection should not be judicially imposed on Ohio excess insur-
ance providers as a matter of public policy. 49

In Zurich Ins. Co. v. Heil Co., 50 the policy contained a provision
which provided that the insurance would be excess of any "re-
duced primary insurance" and that it would be underlying insur-
ance "in the event of exhaustion" of the primary insurance. 51

“Other Insurance” and “Coverage” clauses were similar to those at issue in Thompson Trucking. As a matter of contract analysis, the court rejected the notion that the term “collectible” meant the actual payment of money. On this point, the court took the rather novel view that “whether payment of other applicable and available insurance (be it primary, contributing, excess or contingent) actually takes place is not the focus of the inquiry under the paragraph in question. Instead, the focus is on the existence of such applicable and available insurance.” Id. at 330, 518 N.E.2d at 612. (emphasis added).


50. 815 F.2d 1122 (7th Cir. 1987) (applying Wisconsin law).

51. The provision stated:

In the event that the aggregate limits of liability of the underlying policies listed
in Schedule A are reduced or exhausted, the company shall, subject to . . . the other
conditions of this policy, . . . continue in force as excess of reduced primary insurance
or, in the event of exhaustion, continue in force as underlying insurance. Id. at
1124 (emphasis added).
The insured argued that this language was ambiguous, since it was unclear whether the primary policy could be reduced or exhausted solely by the payment of claims or also by the insolvency of the primary carrier. Looking at the policy's maintenance provision, which referenced reduction of the primary policy solely to the payment of covered claims, the court held that there was no ambiguity.\textsuperscript{52}

While the contract language alone was sufficient to support the court's finding in favor of the insurer, extra-contractual considerations also supported the decision.

[T]he consequences resulting from a rule requiring an excess insurer to bear the risk of a primary insurer's insolvency when not mandated by the clear language of the policy dictate our conclusion that [the insurer] is under no obligation to assume [the underlying insurer's] role . . . . [The excess carrier] did not contract to bear the risk of the primary carrier's insolvency, nor do its premiums reflect the cost that the assumption of the risk would entail.\textsuperscript{53}

Other courts have also recognized that the commercial realities associated with excess insurance mitigate against drop down coverage.\textsuperscript{54} Still other courts have construed policies similar to the ones just discussed so as not to impose drop down coverage, but without the extra-contractual gloss evident above.\textsuperscript{55}

\textsuperscript{52} That provision stated:
It is warranted by the insured that the underlying policy(ies) listed in Schedule A, or renewals or replacements thereof not more restricted, shall be maintained in force as collectible insurance during the currency of this policy, except for any reduction of the aggregate limit(s) contained therein solely by reason of losses in respect of occurrences happening during the policy period.

\textit{Id.} at 1124-25 (emphasis in opinion).


\textsuperscript{54} \textit{See, e.g.,} U.S. Fire Ins. Co. v. Capital Ford Truck Sales, Inc., 257 Ga. 77, 355 S.E.2d 428 (1987) (applying Georgia law), where the court cited a number of cases discussed herein with approval regarding this issue; Maricopa County v. Federal Ins. Co., 157 Ariz. 308, 757 P.2d 112 (Ct. App. 1988) (applying Arizona law) where the court refused to "rewrite[ the contract] because "[a]n insured pays a reduced premium to the excess carrier expressly because that carrier will be obligated to pay a claim only after a certain amount has been paid by the primary insurer." \textit{Id.} at 310, 757 P.2d at 114.

\textsuperscript{55} For example, in Guaranty Nat'l Ins. Co. v. Bayside Resort, Inc., 835 F. Supp. 1456 (D.V.I. 1996) (applicable law unclear), the court — after acknowledging that the insured was a "victim" of the insolvent primary insurer — recognized that a policy's reference to "collectible" underlying insurance did not allude to the listed primary insurer. The
A Comment

Excess policies commonly contain terms such as “applicable,” “inapplicable,” “collectible,” “reduced,” or “exhausted.” When courts have construed such terms to impose drop down liability, implicit or explicit concerns for the insured appear to have been considered. For example, the majority’s analysis in Poirrier is so strained — one court has called it “more creative than convincing” — that the court’s desire to benefit the insured is evident. And the peculiar linguistic twist given to a seemingly


57. The dissent in Poirrier found that policy considerations pointed in the other direction, stating that it “is more equitable and realistic [to deny drop down coverage]
clear policy term in *Deisch & Marion* indicates an unstated preference in favor of the insured. In addition, in viewing a coverage gap as "unconscionable" in *Gulezian* and by reviewing an excess policy in light of "a hypothetical insured's reasonable expectations" in *Continental Casualty Co.*, the Supreme Judicial Court of Massachusetts explicitly recognized extra-contractual considerations that favored the insured.

By contrast, a great number of courts that have declined to impose drop down coverage when faced with "variable limit" wordings were clearly influenced by the commercial realities associated with the procurement of excess insurance. In cases such as *Continental Marble, Thompson Trucking, Wurth, and Zurich*, this commercial reality reinforced the court's determination that the parties did not contract for drop down coverage.

C. The "Held Liable To Pay" Cases

A standard clause in an excess policy provides that the duty of indemnification does not attach until the insured or the primary insurer has "been held liable to pay" the underlying limit of liability. This clause, too, has been the subject of varying interpretations.

1. Drop Down Liability Imposed

In *Northmeadow Tennis Club, Inc. v. Northeastern Fire Ins. Co. of Pa.*, an excess policy provided that liability shall attach only after the primary insurers

have paid or have been *held liable to pay* the full amount of their respective ultimate net loss.\(^{59}\)

The court construed the phrase "held liable to pay" to posit an eventuality in which the insured, and hence the primary insurer, are liable but the insurer for some reason has not paid. According to the court, the case of insolvency would be such an

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59. *Id.* at 332, 526 N.E.2d at 1335. (emphasis added).
eventuality. The resulting ambiguity meant that the excess insurer had to provide first-dollar coverage.

2. No Drop Down Liability

In *Seaway Port Auth. of Duluth v. Midland Ins. Co.*, the policy stated:

The [insurer] shall only be liable hereunder for any loss after the Primary Policy has admitted or has been *held liable to pay* the amounts shown in ... the Declarations ....

The insured argued for a Northmeadow-like interpretation of this language, but the court concluded that it is impossible to get around the fact that [the language] specifically refers to [the] Declaration ... which limits the policy coverage to amounts in excess of [the primary limits].

The court also cited with approval decisions that declined to require excess insurers to provide "drop down" coverage in the absence of an express agreement to do so, because of the established customs and practices of the insurance industry.

A similar "held liable to pay" provision was at issue in *American Re-Insurance Co. v. SGB Universal Builders Supply*, where the court rejected the insured's drop down demand, in part because:

Excess liability insurance is a low-cost method of providing extended protection where primary (and secondary) insurance leaves off; its premiums do not reflect the assumption of risk of the primary carrier's insolvency. In the instant case it would seem that they do not even reflect the cost of scrutinizing the financial condition of the primary providers. Those risks and costs are

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60. Id. at 333-334, 526 N.E.2d at 1336.
61. The court construed another excess policy with different language to be unambiguous and did not impose drop down liability with regard to that policy.
63. Id. at 246 (emphasis added).
64. Id. at 248-49.
65. Id. at 249. Since the policy itself could not be construed to provide drop down coverage, the court recognized that such coverage could only be imposed if, "as a matter of public policy, ... an excess insurer must cover the full loss in cases where the primary insurers are insolvent." Id. The court, however, saw "no compelling public policy reasons for holding [the excess insurer] liable ...." Id.
better left with the purchaser of the primary policy.67

3. A Comment

Northmeadow — the only reported case where drop down liability was imposed on the basis of a “held liable to pay” policy — was decided by a Massachusetts appellate court guided by the teachings of Gulezian and Continental Casualty. Thus, while the court stated that its decision was based strictly on the policy language before it, a consumer-protection influence cannot be discounted. In Seaway and American Re-Insurance, by contrast, the commercial realities of excess insurance were recognized as one reason to not impose drop down liability on insurers who issued “held liable to pay” policies.68

IV. CONCLUSION

Granting drop down coverage contrary to policy terms solely to protect the insured is not warranted. Judicial consumerism should not provide the means for recasting excess policies to obtain a result that contradicts commercial reality and the expectations of the insurance buyer and seller.69 As one court has noted, a “consideration of the function of excess policies” argues against a consumer-protection approach, even though it would be

67. Id. at 379-80, 532 N.Y.S.2d at 715 (citation omitted). See also Hudson Ins. Co. v. Gelman Sciences Inc., 706 F. Supp. 25 (N.D. Ill. 1989) (applying Illinois law). In Hudson, the court concluded that, irrespective of the insolvency of the underlying carrier “until [the insured or its underlying insurance has paid or has been held liable to pay the underlying limit of liability, the excess insurer] does not become liable under its policy.” Id. at 28 (emphasis added). It is interesting to note that the language which doomed the insurer in Northmeadow was cited to support a judgment against the insured in Hudson.


69. APPLEMAN, supra note 6, at § 7386 notes:

[Contract construction] cannot be based solely upon the fact that a different construction would work a hardship on one of the parties, that the policy might have been a poor one for the insured, or that it may have operated unfairly and within narrow limits. Insurance is [a] matter of contract, not sympathy; and equitable considerations generally are not considered sufficient to overcome the contractual provisions of a policy. The mere fact that an insured is compelled to assume a loss which is not covered by his policy does not warrant a construction stretching the words of a policy to compel the insurer to accept the risk.
“tempting ... to protect an injured party and to mitigate the seemingly harsh result [of an underlying insurer's insolvency].”

On the other hand, recognizing that the nature and purpose of excess insurance is indicative of an excess insurer's intent to not provide drop down coverage furthers “[t]he rule ... that a contract of insurance must be construed ... with reference to the subject matter and the nature of the risk involved.”

It has been observed that drop down liability “subject[s] the insurer to unforseeable and variable risks” — precisely the type of risks assumed by a primary carrier for a greater premium than charged by the excess carrier. The paradox of judicially aiding the insurance buyer by rejecting commercial reality is that increasing the insurer's risk through drop down liability can result only in premium adjustments that will ultimately become the insured's burden. Thus, judicial consumerism, to the extent it disregards policy terms, is not only unwarranted; it is injurious to the very class it purports to protect.

73. It is entirely proper to recognize that the reduced premium charged for excess coverage is indicative of the limited risk accepted by the insurer. “Since there is an obvious relationship between the risk accepted by the insurer and the amount of premium charged for the coverage, such charge may often be relevant in determining the scope of coverage intended by the parties.” APPLEMAN, supra note 6, at § 7389.
McCARRAN-FERGUSON REPEAL AND ISO'S ADVISORY RATE BAN: A CHANCE FOR COMPROMISE?

Kevin Thompson*

Since the Supreme Court handed down its *South-Eastern Underwriter*’s decision in 1942, attempts to apply antitrust laws to the business of insurance have been a constant source of controversy. As the antitrust debate rages on into its fifth decade, forces on each side of the issue have painted themselves into their respective corners with inflammatory rhetoric. Ironically, the fallout from *In re Insurance Antitrust Litig.*, a controversial antitrust suit against several insurers by 19 state attorneys general, provides an opportunity to reach a tenable solution to the drama revolving around the moves to repeal the McCarran-Ferguson Act.

In 1989, the Insurance Services Office (ISO), an insurance industry rating bureau, announced it would no longer publish advisory rates for its member companies. Instead it would only issue policy forms and actuarial data.

ISO’s move has opened the door to at least limited repeal of the McCarran-Ferguson Act. The Act’s repeal could appease those clamoring for the application of antitrust laws to the business of insurance. In addition, insurance industry interests could refrain from opposing such repeal because ISO’s new rate promulgation

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The author wishes to thank Robert Nadler, law student at Tulane University, for his research, and Kathy Faroba, Texas Assistant Attorney General.

2. 723 F. Supp. 464 (N.D. Cal. 1989) (defendants were entitled to antitrust immunity under the McCarran Act).
3. 15 U.S.C. §§ 1011-12 (1976) (Congress declares that the business of insurance shall be subject to the laws of the several states which relate to the regulation or taxation of such business).
policy works to bring ISO’s activity under the protection from antitrust enforcement afforded by the line of cases immunizing the actions of trade organization.

By examining the history of the insurance antitrust exemption, ISO’s recent rate and form promulgation actions, and the application of the antitrust trade-organization activity exemption to the insurance industry support groups, it becomes clear that ISO’s new policies make reconciliation of the McCarran-Ferguson controversy a possibility.

I. THE MCCARRAN-FERGUSON ACT

The legislative history associated with McCarran-Ferguson chronicles the polarization of the issue of antitrust oversight of insurance. Participants in the struggle draped the issue with doomsday scenarios. Supporters of the Act predicted that continued antitrust oversight of insurance would eventually lead to the collapse of the insurance industry. Opposition forces said McCarran-Ferguson passage would be an emasculation of the Constitution and would benefit robber-baron insurance executives named in criminal antitrust proceedings.

Insurance industry support for such federal intervention to protect the rights of the states to regulate insurance came in the wake of United States v. South-Eastern Underwriters Ass’n. In that case, the Court held insurance to be within interstate commerce and therefore within the ambit of antitrust. Industry support for federal intervention signaled a change in position for insurance advocates. Until this issue arose in Congress, they resisted attempts to seat regulation of their industry at the state level. This change in attitude by the insurance industry was not lost on Congress:

At the National Board of Fire Underwriters held in New York on February 19 and 20, 1868, the committee on legislation and taxation reported on the first duty assigned to it, namely, proposing some practicable plan to rid the country of unfair State legislation, and of securing, if possible, one general law for the governing of insurance companies throughout the Union.... Ignoring the antagonism to State legislation which they maintained for half a century

5. 322 U.S. 533 (1944).
6. Id. at 553.
or more in the face of an indictment charging them with conspiracies in restraint of [trade] and to monopolize interstate commerce, a Federal offense, the insurance companies now swear allegiance to the very States whose laws they repudiated. 7

Originally, the industry fought state regulation in Paul v. Virginia. 8 The Court in that case held that the act of insuring against risk was not an act within commerce:

Issuing a policy of insurance is not a transaction of commerce. The policies are simple contracts of indemnity against loss by fire, entered into between the corporations and the assured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word.... Such contracts are not interstate transactions, though the parties may be domiciled in different States ... they are, then, local transactions, and are governed by the local law.... They do not constitute a part of the commerce between the States.... 9

For decades, the insuring companies tried to repudiate that holding on the grounds that it subjected them to unfair state regulation.

The position adopted by these fire insurance companies, in advocating this legislation, is in complete contrast to that formerly assumed. In the past these insurance companies have always sought to avoid State regulation and State tax. They always invoked Federal jurisdiction under the commerce clause. Now charged with a violation of a Federal statute, they find the shoe on the other foot and claim that they are immune from Federal laws and can only come under State regulation. Thus charged with a conspiracy in restraint of interstate commerce, they seek to escape just penalties by repudiating a position they have maintained since the famous decision of Paul v. Virginia .... 10

Why did the insurance companies shift positions on the issue of state regulation? The answer lies in the purpose of the McCarran-Ferguson Act. The bill's stated purpose could not be clearer: “It would affirm the intent of the Congress that the regulation of the business of insurance remain within the control of the several States, where it now exists.” 11

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8. 75 U.S. 168 (1869).
9. Id. at 183.
From this nation's birth, the federal system of government created tension between the rights of the several states and the power of the federal government. In the last years of President Franklin Delano Roosevelt's tenure, the states' rights issue began to gain importance. For those concerned about growing federal intervention, the McCarran-Ferguson debate presented a chance to reverse the tide of the New Deal's centralization of power. It presented an opportunity to prevent yet another power shift from the statehouses to Capitol Hill. When pro-insurance forces raised the banner of states' rights, those fearing a swing toward stronger centralized government flocked to support the legislative action.

The vast and intricate business of insurance — all types of insurance — has been developed under State laws. Forty-eight States have departments of insurance to regulate and control rates, investments, commissions, and the other details of the business for the benefit and protection of their citizens. There is no Federal department of insurance, no machinery to regulate it. But a New Deal Attorney General contended that insurance is commerce and subjected to the anti-monopoly laws. He indicted 197 fire insurance companies and 28 individuals for the crime of maintaining noncompetitive rates. The trial court dismissed the indictment on the strength of a long unbroken line of Supreme Court decisions. The Attorney General appealed to the New Deal Supreme Court and that Court has sustained his contentions. In effect, the highest court in the land holds that companies and individuals are criminals for obeying the laws of the States and the decisions of the Supreme Court itself. 12

Supporters of the insurance industry acted as if they were insulted by the antitrust official's attempt to enforce the Sherman Act. They escalated the war of rhetoric by attempting to paint a Norman Rockwell-like picture of the insurance industry.

Mr. Speaker, why should we tamper with a business that has blessed the citizens of this country for three-quarters of a century? Many an individual when everything else has failed him, has thanked God for his insurance policies. The records of the insurance companies through the years of depression are a monument to the integrity of those companies and to the efficiency of our present system of regulation. Today

we are not faced with a request from policyholders, their widows
and orphans, or the beneficiaries of any insurance other than life,
for Federal regulation, supervision, and control of insurance. We
are faced with the demands of an eager, grasping bureaucracy
which wants to extend its control to all insurance. I do not believe
that such a thing is for the best interests of the men, women, and
children of America.13

Senate support for the measure even implied that untold dangers
would beset every household in the United States if McCarran-
Ferguson passage was defeated. "The safeguards which offer
protection for every home and almost every life in America have
been disturbed by this precedent-smashing decision."14 Most ed-
ucated citizens who accept the basic tenets of mainstream Amer-
ican culture would probably agree that the insurance industry is
not populated with robber barons. But to take to heart the
unabashed praise heaped upon the industry by Rep. Curtis, one
would have to suspend disbelief for a moment.

Opponents of the McCarran-Ferguson Act also reached the
outer-limits of the rhetorical spectrum. Just as the pro-insurance
interests questioned the motivation of the Attorney General's
antitrust prosecution, forces opposing passage of the McCarran-
Ferguson Act questioned the motivation for the legislation. The
anti-McCarran forces suspected that the attack on the New Deal
encroachment of states' rights amounted to a mere smoke screen.
They pointed to the industry's apparent shifting of position. Until
the specter of antitrust enforcement raised its ugly head, the
insurance industry advocated federal regulation instead of state
regulation. But realizing that grass isn't always greener on the
other side of the fence, state regulations paled in comparison to
the seemingly draconian penalties available to antitrust enforcers.

Here we see the real reason for the bill. Indicted in the Federal
court under the antitrust laws on the charge of having conspired
to fix the premium rates that consumers should pay and the
commissions that agents should receive and of having boycotted
other legitimate business and employed intimidation and coercion
to compel other insurance companies to join in their agreements,
the defendants rushed to Congress for a bill to head off the
prosecution before the courts could act. This is the explanation of

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the tremendous pressure which has been applied to force this bill through Congress.
The issue is not the power of the States to regulate insurance, but the power which certain insurance combines have seized to drive out competition by monopolistic practices.\textsuperscript{15}

It is a safe assumption that had antitrust indictments not been handed down, there would have been no McCarran-Ferguson Act. Of course, if one accepts as truth the pro-McCarran rhetoric, then petitioning Congress for protection from prosecution would be a means of defense. But for those not accepting the industry's accusation of a New Deal plot to emasculate states' rights, the real reason for McCarran-Ferguson was to obtain legislative immunity for alleged wrongdoing.

Much was heard at the hearings and in the cloak rooms that the very existence of the United States fire companies were threatened by this suit: that there was a gigantic scheme on the part of the administration to destroy States' rights and local self-government. Frankly, I am convinced that neither States' rights, local self-government, Federal regulation, etc., have anything to do with this case. They are duststorms raised to hide the real issues. Stripped of all trappings, these bills are simply an attempt to secure immunity from prosecution for fire insurance companies charged with criminal conspiracy to fix rates.

If we pass any of these bills, I would say that we have come to a pretty low level in public decency and morals. It would mean that any special group of defendants in a criminal indictment could successfully come to Congress, be they bootleggers, racketeers, Office of Price Administration ceiling violators, toupe makers, pretzel benders, doctors, lawyers, Indian chiefs, and say "we should not be prosecuted on a pending indictment."\textsuperscript{16}

Criticisms of McCarran-Ferguson that highlight the indictment as the driving reason behind the bill's support point to the legislation's attack on the separation of powers among the three branches of government. If Congress can simply legislate rulings that directly overrule the Supreme Court's mandates, then separation of powers becomes useless. With the benefit of hindsight, the passage of this legislation did not signal the end of judicial independence. But it is instructive to note that both sides of the aisle seemed to be defending the same values.

\textsuperscript{15} S. Rep. No. 1112, 78th Cong., 2d Sess. 3 (1944) (minority view).
By heightening the states’ rights rhetoric, proponents of the measure raised a flag for the federal system of government. That system requires that power be divided between the state governments and the federal government. The measure’s opponents defended the principle of separation of powers between the three branches of government. In this instance the judiciary and the legislature were to be separated. In essence, opposition forces postured themselves as being the defenders of one of our system’s great legal foundations — the independent judiciary.

Conversely, the proponents also fancied themselves as great defenders of the American legal system. Instead of choosing separation of powers, their legal tenet was stare decisis. Advocates of McCarran-Ferguson passage questioned the survival of stare decisis if the Court’s ruling in South-Eastern Underwriters were allowed to stand. For decades, court decisions upheld the principle placing insurance outside of the stream of interstate commerce and, by analogy, outside of the federal government’s field of regulation. Using legislative fiat to insert insurance into the stream of commerce seemed to the bill’s advocates to be an improper use of legislative power. On this issue, (as with every other issue addressed by Congress relating to this legislative initiative) the rhetoric tremendously inflated the bill’s ramifications:

I thought it was unfortunate that the House was engaged in debate on a resolution concerning the court martial of high officers of the Army and the Navy on the day when our armed forces were invading fortress Europe. Press dispatches reporting strikes in war plants on that very day were simple recordation of deplorable events, but the decision of the Supreme Court of the United States in the South-Eastern case rendered on that day, destroying old landmarks of American constitutional law and spreading chaos and confusion throughout the country, was tragic. No issue of greater importance, nor one involving greater consequences, has been debated before the House than the one before us.

Even from our vantage point four decades later, safe from threats

of Nazi Germany and Imperial Japan, the grave issues of national security should have been deemed more important a consideration of Congress than an exemption from a portion of the nation's commercial law for one industry. Certainly through the annals of congressional debate, issues of greater importance can be found. As one might expect, the opposition drew similar conclusions about the doomsday effects of a wrong decision:

To vote approval of any of these insurance bills would be to destroy the very foundations of our antitrust laws. In the post-war era I know of nothing more essential for the maintenance and strengthening of private initiative and enterprise than the antitrust laws. Destroy them and you build for your Frankenstein monopolies and cartels — the very antithesis of private initiative, enterprise, and competition.19

Rep. Voorhis of California reasoned that the insurance industry's resistance to federal antitrust oversight could backfire in their faces. Assuming that the opposition's perceived need for antitrust oversight of the business of insurance was correct, and exemption for the industry would create an environment devoid of competition. Harm to the consumer created by such an environment would then lead to a call for extensive, direct federal regulation of the insurance industry.

The antitrust laws of the Nation are the major means we have therefore to inject the element of freedom into the business life of this Nation. The only other manner in which the public interest can be protected, if competition has been destroyed by private monopolies or combinations is by means of governmental regulation. Nor can such governmental regulation begin to be effective in the case of the huge industrial and financial lines of business of the Nation if it is exclusively limited to the States. In other words, vigorous enforcement of the antitrust laws is in a very real sense the only alternative to a further extension of Federal regulation and control. And the only valid argument that can be advanced by any industrial or financial group against enforcement of the antitrust laws is that it is already subject to effective public regulation.20

Those words proved to be prophetic. Indeed, activists concerned with the present-day problems of the insurance industry call for

federal regulation of the insurance industry. Many of the statements read into the record by the opposition refer to the detrimental effects on the consumer that an antitrust exemption could bring. One does not ordinarily think of the consumer movement being strong in the 1940s, but the positions of the congressmen speaking out against McCarran-Ferguson certainly sound a great deal like those voiced by consumer advocates of the last two decades.

Perhaps Sen. Ferguson knew that the state regulations lacked the necessary power to insure competition would survive in the insurance industry. Supporters of the McCarran-Ferguson Act in the Senate and the House did not declare that the nature of the insurance industry required a noncompetitive environment. But Ferguson himself noted in the Congressional Record that state regulation had not proved sufficient to control the actions of the mammoth insurance companies.

[T]here may be some vicious practices growing out of rating, which is believed, at least by some insurance companies, to be essential, that could not be permitted under Federal law. We do, however, find that for many years the States have had charge of the insurance business, and I for one want to say that I think many of the States have done a very poor job in regulating insurance. I think that if nothing else comes of the hearings before our committee, we may awaken in the minds of some insurance commissioners and the people back home that they ought to spend more time and efforts in making rules and regulations which will eliminate any vicious practices from the insurance business.

In a shrewd display of positioning, Sen. Ferguson insured that if the opposition's criticisms of his legislation proved correct, he could sidestep responsibility.

Examining the Congressional Record reveals that what started as a debate about whether to allow an antitrust prosecution of those involved in the business of insurance had blossomed into a fight about states' rights, separation of powers, stare decisis, and the economic well-being of the nation. Ironically, states' rights and antitrust share a common goal — the decentralization of power. By retaining certain powers in the statehouses, central-
ization of power in Washington can be avoided. By strong enforcement of the antitrust laws, centralization of market share can be avoided in the business environment.

In this confrontation, both sides made one grave error. They failed to appreciate how all of the components of our system work together. America's unique system of laws is a jigsaw puzzle. The rights of the states must be protected, but the power of federal law cannot be emasculated. Common-law systems depend upon *stare decisis* to give the law uniformity and predictability, but judges must be allowed to interpret the law so it grows and matures with society. For economic growth, corporations need to be free of needling regulation, but competition must be protected to insure a robust marketplace.

Politics is the art of compromise. Congress failed to construct a compromise that effectively dealt with the issue raised during the debates over McCarran-Ferguson. Instead, the players in the controversy built rhetorical walls behind which they could hide. Such behavior brought us a situation where those in the insurance industry believe a repeal of the McCarran-Ferguson Act will bring their industry tumbling down. Critics outside the insurance industry believe repealing the McCarran-Ferguson Act will allow them to use the antitrust laws to solve the insurance consumer's problems. When the passage of McCarran-Ferguson was being debated, industry advocates may have believed the bill's passage would signal an end to their antitrust problems. It did not.

II. THE ISO'S NEW POLICY

ISO's new policy on advisory rate promulgation adds a new twist to the current battles to repeal McCarran-Ferguson. The move came in the wake of efforts in Congress to repeal the antitrust exemption, an antitrust suit filed jointly by 19 state attorneys general. Even four decades after passage of McCarran-Ferguson, the Act engenders strong feelings. As Rep. Jack Brooks said: "It would be a case of severe understatement to observe that the antitrust exemption for the insurance industry is an issue which unleashes strong passions on all sides."

25. *In re Insurance Antitrust Litig.*, 723 F. Supp. 464 (N.D. Cal. 1989) (defendants were entitled to antitrust immunity under the McCarran Act).
Even the move by ISO to change its rating activities led to debate and public comment. Taking the high ground, industry insiders accused critics of being naive about the forces influencing the insurance business:

Insurance critics are playing out a "Hollywood fairy tale script" by urging the destruction of the vital information-gathering mechanisms that encourage competition among insurers, according to Fred R. Marcon, president of the Insurance Services Office.... "Advisory pricing information makes our industry more competitive, not less competitive, by making it easier for more companies to compete in more markets." 27

This rhetoric accusing the opposition of the naivete of scriptwriters is disturbingly similar to the invective found in the original McCarran-Ferguson debates of the 1940s. One of the delightful developments of the ISO rate-promulgation policies is that it opens the door to effective compromise. But if the players in the industry continue to be condescending to the opposition, chances for a compromise solution may evaporate.

In March, 1989, state insurance commissioners called for a ban on the ISO's issuing of advisory rates. 28 The National Association of Insurance Commissioners recommended that rate-making organizations not be allowed to file or distribute advisory rates. "We think at a minimum, companies need to factor in their own figures for profit and their own experience to calculate expenses," said Nebraska Insurance Director William H. McCartney. 29 The group's primary criticism was that using the average expense factors for each company rewarded inefficiency. 30 This represents a move in the right direction for the forces calling for insurance reform. The Insurance Commissioners called for a ban on the advisory rate promulgation, but at the same time conceded that the insurance industry does need to share loss and expense data.

ISO's representatives warned the Insurance Commissioners that a ban on advisory rate promulgation bode ill for consumers:

"If no ISO advisory benchmark rate or loss-cost projections — reflecting both industry experience and actuarial analysis — were

27. ISO Defends Collective Activities, supra note 4, at 6.
29. Id.
30. Id.
available, the result would be less competition and higher prices,” said Michael Fusco, executive vice president of the New York City-based ISO.\textsuperscript{31}

The ISO decision to stop issuing advisory rates was part of a plan to quell harsh criticism of the industry by consumer interests. In addition to cessation of the advisory rate issuance, ISO agreed to include three public representatives on its board of directors. While the move vanquished advisory rates, the rating bureau plans to provide its 1,400 members with advisory average prospective loss costs.\textsuperscript{32}

Prospective loss costs are estimates of future loss payments, including costs such as claims-handling and legal defense, while final advisory rates include provisions for insurers’ marketing and overhead expenses as well as underwriting profit and contingencies.\textsuperscript{33}

The most intriguing question since the passage of McCarran-Ferguson is why, after 47 years of resistance to tampering with industry status quo, has ISO given up the fight? One might say that the industry’s experience during the “insurance crisis” nurtured a keen awareness of trends in public opinion, fostering a desire to move toward compromise. A more cynical view would have outside pressures of tremendous strength bearing down on the crumbling mandate on which the legislation was founded.

These external pressures are not to be underestimated. Foremost among these pressures are the most recent moves of Congress to repeal the McCarran-Ferguson Act.\textsuperscript{34} The pressure from the massive antitrust litigation brought by attorneys general from 19 states\textsuperscript{35} also cannot be discounted.

The motive for industry efforts to stop the McCarran-Ferguson repeal movement\textsuperscript{36} seems obvious at first glance. Although industry efforts appear to offer a compromise, in fact they are part

\textsuperscript{31} ISO Defends Its Role As a Rating Advisor, NATIONAL UNDERWRITER, PROPERTY & CASUALTY/RISK & BENEFITS MANAGEMENT EDITION, Mar. 20, 1989, at 4.
\textsuperscript{33} Id.
\textsuperscript{34} New McCarran Repeal Proposals Introduced, BUS. INS. 152 (Apr. 10, 1989).
\textsuperscript{35} In re Insurance Antitrust Litig., 723 F. Supp. 464 (N.D. Cal. 1989) (defendants were entitled to antitrust immunity under the McCarran Act).
\textsuperscript{36} ISO To Stop Providing Final Rates, BUS. INS. 1 (Apr. 10, 1989) (“ISO admitted its actions are designed to repeal the McCarran-Ferguson Act.”)
of a broader industry-wide attempt to keep McCarran-Ferguson intact.

Should the insurance industry truly compromise, nearly five decades of strife will be replaced by a more tranquil relationship with the public. Unwarranted hyperbole typified by the rhetoric associated with this debate only serves to confuse the issue. The ISO ban is encouraging because it represents a move toward forging a workable compromise between opposing forces.

This compromise's appeal springs from the fact that ISO's new rate policy removes the need for McCarran-Ferguson protection. Since the development of trade association antitrust doctrine, the possible price-fixing charges supported by the rate-making bureau's activities have been the only hindrance toward using the body of trade association law as protection for the insurance industry.

III. TRADE ASSOCIATION DOCTRINE

With ISO's new rate and form promulgation policies, the application of antitrust law to the activities of trade organizations takes on a greater importance.

Price-fixing schemes seeking a cloak of credibility scrambled for the shelters of trade associations. The first test of this principle\(^\text{37}\) came in the form of an "Open Competition Plan" in which trade associations could share production, shipping, and pricing information. The plan's participants controlled just five percent of the country's hardwood mills but turned out one-third of the United States' production.\(^\text{38}\) Supporters of the plan winced at the prospect of facing tough competition.

Competition, blind vicious, unreasoning, may stimulate trade to abnormal activity but such condition is no more sound than that medieval spirit some still cling to of taking a club and going out and knocking the other fellow and taking away his bone.\(^\text{39}\)

This system assures mutual prosperity through exchange of price information. While there was no explicit statement of price-fixing, the scheme had a \textit{de facto} effect of increasing prices.

\(^{37}\) American Column & Lumber Co. v. United States, 257 U.S. 377 (1921).
\(^{38}\) Id. at 391.
\(^{39}\) Id. at 393-94.
But not only does the record thus show a persistent purpose to encourage members to unite in pressing for higher and higher prices, without regard to cost, but there are many admissions by members, not only that this was the purpose of the “Plan”, but that it was fully realized.40

Thus the Supreme Court equated systems of information exchange including prices with prices-fixing. This presumption established the mens rea requirement upon proof of an objective standard, thus transferring price-fixing into the realm of strict liability offenses.

In the dissent, Justice Holmes questioned a restriction of the flow of information throughout the marketplace as proof of an economic offense:

I should have thought that the ideal of commerce was an intelligent interchange made with full knowledge of the facts as a basis for a forecast of the future on both sides. A combination to get and distribute such knowledge, notwithstanding its tendency to equalize, not necessarily to raise, prices, is very far from a combination in unreasonable restraint of trade.41

Holmes made a mistake by overlooking the principle that drives antitrust. Market dominance is gained through the use of power. Information is power. Controlling the channels of information creates market dominance.

Perhaps to stifle feelings that the Court’s holding causes imperfect market conditions by restricting the flow of information, case law developed to refine the American Column & Lumber Co. decision in which the plan encompassed mandatory prices to be charged in the future.42

The Court distinguished that point in two cases decided on June 1, 1925: Cement Mfrs’ Protective Ass’n v. United States,43 and Maple Flooring Mfrs’ Ass’n v. United States.44 In those cases the defendants only exchanged prices from past transactions. Thus, the plan’s participants operated in a marketplace allowing free-flow of information pertaining to historical and existing conditions. From these perspectives, the players could use precedent

40. Id. at 407.
41. Id. at 412.
42. Id. at 394.
43. 268 U.S. 588 (1925).
44. 268 U.S. 563 (1925).
to predict future market conditions. The more perceptive competitors gained tremendous competitive advantages by being able to more accurately forecast trends.

If competitors were not allowed to track past market events, competition would be ruined. The market players would be forced to try to nimbly navigate the business world's pitfalls while blindfolded. Thus the fear expressed by Justice Holmes could become a real threat. Without such information availability, luck, not savvy, would determine which businesses survived. Many worthy competitors would be unfairly dismissed from the field.

If the dissemination of future pricing strategies were available, however, the marketplace would be skewed again. With such information disseminated, a vibrant marketplace brimming with competitors would become a slow-moving monolith. Even though many competitors might be present in the market, their collusion would enable them to act as one. In such a system, supporters of the status quo would point to the large number of financially healthy players as a proof of rigorous competition. Consequently, they would dismiss measures that tended to decrease the number of competitors as anti-competitive. A number of unworthy competitors would remain on the playing field.

A competitive marketplace enforces discipline upon competitors. Accountability in business is vital. Unless players know that bad decisions will drive them out of business, they will not fight for a competitive edge. Pointing to an industry packed with competitors may actually signal a weak competitive environment.

To nurture a healthy marketplace, the flow of information must reach some level of moderation. Such surroundings will allow competitors to forecast future market conditions instead of dictating them. Liability will be inferred only when the action is undertaken with knowledge of its probable consequences and it has the requisite anti-competitive effect. Liability will not be inferred from the dissemination of historic pricing information.

We realize also that uniformity of price may be the result of agreement or understanding, and that an artificial price level not related to the supply and demand of a given commodity may be evidence from which such agreement or understanding or some concerted action of sellers operating to restrain commerce, may

be inferred. But here the Government does not rely upon agreement or understanding, and this record wholly fails to establish, either directly or by inference, any concerted action other than that involved in the gathering and dissemination of pertinent information with respect to the sale and distributing of cement to which we have referred, and it fails to show any effect on price and production except such as would naturally flow from the dissemination of that information in the trade and its natural influence on individual action. 46

These rules of law, coupled with ISO's new moves, create a situation in which the McCarran-Ferguson Act becomes obsolete. Instead, the market is aided in its struggle to maintain equilibrium by the line of cases dealing with trade associations. Some may argue that ISO is more than a mere trade association. Perhaps ISO does constitute more than a trade union. That distinction is not important here. The relevancy of trade association cases springs from their involvement with information flow.

Two of ISO's functions were to promulgate both an advisory schedule of rates and policy forms. To allow the insurer to predict losses, the rates were geared to the probability of events covered by the language of the form. If the forms were not used, the advisory rates did not relate to the expected loss ratios. In that case the insurer could lose more than it received in premium and investment income. Instead of publishing the rates, ISO now supplies the loss data, and each company reaches its own decision on rates.

Probably many of ISO's 1,400 members will fail to predict the optimum pricing level for their products. Some of them will fail. To argue that this circumstance is undesirable is to mistake a marketplace packed with competitors with a competitive marketplace. During ISO's annual meeting, ISO's president made this mistake: "Advisory pricing information makes our industry more competitive, not less competitive, by making it easier for more companies to compete in more markets . . . " 47

Publishing of advisory rates by its very nature is the publication of suggested rates to be used in the future. This activity would amount to an antitrust violation because it is price-fixing. Yet, the insurance companies to this point have evaded liability

46. Cement Mfrs' Protective Ass'n v. United States, 268 U.S. at 606.
for these actions because McCarran-Ferguson creates an exemption. This exemption removes individual accountability for miscalculations in pricing strategies. In effect, the exemption insures that accountability will be spread widely in the same manner that re-insurance is used to spread risk widely. Accountability and responsibility are two concepts not readily accepted by some industry players.

All this is happening in an environment where managing general agents are being forced to bear more responsibility for their company's solvency, he warned[,] during the annual meeting of the Kansas City, Missouri-based American Association of Managing General Agents. [statement of Joseph L. Petrilli, an actuary and president of Demotech Inc.]48

Accountability and responsibility are the keys to a competitive marketplace. ISO's abandonment of advisory rates should be applauded as bringing these two elements back into play. It seems highly unlikely that an environment driving its competitive nature from a mechanism to renew accountability and responsibility would be a place to find any antitrust violations. Thus if McCarran-Ferguson were lifted, it is unlikely that any antitrust violations could be successfully prosecuted without evidence of a circumvention of ISO's system.

Some insurance executives fail to see ISO's rate policy as an antitrust panacea:

The move by the Insurance Services Office to publish loss costs rather than advisory rates will not serve as a panacea for the industry's antitrust problems, according to Joseph Petrilli, an actuary and president of Demotech, Inc.

"The only thing loss costs take out are the expense ratios. All the judgment areas, all the things regarding industry collusion, are all taking place in the loss costs; it's not expenses," he said.49

Such an analysis fails to take into account American Column & Lumber Co. and its progeny. In an effort to protect the free flow of information so important to Justice Holmes in his dissent,50 the later cases allowed all types of information exchange except

49. Id.
for information directly relating to future prices. Certainly, loss information does not comprehend such pricing information.

IV. CONCLUSION

ISO's new ban on advisory rates enables the insurance industry and those responsible for regulating it to move into a new era. Since the industry no longer has systemic antitrust violations built into its way of doing business, McCarran-Ferguson has outlived its usefulness. Since there are no remaining regular insurance activities prohibited by antitrust laws, why not repeal the Act? To allow the Act to stand would be to encourage truly collusive conduct among the insurance companies.

By voluntarily removing advisory rates, the industry has given some credence to the charges of an unnecessary exemption from the antitrust laws. But we should not dwell on the past. We should instead welcome this as an opportunity to put the McCarran-Ferguson issue to rest.

The antitrust principles that have grown up around trade association practices provide the insurance industry with the safest means of antitrust protection while removing the shield that allowed the insurance industry to develop into a comfortable cartel.

I. INTRODUCTION: EMERGENCE OF WORKPLACE MENTAL DISABILITY CLAIMS

The 20th century has seen the development in the United States of the workers' compensation system. Under this system, ideally, an employee injured on the job waives the right to sue the employer in return for a statutorily imposed mechanism providing scheduled benefits for specific injuries.¹

Most states allow these workers' compensation benefits to be provided through insurance policies purchased by the employer from insurance companies, although some states exercise a monopolistic control over the workers' compensation system.² The typical workers' compensation policy applies to bodily injury (including resulting death) by an accident that occurs during the policy period or bodily injury by disease caused or aggravated by employment conditions. The insuring agreement states that the insurer will pay promptly, when due, the benefits required by the workers' compensation law.³ Thus the system works relatively smoothly in most cases: A box falls on an employee's foot and breaks three toes; a claim is made for the injury; the workers' compensation statute mandates a $300 payment for broken toes; the claim is paid, and all parties involved are satisfied.

The above illustrates a simple claim, involving definite, easily diagnosed physical injury. Problems arise, however, when the

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³ Workers Compensation and Employers Liability Insurance Policy, 1983 Nat'l Counsel on Compensation Ins.
claim involves an injury not so easily diagnosed, as in a mental
disability claim. The problem is compounded where the mental
disability is caused by mental distress. In such an instance, there
is no physical injury to be measured against a legal schedule of
payments. How is the employee to be compensated, then, if indeed
he is to be compensated at all?

This question promises to be in the forefront of future workers'
compensation issues, especially as they pertain to the insurance
industry. Mr. William Marquette, Vice-President Corporate Claims,
The Continental Corporation, has noted that an increasing num-
ber of employees are claiming that emotional stress in the work-
place has caused the development of a mental disability that
impairs the ability to work. He cites an informal study conducted
by the National Council on Compensation Insurance that indicates
an increase in such claims, notably among white-collar workers.4

In a 1987 speech to the Workers Compensation Academy on
Medicine and Law for the Defense, Mr. Donald DeCarlo, Senior
Vice-President, Workers' Compensation, of the American Insur-
ance Association, offered the opinion that cases involving stress
or trauma with no physical injury will proliferate.5

II. THE COMPENSABILITY OF MENTAL DISTRESS CLAIMS

Granting that workers' compensation claims for mental distress
with no concomitant physical injury will continue to be put
forward, the issue becomes one of response. Are such claims
compensable? If so, how are damages to be assessed? Is compen-
sation to be paid through the exclusive remedy of the workers'
compensation system, or can the injured employee seek compensa-
tion through some other channel?

As noted, the workers' compensation policy applies to bodily
injury by accident or bodily injury by disease. The term "bodily
injury" is not defined in the policy, although it must occur during
the policy period and must arise out of and in the course of
employment.6 The initial inquiry then naturally follows: Is mental
distress a bodily injury under the workers' compensation policy?

5. 36 INS. ADJUSTER No. 9 (1988).
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Generally, workers' compensation cases involving emotional or mental conditions can be divided into three groups: (1) mental stimulus resulting in physical injury, (2) physical trauma resulting in mental injury, (3) mental stimulus resulting in mental injury. Most jurisdictions and workers' compensation boards have no problem awarding benefits under the first two groupings, because the employee is disabled due to an injury that is associated with a physical manifestation, a definite bodily injury. In the last category, the mental injury as a result of mental stress, decisions vary from jurisdiction to jurisdiction. 7

The most substantial factor found in those cases denying compensation without bodily injury is the difficulty of proof in order to prevent fraud. Because mental injury is vague, shadowy, and intangible, and could be within the control of the sufferer, it was feared that without some corresponding bodily injury, the disability could too easily be stimulated. 8 Mental pain or anxiety was regarded as something metaphysical, too subtle and speculative to be capable of measurement by any standard known to law. 9 It is as if the courts were saying they could not comprehend a method to objectively value a claim based on mental pain without any bodily injury to evaluate; therefore, such claims had to be denied.

Jurisdictions that permit compensation for claims for mental injury without accompanying bodily injury emphasize the idea that the difficulty of formulating appropriate legal tests does not


8. See Annotation, Negligence: Fear of Injury to Another, or Shock or Mental Anquish at Witnessing Such Injury, as the Subject of Damages, 18 A.L.R.2d 220, § 2 (1951); Annotation, Right To Recover for Emotional Disturbance or Its Physical Consequences, in the Absence of Impact or Other Actionable Wrong, 64 A.L.R.2d 100, § 6 (1959).

justify denying claims for mental injury caused by mental stress. In *NPS Corp. v. Insurance Co. of North America*, the New Jersey appeals court held that emotional distress and mental anguish caused to an employee by sexual harassment from a fellow employee constituted bodily injury. The court stated that New Jersey has come to recognize that mental and emotional distress is just as real as physical pain and that its valuation is no more difficult. Within that framework, the court disagreed with the defendant's argument that bodily injury necessarily entails some physical or corporeal harm caused by the application of external violence. "We are unable to separate a person's nerves and tensions from his body," since "clearly, emotional trauma can be as disabling to the body as a visible physical wound."

The question of the need for bodily injury to be present in order to recover for a mental injury claim will not be settled quickly. If a trend is discernible, it is toward a recognition that mental injury due to stress and tension is comparable to bodily injury on the theory that there is no rational distinction between mental stress causing a heart attack as opposed to causing some mental reaction. The trend is toward accepting the idea that incapacity due to mental disability is just as real and acknowledgeable as that due to physical injury, such as heart attack; the disturbance to the claimant, in either case, is not imaginary.

This rational procession from recognizing only claims for physical injury to recognizing also claims for mental injury standing alone is further aided by a sense of fairness toward the claimant. The Michigan Supreme Court, in holding that a claimant is entitled to compensation if it is factually established that an injury incurred during employment-caused disability, declared that any proof of injury through the use of physical manifestation places a heavier burden of proof on mental injury claimants without any basis for such a distinction.

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11. Id. at 552, 517 A.2d 1214.
12. Id.
15. Deziel v. Difco Laboratories, 268 N.W.2d 1, 15 (1978) (superseded by statute, as
III. MENTAL INJURY CLAIMS AND THE WORKERS' COMPENSATION POLICY

The standard workers' compensation policy lends itself to including mental distress within the meaning of bodily injury. As noted above, the policy does not define the term "bodily injury," leaving that part of the policy open to the charge of ambiguity. It is well settled, of course, that a contract of insurance, couched in language chosen by the insurer, is to be construed strictly against the insurer and liberally in favor of the contention of the insured.16 If a word or phrase in an insurance policy can be given more than one meaning, or is left open to multiple definitions, any dispute over the meaning of that word or phrase generally will be settled against the insurer, regardless of the original intention of the policy drafters. A bolstering argument is that some insurance forms other than the workers' compensation policy do specifically define bodily injury;17 therefore, if the term is to be limited in its scope of coverage, the entity that wrote the policy could have restricted its meaning. Bodily injury may, at first blush, conjure up in the minds of the general public physical injuries to the body, like broken bones or open wounds. However, to attorneys bent on securing benefits for an injured worker, bodily injury, unless confined by definition, can be readily expanded to include mental distress.

Working on the assumption that mental distress will be accepted in court as a bodily injury, it still cannot be taken for


17. See Commercial General Liability Coverage Form, CG 00 01 (1985), Insurance Services Office; Business Auto Coverage Form, CA 00 01 (1987), Insurance Services Office; Personal Auto Policy, PP 00 01 (1988), Insurance Services Office; Homeowners 1, 2, 3, HO-1, HO-2, HO-3 (1984), Insurance Services Office.
granted that the mental distress claim is considered compensable under the workers' compensation policy. The insurance applies to bodily injury by accident or by disease that occurs during the policy period and arises out of and in the course of employment; it needs to be shown that the mental distress touches all these bases. In addition, there may be exclusions and conditions that apply to and modify the insuring agreement. As in any case involving a claim under any insurance policy, questions of coverage can be answered only after a review of the policy in its entirety.

**IV. CAUSAL RELATIONSHIP BETWEEN WORKPLACE AND MENTAL INJURY**

There is a lack of judicial agreement as to the requisite causal relationship between the workplace and the alleged work-connected mental disability, just as there is disagreement about the type of activity or injury accepted as one that may lead to a compensable condition.\(^{18}\) Basically, though, courts dealing with a mental stress claim for compensation under a workers' compensation policy need to focus on two issues: (1) Does the mental injury constitute an accident (or disease) within the meaning of the workers' compensation policy; and, (2) if the definition is met, is there sufficient causation?\(^{19}\) In other words, if the worker suffers a bodily injury (including mental injury within the definition of that term), is the injury work-related, and thus, compensable?

According to the English case of *Yates v. South Kirby Collieries, Ltd.*, when a person in the course of employment sustains a nervous shock producing injury, he meets with an accident arising out of and in the course of his employment.\(^{20}\) If only the matter were as simple and clear cut as in this decision, which granted compensation for a nervous disability claim with no attendant

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physical injury. However, as noted above, there is no judicial consensus in the United States when it comes to the issue of the compensability of employee mental stress claims. Generally, those courts that recognize the right to compensation have reasoned that compensability should not be made to depend on the nature of the cause of the disorder.21 Those courts denying compensability reason that mental disorders could not be said to have been caused by a claim within the terms of the workers' compensation policy.22

As an example of the latter type of reasoning, an appeals court in Michigan denied compensation to employees since the type of injury sustained (mental stress) was not the type contemplated by the workers' compensation statute and policy.23 Without going into an expanded discussion of the reasoning behind the decision, the court simply stated its belief that the gist of the action in the case was such that the plaintiff did not suffer they type of personal injury covered under the workers' compensation act. In a 1988 case, a Pennsylvania court added the requirement that, when claiming workers' compensation benefits for a mental injury, the employee must demonstrate that the injury was not due to a subjective reaction to normal working conditions.24 As the claimant could not show that she was entitled to the benefits based on the terms of the workers' compensation policy, compensation was denied.

One of the better-stated defenses against awarding compensation is the dissenting opinion in Deziel v. Di£co Laboratories,25 a Michigan decision that did allow compensation. The dissenting judge noted that trauma associated with employment is usually the last straw for one predisposed toward mental disorder. The job becomes a convenient hook upon which to hang all one's troubles even though they have been building up for a lifetime, and such mental disorders prior to employment put a claim beyond the ambit of workers' compensation disability.26 Basically

22. Id. at 167.
26. Id. at 57, 268 N.W.2d at 25.
put, the ailment was caused by lifestyle factors or habits and not by work-site exposures. The claim may have been made under the workers' compensation system, but the causing injury did not fall under the cover of the workers' compensation policy terms.

In contrast, the reasoning favoring compensation in the Deziel case did not dwell on the cause of the disability. Rather, the idea of making mental stress compensable under the workers' compensation policy in the Deziel case (and, in general, on that side of the compensability question), finds its rationale in the workers' compensation system itself.

V. MENTAL INJURY AND THE SCOPE OF WORKERS' COMPENSATION

The purpose of the workers' compensation system is to compensate a worker for his disability losses, period. It is not meant to sit in judgment on the workers' lifestyle or nit-pick to death a rightful claim for assistance. The workers' compensation statutes are there to compensate the worker and his dependents for at least part of the wage loss and medical expenses incurred as a result of industrial injury. They are there to rehabilitate the employee so that he can re-enter the labor force and again become a productive member of the community. And, they are there to provide a monetary incentive to the employer to minimize occupational injury. Any judicial decision that does not recognize this basis for workers' compensation thwarts the goals of the system and destroys its meaning for the injured worker.

In the Deziel case, the concern over the cause of the disability was weighed against the spirit in which compensation laws were enacted, and the majority on the court chose the latter. The court held that, under a strictly subjective causal nexus standard, a claimant is entitled to compensation if it is factually established that the claimant honestly perceives that some injury, incurred during employment, caused a disability. A simple three-step test was applied to the question of compensability: (1) Is the claimant

28. Id.
29. Id.
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disabled; if so, (2) is he disabled on account of some personal injury; (3) did the employment aggravate, accelerate, or combine with some internal weakness or disease to produce the injury? If the response to these guidelines is positive, the claimant has a work-related injury that is compensable, and the workers' compensation policy responds with payment for the claim.

VI. MENTAL STRESS AS AN "ACCIDENT"

There is another aspect that should not be overlooked at this point. Since the workers' compensation policy applies to injury by accident, can mental stress be equated with "accident" for purposes of recovery under the policy? Mental stress severe enough to cause disability generally does not develop overnight, and if it is a gradual process over a long period, can it be termed an accident? The workers' compensation policy offers no definition of the word, but Black's Law Dictionary does offer the following: with reference to workers' compensation acts, an accident is an event that takes place without one's foresight or expectation; an undesigned, sudden, and unexpected event. Its synonyms are chance, mishap, mischance, misfortune.

Many terms used in insurance forms are open to differing judicial interpretations, and "accident" is no exception. The general principle is that impairments, albeit physical ones, developing by imperceptible stages as a result of continuing in particular work over an appreciable period of time are not compensable as accidental injuries. This principle has been adhered to in cases that decline compensation for a mental disability claim.

For example, in Lawson v. Employers Ins. of Wausau, a federal court decided that a general mental breakdown resulting from

31. Id. at 37, 268 N.W.2d at 16.
32. Georgia offers another example of the liberal view toward the compensability of mental stress claims under the workers' compensation system. An appeals court decided that the law does not specify that which must produce disability. If disability exists, whether physical or mental, and is brought on by accident, the workers' compensation law being a humane law and liberally construed, the disability is compensable. Indemnity Ins. Co. v. Loftis, 103 Ga. App. 749, 120 S.E.2d 655 (1961).
33. BLACK'S LAW DICTIONARY 14 (5th ed. 1979).
34. See Lawson v. Employers Ins., 330 F. Supp. 321 (E.D. Tenn. 1971); Young v. Melrose Granite Co., 152 Minn. 512, 189 N.W. 426 (1922). See also Annotation, Injury to Muscles or Nerves Attributable to Occupation, But Not Due to a Sudden Event, as Within Workmen's Compensation Act, 29 A.L.R. 510 (1924).
overwork or long employment at a particular type of activity was not a compensable accident.\textsuperscript{35} In \textit{Lawson}, the employee had to work long hours involving rotating shifts over a period of time and claimed this caused a disabling anxiety reaction and hyper-tension. The court, in interpreting the Tennessee workers' compensation law, stated that the employee was not disabled by an accident within the meaning of the law, and, therefore, compensation would not be paid. The court stated that it was "not yet prepared to hold that shift work or a requirement that supervisory personnel work long hours during a strike is a "risk connected with employment."\textsuperscript{36}

However, other jurisdictions have ignored the general principle upheld in \textit{Lawson} and granted compensation, equating a gradual deterioration of mental stability with an accident. The Supreme Court of Arizona held that an employee who suffered a mental break-down as a result of constant work pressures did sustain a personal injury claim arising out of and in the course of her employment.\textsuperscript{37} The claimant in this case worked at a place where business was rapidly expanding, and the employer had placed more and more responsibility on her. Eventually, the worker suffered a mental breakdown and sought disability compensation. The court agreed with the worker's contention that the mental breakdown resulted from a gradual buildup of stress and tension at work and was sufficiently unanticipated to be called unexpected, and hence, accidental within the meaning of the statute providing compensation.\textsuperscript{38} The court said that Arizona followed English law that injury is caused by accident when either the external cause or the resulting injury itself is unexpected or accidental.\textsuperscript{39}

Basically, then, the differing court decisions on compensation for impairments that develop over a period of time are reduced to disagreeing about whether "accident" means only a sudden

\textsuperscript{36} Id. at 323.
\textsuperscript{38} ARIZ. REV. STAT. ANN. § 23-1021(B) (1983).
See also Baker v. Workmen's Compensation Appeals Bd., 18 Cal. App. 3d 852, 861, 96 Cal. Rptr. 279, 285 (1971) (an injury may be the result of the cumulative effect of each day’s stress and strains; it is not necessary to find a single, identifiable, traumatic experience or accident).
one-shot trauma or whether the word can encompass gradual trauma. This point raises the importance of defining words and phrases used in an insurance policy, be it a workers' compensation policy or any other, in the policy format itself.

The definition of words, whether they are provided in a statute or in an insurance form, determines to a large degree whether a claimant will be successful in getting, for example, disability benefits, and insurers would, no doubt, want to control the situation as much as possible. Otherwise, control of a claim will be assumed by the court, leading to divergent opinions at best and eventually hostile opinions, perhaps nationwide, against the insurer. Courts may eventually come to look at all workers' compensation claims in the spirit of unbridled sympathy and agree with the declaration that "in the absence of substantial evidence to the contrary, any disability occurring in the course of employment must be presumed to have arisen therefrom."  

VII. MENTAL STRESS CLAIMS AND FEDERAL STATUTES

Up to now, this paper has looked at mental distress claims as being compensable or not, with reference to insurance policies and state workers' compensation acts. There is also a developing field of law with respect to mental distress claims under federal statutes that should be noted. The specific statutes are the Labor and Management Relations Act, 29 U.S.C. § 185, and the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132.

In general, under the particular circumstances of each case, courts have allowed no recovery for mental distress claims but have recognized the basic right to recover for such claims. 41 This right has been found to exist, at the least, under § 185, dealing with the liabilities of and restrictions on labor and management. Under § 1132, the right of recovery is not quite as clear; this section of ERISA deals with the administration and civil enforcement action for the protection of employee benefit rights.

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40. See American Nat'l Red Cross v. Hagen, 327 F.2d. 559, 560 (7th Cir. 1964) (quoting Travelers Ins. Co. v. Donovan, 221 F.2d 886, 888 (D.C. Cir. 1955)).

In a 1970 Puerto Rico case, discharged employees sought recovery for mental damages under provisions of § 185. The federal court denied any compensation but stated that it could conceive of circumstances that might warrant such an award. The court, in effect, and apparently with intent, left open the possibility that circumstances could in some future case support a claim for mental distress under § 185.

In UAW v. Federal Forge, Inc., a federal court for the Western District of Michigan also found a basis to support some future potential claim for mental distress damages. In this case, employees brought an action arising from the termination of health insurance benefits in connection with the closing of the plant where they were employed. The employees claimed to suffer mental distress as a result of the lost health insurance. The court noted that no federal law precisely determines whether damages for mental distress are available under § 185. However, where it could reasonably be said that matters of mental concern and solicitude were within the contemplation of the respective parties to the negotiation and execution of a collective bargaining agreement, the claimants could maintain a claim for mental distress damages under the Labor Management Relations Act and ERISA. Here again, the door is specifically left open for coverage of mental distress claims by workers under provisions of the U.S. Code.

Regardless of the comments by the court in Federal Forge concerning ERISA, a much harder attitude toward mental distress claims under 29 U.S.C. § 1132 exists. There are several examples of claims being denied and one court decision even denies the right to sue for mental suffering.

A federal court in Wisconsin apparently did not consider even the possibility of damages for mental distress claims under § 1132. The plaintiff and his family were covered by a benefits plan, but after a claim was made and denied, the plaintiff filed a lawsuit charging emotional distress among other things. When the plaintiff was fired, he filed another suit under ERISA; how-

43. Id. at 293.
45. Id. at 1357.
ever, the court denied compensation and did not recognize mental stress as a compensatory damage for violation of ERISA rights.\textsuperscript{46} According to a federal court in Mississippi, the Employee Retirement Income Security Act confers no right to sue for mental suffering caused by violations of the terms of the employee benefit plans.\textsuperscript{47} The plaintiff was an employee of a company where a collective bargaining agreement established a medical plan. The plaintiff was laid off and then had a claim for medical benefits denied on the grounds that the plan had been terminated. A lawsuit was filed claiming, among other things, the negligent infliction of emotional distress. This lawsuit was filed under state law, and the court stated that ERISA preempted state law in the enforcement and regulation of welfare benefit plans for employees. It also said that, even if the suit were filed properly, ERISA would not permit such a lawsuit grounded as it was on complaints of mental distress; the Act simply does not confer the right.

Another example of a federal court declaring that the plaintiff could not obtain emotional injury damages under ERISA can be found in \textit{Pokratz v. Jones Dairy Farm}.\textsuperscript{48} The plaintiff, a former employee, sought disability benefits under a plan offered by the former employer, claiming an eye disease and depression. The claim was denied since the defendant, after a very long investigation, said Pokratz could work if he wished but that he had a lack of motivation. Pokratz sued under ERISA, but the court denied the claim. The court chose not to interpret the differing reports it had received on Pokratz’s eye disease and, as noted before, found that ERISA does not authorize awards for emotional distress.\textsuperscript{49}

The feeling throughout those cases involving the U.S. Code seems to be one of either denying benefits for mental stress claims or searching for a way to grant them. Either way, the federal courts still seem to have some trouble justifying the awarding of benefits to an employee claiming mental stress. It

\textsuperscript{46} See Bittner v. Sadoff & Rudoy Indus., 728 F.2d 820 (7th Cir. 1984).
\textsuperscript{47} Light v. Blue Cross & Blue Shield, Inc., 616 F. Supp. 558, 562 (S.D. Miss. 1985) (quoting Bittner v. Sadoff & Rudoy Indus., 728 F.2d 820, 825 (7th Cir. 1984)).
\textsuperscript{48} 597 F. Supp. 326 (W.D. Wis.), aff’d in part and vacated in part, 771 F.2d 206 (7th Cir. 1984).
\textsuperscript{49} Id.
is acceptable to pass over those court decisions denying benefits
as simply a particular interpretation of a statute or as a contin-
uation of that disinclination to grant compensation for injuries
that cannot be measured by physical evidence. This paper is not
intended to reargue those cases.

What is of interest here is the thinking behind those decisions
that, while actually denying compensation, recognized the exis-
tence of the employee's right to recover for mental stress under
federal statutes. The central theme running through such deci-
sions is a search for a basis upon which compensation for mental
distress absent physical injuries can be found. Whether that basis
is breach of contract or extreme, reckless conduct, the courts
realize that employee mental distress is an injury that can and
should be compensated.

Of course, workers' compensation is not concerned with finding
a basis like breach of contract or reckless conduct upon which
to support payments for disability; it is, ideally, a no-fault system
of compensation. However, as noted previously, when it comes
to mental disability caused by mental distress, the workers'
compensation system can break down through denial of compen-
sation. Under such circumstances, the injured employee needs to
resort to other options to uphold his claim. If mental stress
claims are not compensable injuries under the workers' compen-
sation system, an injured employee should not be left without
remedies.

VIII. MENTAL STRESS CLAIMS AND TORT LAW

The law in general is changing with respect to recovery for
emotional distress. Historically, the law was reluctant to recog-
nize the existence of a legally protectable interest in emotional
tranquility.50 Nevertheless, the tendency today has been toward
a greater recognition of that tranquility as worthy of legal pro-
tection.51 This trend under the workers' compensation system has
been recognized in many jurisdictions.52 Yet, if workers' compen-

50. Annotation, Modern Status of Intentional Infliction of Mental Distress as Independent
51. Id.
52. Id.
sation is not used or is not permitted to be used as legal protection for a worker suffering a disturbance to his mental peace, can tort law or some other theory of law be utilized to fill the void? And if so, is there an insurance program available to respond and provide coverage for any payments due?

The law of torts and workers' compensation have had a significant relationship through the years. For example, there were parallel developments of the physical impact rule in torts and in workers' compensation; also, there is a propensity on the part of some courts dealing with workers' compensation cases to rely on tort law in determining the compensability of certain employment-related injuries. And, prior to the advent of workers' compensation, an injured employee could sue in tort for compensation. Even today, as a supplement to or a substitute for workers' compensation, an employee can use tort law to recover for a disability.

The traditional standard for compensating mental distress under tort law is similar to that originally followed under the workers' compensation system; the standard is found in the Restatement: If the actor's conduct is negligent as creating an unreasonable risk of causing either bodily harm or emotional disturbance to another, and such conduct results in emotional disturbance alone, without bodily harm, the actor is not liable for such emotional disturbance. In tort law, then, as in workers' compensation, hesitancy in paying compensation for mental distress without a physical injury is customary and stems, no doubt, from the fear of fraud.

However, it is reasonable to assume that, just as some court rulings in workers' compensation cases have moved away from the absolute necessity of physical injury in order to justify payments for mental disability, future decisions in negligence lawsuits will depend not so much on any accompanying physical injury (or lack thereof) but on the actual disability itself, the actual inability to perform suffered by the claimant. The trek

54. Id. at 736.
56. Restatement (Second) of Torts § 436A (1965).
toward that point may have already begun. It has been written that a mental illness or emotional reaction of a significantly disabling nature, capable of discrete diagnosis within the American Psychiatric Association's Manual for Classification of Mental Disorders, would be recognized by most courts today as a compensable illness. And, in a 1988 decision, the U.S. Ninth Circuit Court of Appeals, interpreting California law, declared that emotional or mental injuries are not inextricably linked to bodily injury under state law.

IX. MENTAL INJURY CLAIMS
AND THE GENERAL LIABILITY POLICY

Even if mental stress claims with no physical injury are recognized by more and more jurisdictions, the injured worker needs to move cautiously when seeking compensation. If the injured worker cannot or chooses not to use the workers' compensation system to seek payment for his mental disability, and seeks recovery under the law of torts, he should be aware that the general liability insurance system differs from workers' compensation insurance.

In the first place, the defendant in a lawsuit brought by an injured employee may not even have general liability insurance. Liability insurance, unlike workers' compensation, is not always prescribed by state law, and in the absence of such insurance, an employee may find himself winning the case and seeking recovery from a bankrupt defendant.

Furthermore, even if the defendant has insurance, there is no guarantee that the policy will apply to the injuries that are claimed. The insuring agreement of the standard general liability coverage form states that the insurer will pay those sums that the insured becomes legally obligated to pay as damages because of bodily injury or property damage.

The bodily injury or property damage must occur during the policy period and be caused by an occurrence. And, if these prerequisites are met, the claim must still survive the exclusions,

conditions, and definitions that are written into the policy and that tend to curtail the scope of coverage.

Assuming, then, that the employee suffering a mental disability does file a lawsuit based on the tort of negligence, and assuming further that the defendant does have a general liability policy, the issue can be framed in a question similar to that asked with reference to the workers' compensation policy. Is mental distress a compensable injury for a worker under the general liability coverage form?

Unlike the worker's compensation policy, the general liability coverage form does define bodily injury; unfortunately, however, the definition is not too specific. Bodily injury means bodily injury, sickness, or disease sustained by a person, including resulting death.\(^60\) Can this definition encompass mental stress as a compensable injury? Not surprisingly, courts differ on that point.

For example, defense costs and indemnity obligations were imposed in an action for mental anguish suffered as a result of misinterpretations made by the insured in the sale of property and the purchaser's reliance thereon. The Alabama Supreme Court held that the insured's actions were bodily injury within the scope of the policy coverage; the mental stress suffered by the claimant was bodily injury and, as such, was compensable.\(^61\) Another example can be found in the decision of a Louisiana Court of Appeals.\(^62\) In this 1975 case, the claimant was accused of shoplifting and subjected to mental abuse. The lawsuit that followed was successful for the claimant, with the court noting that bodily injury has been held in the state to include not only physical abuse but also mental distress.\(^63\)

In opposition to these holdings, an appeals court in Michigan declared that the term "bodily injury" as used in the liability policy under review was not ambiguous, that bodily injury does not include mental anguish and distress.\(^64\) This case involved construing a policy based on an action for declaratory judgment.

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60. Id.
63. Id. at 9.
after an individual brought suit alleging denial of civil rights and other theories of recovery. The insurer denied coverage, and the appeals court agreed with the insurer's interpretation of the insurance contract. The court said that the damages alleged, such as humiliation, mental anguish, and mental suffering, were not bodily injuries covered by the policy.\footnote{Id. at 335, 356 N.W.2d at 633.} The court noted that (even though the term was undefined in the policy) bodily injury limited the harm to physical injury and did not include nonphysical harm to the person.\footnote{Id. at 333, 356 N.W.2d at 633 (citing Rolette County v. Western Casualty & Sur. Co., 452 F. Supp. 125 (D.N.D. 1978)).} Extensive case law was cited to support the proposition that mental suffering has been consistently distinguished from physical harm in tort actions.\footnote{Id. at 333-35, 356 N.W.2d at 632-33.}

A federal district court in Virginia agreed with the Michigan decision. A former employee filed suit seeking damages for emotional distress against his previous employer. The insurer denied coverage to the employer, who promptly sought a declaratory judgment. The insured contended that the general liability policy included mental distress within the definition of bodily injury. However, in answer, the district court noted that in giving bodily injury coverage its plain meaning, the term simply did not cover claims for purely emotional injury.\footnote{West American Ins. Co. v. Bank of Isle, 673 F. Supp. 760, 765 (E.D. Va. 1987) (quoting American & Foreign Ins. Co. v. Church Schools, 645 F. Supp. 628 (E.D. Va. 1986)).} Mental distress was held not to be bodily injury, and the policy covered only claims for bodily injury; therefore, no recovery was allowed under the general liability policy.

It may be that, at this time, a majority of authorities hold that bodily injury does not include mental distress; however, the minority opinion does exist and is not fading silently away. Unless the definition in the general liability form is clarified one way or the other, there is no certainty that more and more courts will not be persuaded that the term "bodily injury" as used in the insurance policy is ambiguous and generalized enough to include mental stress. Future court rulings could come to depend on the proved existence of an actual disability, an actual injury. The current distinction in the minds of some courts between physical and mental injuries could be abolished in the face of advanced
psychiatric knowledge and acceptance by reputable physicians that mental injuries are real and do cause disability.

Nevertheless, to regard mental stress as the equivalent to bodily injury is still, of course, only one step in finding coverage for mental stress claims under the general liability policy. The injury must also have been caused by an occurrence for coverage to exist.\textsuperscript{69} It should be noted that this represents another distinction between the workers' compensation policy and the general liability form, since workers' compensation applies to bodily injury by accident. However, while there is no definition of "accident" on the workers' compensation policy, the general liability coverage form does define "occurrence." Occurrence means an accident, including continuous or repeated exposure to substantially the same general harmful conditions.\textsuperscript{70} This definition would seem more in tune with a mental stress claim since such stress, of a nature significant enough to cause disability, usually develops only after continuous exposure to certain conditions. Nevertheless, just like "accident" in the workers' compensation policy, the term "occurrence" in the general liability policy may or may not be interpreted as a proper setting for emotional distress.

The \textit{American States Ins. Co. v. Cooper} case, for example, offers the view that occurrence within the scope of the policy coverage does apply to an action for mental anguish.\textsuperscript{71} \textit{West American Ins. Co. v. Bank of Isle}, on the other hand, holds that even if emotional distress were bodily injury, it is not an occurrence covered by the policy.\textsuperscript{72}

However, the terms "bodily injury" and "occurrence" are interpreted by the courts, there is at least one more, perhaps fatal, impediment to an employee attaining recovery for a mental distress claim under the general liability policy — the policy exclusions. There are specific exclusions that deal with (and indeed, are meant to deal with) employees and any claims that they might make against the insured employer. General liability

\textsuperscript{69} Commercial General Liability Coverage Form, Section I, Coverage A, Insuring Agreement, CG 00 01 (1985), Insurance Services Office.


\textsuperscript{71} 518 So. 2d 708, 710 (Ala. 1987).

\textsuperscript{72} 673 F. Supp. 760, 766 (E.D. Va. 1987).
insurance does not apply to any obligation of the insured under a workers' compensation law; it also does not apply to bodily injury to an employee arising out of and in the course of employment, whether the insured may be liable as an employer or in any other capacity.

It is logical that if an employee suffers a mental injury due to mental stress encountered on the job, and then seeks compensation for that injury, it is arising out of and in the course of employment. The ideal solution is, of course, workers' compensation; and if state law or court decisions have dictated that mental stress be considered a compensable injury under workers' compensation, that system will make any required payments. The general liability form will not respond since it excludes coverage for such obligations.

However, if mental stress has not been rendered a compensable workers' compensation injury for whatever reason, and the employee files a negligence suit for recovery, the insured employer will seek coverage under the general liability policy; but, based on the nature of the injury, that policy will not respond. The exclusion is quite clear: Bodily injury to an employee arising out of and in the course of employment is not an insured obligation.

As a general rule, in a dispute over the meaning of terms in an insurance policy, a court is to ascertain the meaning which the insured would reasonably expect from the language of the insurance contract, but if the language is clear and unequivocal, the court will enforce its terms and will not rewrite the contract.

In summary, even if mental disability is ratified as bodily injury and even if the mental stress causing that disability is deemed an occurrence, the injured worker is not likely to receive compensation from the general liability coverage form. This is not to say that the worker would not win a lawsuit against the

74. Id.
employer based on negligent, tortious conduct. The general liability insurance policy simply will not be the vehicle by which compensation is paid. If compensation paid to a worker disabled by mental stress is to be analyzed in relation to the field of insurance, then workers’ compensation is the best path to choose.

X. ALTERNATIVE ROUTES TO RECOVERY

There are interesting developments that promise to open different avenues of opportunity for the disabled worker. One of the avenues is to explore the right of an employee to maintain an action for negligence against the workers’ compensation insurance carrier itself. The theory behind this point is that some insurance carriers take it upon themselves to inspect the workplace for safety engineering purposes, and if an accident then occurs, the injured worker charges negligence on the part of the insurer for failure to perform its assumed duty to uncover and correct unsafe working conditions.

It is true that lawsuits brought on such a basis have been the result, up to this point, of physical disabilities. However, if some jurisdictions permit such lawsuits, and those same jurisdictions consider mental disability without accompanying physical injury to be a compensable disability, it is a logical progression that mental stress claims could form the basis for negligence suits against the insurer. If an insurer has inspected a workplace and failed to notice (or has noticed but has not recommended correcting) stressful conditions that eventually lead to mental disability of an employee, why cannot that employee have the right to file suit against the insurer for negligent performance of its duty?

To date, however, most of the decisions in this area have come down on the side of the insurer. A federal district court in Michigan stated that nothing in Michigan’s workers’ compensation act reveals the intention to allow the insurance carrier, which is performing safety inspections as an integral part of its function, to be sued as a negligent third party on the theory that its liability arises from the negligent performance of a voluntary undertaking.\footnote{Kotarski v. Aetna Casualty & Sur. Co., 244 F. Supp. 547 (E.D. Mich. 1965), aff’d, 372 F.2d 95 (6th Cir. 1967).} An employer’s compensation carrier is not subject
to suit by an injured employee for alleged negligence in the failure to inspect machinery, failure to warn the employee of the danger, and neglecting to provide devices to negate the danger.\(^7\)

And, in an Illinois case, it was held that the workers' compensation carrier engaged in making safety inspections incident to its compensation coverage was not amenable to suit by an employee for injuries caused by the carrier's negligence in performing safety inspections.\(^8\)

There are some cases on the other side of the issue. In New Hampshire, a compensation carrier, which undertook to assist accident prevention by inspections and advice rendered to the employer company, was liable to an injured employee for negligent inspection.\(^9\)

And, in New Jersey, a court declared that a workers' compensation carrier is a third person liable to an employee in a common law action if its acts negligently cause harm to the employee.\(^0\)

The reasoning behind the decisions rejecting liability on the part of the insurer rests mainly upon two points. The first is that the insurer stands in the place of the employer, with all the subsequent rights, duties, and exemptions enjoyed by the employer. Under workers' compensation laws, the employer is, for the most part, protected from lawsuits of employees due to the exclusive remedy aspect of those laws. Since insurers assume the compensation obligations of the employers, the insurer and the employer are considered to be one and the same in relation to employees, and, therefore, assume the protection of exclusive remedy. The employer is entitled to be free from employee-instigated lawsuits, and so is the insurer. This line of reasoning holds, by the way, whether the insurer is placed in the shoes of the employer by statute (as in \textit{Kotarski v. Aetna Casualty & Sur. Co.}\(^81\)), or by judicial interpretation of the intent of the legislature (as in \textit{Reid v. Employers Mut. Liab. Ins. Co.}\(^82\)).

The second point behind the reasoning is mostly one of societal benefits. The insurer inspects the workplace in order to protect

\(^82\) 59 Ill. 2d 194, 319 N.E.2d 769 (1974).
the safety of the worker, thereby benefitting society since a healthy worker makes for a better world. This inspection is a voluntary act, and if the insurer is to be subject to lawsuits or even the fear of lawsuits based on that voluntary act, then, obviously the insurer will refrain from doing the inspections, the worker will ultimately suffer, and society will bear the brunt of injured and disabled workers.

On the other hand, the courts that allow third-party suits against insurance companies rest the decisions on basic negligent performance. For example, in Corson v. Liberty Mut. Liab. Ins. Co., the insurer had a separate and substantial department for the exclusive purpose of inspecting operations of insureds. Advertisements stressed this program, inspectors visited the workplace about four times a year, and the actual inspections took about three hours each. The court decided that the insurer gratuitously undertook an act and did not use due care in performing that act. The plaintiff's claim did not rest upon a bare and unfulfilled promise to inspect, but on the negligent performance of a service. The act of insuring the risk was separated from the act of inspecting the risk, and the insurer was found remiss in the latter task.

Regardless of which argument will prevail in the future, it should be pointed out that the current standard workers' compensation policy contains a rather specific disclaimer about the inspection of the workplace and the duty such an inspection places on the insurer. Under the "Conditions" section of the policy, the insurance company declares that inspections are not safety inspections; they relate only to the insurability of the workplaces and the premiums to be charged. Furthermore, the insurer states that it does not undertake to perform the duty of any person to provide for the health or safety of the employees and does not warrant that the workplaces are safe or healthful, or that they comply with laws, codes, or standards. Thus, the insurance company strives to intentionally limit its duty under the workers' compensation policy, and this applies to both the insured and the worker.

84. Id. at 212, 265 A.2d at 318.
Another choice for the disabled employee could lie in the recognition of intangible rights in a contract, including a contract of insurance that benefits employees, as a protected property right. The idea that rights in or created by an insurance contract constitute property is not a new idea. However, one of the key points that has to be considered here is the role of the worker in such a contract.

A workers' compensation insuring agreement is a contract between the employer and the insurer to pay benefits required of the employer by the workers' compensation law. Any role that the worker may have in this insuring agreement is, at best, that of an incidental third-party beneficiary. The injured worker receives a benefit not because of the workers' compensation policy but because of his injury; the benefit is paid not because of the insuring agreement but because of a statute requiring it. The workers' compensation policy serves as a method for the insured employer to discharge his obligations under the law. Therefore, the worker has no protected property rights on that worker's compensation contract.

It would be different if, as is implied in the case of UAW v. Federal Forge, payment of the claim for mental disabilities of the worker's was an expressed concern of a collective bargaining agreement, an agreement that called for an insurance policy to provide for the mental disabilities of employees. Then the employees would have a direct interest in the insurance contract and would be an intended beneficiary; the workers could enforce the contract by filing a lawsuit if necessary. This is not the case with the standard workers' compensation policy.

XI. Conclusion

Regardless of how an injured worker seeks to get compensation for his mental disabilities, it should be remembered that the fear of fraudulent claims is perhaps the main barrier to granting such compensation. Therefore, even before courts disposed to awarding compensation, the claimant should call upon expert testimony to establish his claim. The injury should be shown through a

87. 1 COUCH ON INSURANCE § 1.11 (2d Ed. 1984).
complete and accurate examination of the claimant that can prove to the objective mind of the jurist that not only does the injury exist but that it was caused by work-related disturbances. The court's main task when it comes to decisions on the question of disability payments is to review the record for competent evidence that supports a finding that an on-the-job injury caused the employee's disability.\textsuperscript{89} Mental anguish, to be actionable, must be some actual distress of mind flowing from real ills or sorrows; alleged mental sufferings over suppositions or imaginary conditions that never existed are not recoverable.\textsuperscript{90} There is no requirement that work-related stress be the sole cause of the injury, but it must be (and must be proven to be) a substantial contributing factor.\textsuperscript{91}

The role of insurance in this event should remain constant. Whether as workers' compensation or as general liability protection, insurance is an agreement whereby one party compensates another party for loss on a subject specified in the agreement and limited by exclusions and conditions that are part of the agreement. The words and phrases of the insurance policy will be subject to differing judicial interpretations unless definitions of those words and phrases are explicit; therefore, mental disabilities caused by mental stress will continue to be considered insurable, compensable injuries unless they are specifically excluded. Even though this is still a minority position at this time, the discernible trend is there to see.

And this trend is not necessarily an improper one. Fear and anxiety constitute as great an influence on human behavior and health as is known.\textsuperscript{92} A mental disability is a loss suffered by a party. It is not logical to ignore that disability simply because the cause is mental stress, not physical injury, and, thus, more difficult to prove. If that type of loss is not, or cannot be insured against, then let the workers' compensation policy and the general liability coverage form or any other applicable form excludes such losses in writing. If the insurance policy is silent on the subject of compensation for mental stress, courts and legislatures will willingly take the lead. For example, a recently enacted law

\textsuperscript{89} Bostick Tank Truck Serv. v. Nix, 764 P.2d 1344 (Okla. 1988).
\textsuperscript{90} 38 Am. Jur. 2d Fright, Shock & Mental Disturbance § 7 (1968).
\textsuperscript{91} See Courtney v. City of Orono, 424 N.W.2d 295, 297 (Minn. 1988).
in Massachusetts provides that injuries shall include mental or emotional disabilities where a contributing cause of such disability is an event or series of events occurring within the employment.93

The future of compensation for an employee’s mental disability caused by mental distress remains to be written. Ideally, that future will be written with the distress remains to be written. Ideally, that future will be written with the worker being equitably compensated and with insurance playing its proper role.

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UNDERINSURED MOTORISTS: AN EVOLVING INSURANCE CONCERN

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I. INTRODUCTION

An examination of automobile underinsured motorist coverage must begin with an exploration of uninsured motorist coverage because underinsured motorist coverage is a response to problems associated with the latter.¹ Uninsured motorist coverage is protection offered by an insured’s automobile coverage carrier “against bodily injury inflicted by an uninsured motorist, after the liability of the uninsured motorist for the injury has been established.”²

In 1955, for the first time, uninsured motorist policies were offered by New York insurance companies who voluntarily placed the uninsured motorist provision in all motor vehicle liability policies.³ Uninsured coverage was required by statute for the first time in 1957 by New Hampshire.⁴ Uninsured motorist coverage since 1957 has spread quickly and is now available in every state.⁵

⁵ See ALA. CODE § 32-7-23 (Supp. 1988); ALASKA STAT. § 28.20.445 (1984); ARIZ. REV. STAT. ANN. § 20-259.01(A) (Supp. 1988); ARK. CODE ANN. § 23-16-302 (Supp. 1987); CAL. INS. CODE § 11580.2(2) (West Supp. 1989); COLO. REV. STAT. § 10-4-609 (1987); CONN. GEN. STAT. ANN. § 38175(c) (West 1987); DEL. CODE ANN. tit. 18, § 3902 (Supp. 1988); Fla. STAT. ANN. § 627.727 (West Supp. 1989); GA. CODE ANN. § 33-7-11(b)(1)(D) (Supp. 1989); HAW. REV. STAT. § 431:10C-103(23) (Supp. 1987); IDAHO CODE § 41-2502 (Supp. 1989); ILL. ANN. STAT.
Uninsured motorist coverage did not, however, provide a solution to situations where a negligent driver complied with the financial responsibility laws of the state, but maintained coverage limits that were inadequate to compensate the injured party for damages sustained, because the statutorily prescribed bodily injury limits were too low. Where such a situation arose, attempts to have the tortfeasor declared “underinsured” for the difference between the amount realized from the tortfeasor’s liability policy and actual damages were uniformly rejected. Automobiles carrying the statutorily required liability limits were consistently held not to be “uninsured” despite their inability to compensate the victim.

In McDonald v. Keystone Ins. Co., an injured passenger recovered the policy limits of $15,000 from the driver of a car in which she was riding. She then sought additional recovery from her own automobile insurer under the uninsured motorist provision of her policy. After a hearing, arbitrators awarded her $15,000

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in uninsured benefits. This award was vacated by a lower court, and the Pennsylvania Superior Court affirmed that decision, noting that "[o]ur legislature did not intend to provide additional insurance to those who although they suffered severe injury had recourse to at least the legal minimum of insurance through the other motorist."

Another instance of uninsured motorist laws proving inadequate or disadvantageous to injured motorists occurs when several persons are injured, and as a result of exhausting the tortfeasor's per occurrence limits, they are not compensated or receive only a portion of the tortfeasor's liability insurance. In Lotoszinski v. State Farm Mut. Auto. Ins. Co., the Michigan Supreme Court ruled that the plaintiff could not recover from her uninsured motorist coverage despite the fact that she had not received payment from the tortfeasor's exhausted policy. In the court's opinion, the tortfeasor was not uninsured because he originally possessed a minimum level of insurance prescribed by the statute.

Another argument made by plaintiffs was that they were entitled to compensation under their own automobile policy's uninsured motorist provision even though they had received the total amount of liability coverage carried by the tortfeasor, since the latter amount was not sufficient to provide full indemnification, as damages exceeded the liability coverage. This approach was also generally rejected.

Several legislators attempted to solve this problem by requiring insurers to make higher limit uninsured motorist coverage available to purchasers of motor vehicle liability insurance. However, insurance companies, when presented with claims under these statutes, often rejected liability under the higher limits. Insurance companies argued that coverage was provided where there was no insurance. The result was that although the tortfeasor's limits were less than the claimant's higher-limit uninsured motorist coverage, the higher-limit coverage was not

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11. 417 Mich. at 10, 331 N.W.2d at 471.
13. *Id.* at § 8.25
applicable.\textsuperscript{14} Thus, despite the legislature's attempt to deal with the inadequacies of uninsured motorist statutes, victims were often better off if the tortfeasor had no insurance rather than if he had the minimum limits required by law.

As a result of the problems presented by uninsured motorist coverages, there was an increasing interest in developing first-party coverage for those insureds who had higher limits of indemnification, especially in situations where accidents involved (1) uninsured motorists and (2) "insured motorists with liability coverages that were not sufficient to provide complete compensation for claimants who were entitled to recover."\textsuperscript{15}

\section*{II. UNDERINSURED MOTORIST COVERAGE}

\subsection*{A. Generally}

Underinsured motorist coverage is designed to allow an individual to protect himself from economic loss and to guarantee himself the right to recover other compensatory damages, should he be legally entitled to such, to the same extent he provides such protection to those he might cause to be injured on the roadway.

Underinsured motorist coverage is a merger of the first-party insurance concept with traditional negligence and tort theories. The insured driver pays for insurance protection for himself and his family members. While uninsured motorist insurance applies only when the person legally responsible for an accident has no liability insurance, or in some cases where the person has less liability insurance than the amount required by the state's uninsured motorist or financial responsibility law, underinsured motorist insurance allows the insured victim to recover where the tortfeasor has liability insurance that is insufficient to fully compensate the injured party.

When examining underinsured motorist cases, three rules of construction adopted from uninsured motorist cases govern the inquiry.

First, the enactment of underinsured motorist statutes indicates a legislative public policy that motorists should be protected

\textsuperscript{14} Id.

\textsuperscript{15} Id. at § 31.4
and that victims of auto accidents should be allowed to prearrange to recover for damages incurred, even if the tortfeasor has insufficient liability insurance. Therefore, because underinsured motorists acts are remedial in nature, courts generally construe their provisions to accomplish the legislative intent of compensating injured parties. 16

The second rule is one that is generally applicable in all insurance cases: “Ambiguous provisions in the insurance policy should be construed against the insurer who prepared them, and in favor of the insured for whose benefit the coverage was adopted.” 17

Finally, despite the language contained in the underinsured motorist statute, a policy may expand, but cannot reduce, the coverage required by the statute. Therefore, courts have generally held that policies which are in conflict with the statute and attempt to reduce the coverage are void. As a result, coverage may be provided by the law even if expressly excluded by the policy. However, nothing precludes the insurance policy from providing coverage that is broader than the minimum requirements of the statute. 18

B. Overview of Underinsured Motorists Statutes

Thirty-eight states currently have statutes that provide for underinsured motorist insurance protection. 19 In some states the

16. MATTHEW BENDER & CO., NO-FAULT AND UNINSURED MOTORIST AUTOMOBILE INSURANCE § 30.20[2]. See, e.g., Wickline v. United States Fidelity & Guar. Co., 530 So. 2d 708, 711 (Miss. 1988) (“uninsured motorist coverage is designed to provide innocent injured motorists a means of compensation”).


18. BENDER, supra note 16, at § 30.20[2].

coverage is mandatory,\textsuperscript{20} while in others it is optional,\textsuperscript{21} and in several jurisdictions the coverage is applicable unless the insured specifically rejects it in writing.\textsuperscript{22}

The purpose of underinsured motorist coverage varies from state to state. While some statutes are designed to provide coverage only in the amount of one’s own liability or underinsured motorists insurance,\textsuperscript{23} others intend to compensate the injured


party in full for his total damages.24

Finally, the amount of underinsured motorist coverage that an insured may purchase once again varies from state to state. It may be mandated by statute, and the coverage available may state a minimum or a maximum amount.

Kentucky's underinsured motorist statute25 was enacted in 1974, but was amended in 1988 and now provides:

(1) As used in this section, "underinsured motorist" means a party with motor vehicle liability insurance coverage in an amount less than a judgment recovered against that party for damages on account of injury due to a motor vehicle accident.
(2) Every insurer shall make available upon request to its insureds underinsured motorists coverage, whereby subject to the terms and conditions of such coverage the insurance company agrees to pay its own insured for such uncompensated damages as he may recover ... because the judgment recovered against the owner of the other vehicle exceeds policy limits thereon, to the extent of the policy limits on the vehicle of the party recovering less the amount paid by the liability insurer of the party recovered against.26

The Kentucky statute as set forth above falls within the class of statutes that make underinsured motorist coverage optional. It is mandatory only that insurance companies make the coverage available upon request. The statute also falls within that group of states whose intent is not to compensate the victim in full, but merely to the extent of one's own underinsurance policy. Although KRS 304.20-020 limits the minimum uninsured motorist coverage to the minimum liability limits required, the statute makes no specific reference to amounts of underinsured motorist insurance.27

Kentucky's optional requirement, and the fact that the statute's language provides that the coverage should be offered only upon

26. Id.
27. Id.
request, led to one of only three reported Kentucky decisions regarding underinsured motorist insurance.

In Flowers v. Wells, the court was asked to determine whether a request for "full coverage" included a request for underinsured coverage. The court began its analysis by noting that the underinsured motorist statute required underinsured motorist coverage to be furnished only "upon request." Therefore, the court decided that "full coverage" meant only that insurance which was mandatory by statute.

In Simon v. Continental Ins. Co., unlike Flowers, the insured had requested and purchased underinsured motorist benefits; however, the policy's declaration page failed to state any specific amount of coverage for the underinsured coverage. The declarations did state that the policy would provide $100,000 coverage for liability to others and $10,000 protection against uninsured motorists. The issue, therefore, was what amount was the plaintiff entitled to recover from his own insurer.

Janet Simon was awarded judgment against the tortfeasor, Page, in the sum of $104,023 as administratrix of her deceased husband's estate and $40,000 as guardian for her daughter who was seriously injured. Page's insurance carrier promptly paid Page's limits of $10,000 on each claim, and Simon filed a claim against her insurer, Continental.

Continental argued that the limits for Simon's underinsured coverage were coextensive with its liability for uninsured motorist coverage, $10,000/$20,000, the amount listed on the face sheet of the policy as the limit of liability for "uninsured motorist" coverage. Simon, however, claimed that the amount of coverage should be determined by looking to the underinsured motorist statute (K.R.S. 304.39-320), which required that underinsured motorist coverage be coextensive with the insured's policy limits which in Simon's case were $100,000.

The Kentucky Supreme Court noted that two questions were presented in this case. First, "whether the statutory obligation

29. Id.
30. 724 S.W.2d 210 (Ky. 1985).
31. Id.
32. Id. at 211.
33. Id.
placed upon the insurer to provide underinsured motorist coverage ... refers to the limits provided for liability to others in the policy, or whether when underinsured motorist coverage is requested the insurer may sell coverage in an amount less that the liability coverage in the policy." 34 The court, however, reserved these questions for another day.

Instead, the court examined whether the "policy language should be construed as expressly limiting underinsured motorist coverage to $20,000, the amount stated for 'uninsured motorist' coverage ... or whether the policy should be construed in the broader context of the limits provided for liability coverage." 35 The court again avoided the more difficult question of whether the underinsured statute required the amount of underinsured motorist coverage to be coextensive with the insured's liability to others coverage when the insured clearly paid for underinsured motor coverage in a lesser amount. 36 The court simply held that the policy was ambiguous and that as a general rule of interpretation the ambiguity had to be settled against the insurer. Therefore, Simon was allowed to recover $80,000 from Continental.

C. Defining Underinsured Motor Vehicle

1. Statutory Definitions

An important distinction between the various state underinsured motorists statutes is when exactly is a tortfeasor underinsured. The applicable statutes fall into two distinct categories. The first type provides coverage whenever the damages suffered by the insured victim exceed the limit of the tortfeasor's liability insurance. The second type of statute provides coverage only when the insured victim's uninsured or underinsured motorist coverage exceeds the liability insurance limits available from the tortfeasor.

A. Where damages exceed tortfeasor's liability limits
(Broad Coverage)

Eleven states consider the tortfeasor's vehicle underinsured whenever the damages or injuries sustained by an insured exceed

34. Id.
35. Id. at 212.
36. Id.
the limit of the tortfeasor's liability coverage. 37 In such states, applicable policy provisions generally provide that "the insurance company agrees to pay its own insured for such uncompensated damages as he may recover ... because the judgment recovered against the owner of the other vehicle exceeds the policy limits thereon, ...." 38

Thus, if for example an insured suffers damages in the amount of $50,000 and the tortfeasor is legally liable for the damages but has $100,000 in applicable liability insurance, the tortfeasor is not an underinsured motorist. However, if the tortfeasor's applicable liability limits were only $30,000, then he would be underinsured and the insured would be entitled to recover under his underinsured policy provided by his own insurance company.

Kentucky's statute falls within this broad coverage since it expressly provides that an "'underinsured motorist' means a party with motor vehicle liability insurance coverage in an amount less than a judgment recovered against that party for damages on account of injury due to a motor vehicle accident." 39 This provision has yet to come under judicial scrutiny, but other jurisdictions have allowed victims to recover amounts in excess of the tortfeasor's applicable policy limits on the theory that underinsured motorist coverage was not merely a stop-gap measure to cure anomalies under existing uninsured motorist coverage, but rather was intended to indemnify insureds for unpaid judgments. 40


38. Widiss, supra note 12, at § 35.2.


B. Where uninsured or underinsured motorist coverage exceeds tortfeasor's liability limits (Narrow Coverage)

Twenty-five states compare the tortfeasor's liability insurance limits to the limits of the victim's uninsured or underinsured motorist coverage when determining whether underinsured motorist coverage applies.\(^{41}\) Under these statutes, the test for determining whether a tortfeasor is underinsured merely involves a comparison of the applicable coverage limits. When the underinsured (or in some states uninsured) coverage limits are either less than, or equal to, the amount of liability insurance carried by the tortfeasor, there is no basis for a first-party underinsured motorist claim.\(^{42}\)

The underinsured statute in California\(^{43}\) is a good example of a statute requiring comparison of the tortfeasor's liability limits and the insured's uninsured motorist coverage. It provides: "[U]nderinsured motor vehicle means a motor vehicle that is an insured motor vehicle but insured for an amount that is less than the uninsured motorists limits carried on the motor vehicle of the injured person."\(^{44}\)

Illinois, on the other hand, requires comparison of the tortfeasor's liability limits and the insured's underinsured motorist coverage. It states: "[U]nderinsured motor vehicle' means a vehicle whose ownership maintenance or use has resulted in bodily injury or death . . . for which the sum of the limits of


\(^{42}\) WIDISS, supra note 12, at § 35.2.

\(^{43}\) CALIF. INS. CODE 11580.2(p)(2) (West Supp. 1989).

\(^{44}\) Id.
liability under all bodily injury liability insurance policies . . . is less than the limits for underinsured coverage provided the insured . . ."\(^{45}\)

The Alaska statute\(^ {46}\) also requires a comparison with the insured’s underinsured coverage, but its statute attempts to prescribe coverage for an area that was often litigated in uninsured motorist cases. It provides:

Underinsured motorist means a motor vehicle . . . [with] a bodily injury or property damage insurance policy . . . and the amount of insurance . . . (2) has been reduced by payments to persons other than an insured, injured in an accident, to less than the limit for uninsured and underinsured motorists coverage under the insured’s policy.\(^ {47}\)

The public policy for these type of statutes “is to require a coverage that will place the insured in the position that would have existed if the tortfeasor had been insured by liability coverage with the limits that the purchaser of the underinsured motorist insurance selected for the first-party insurance.”\(^ {48}\)

C. Comparing the two types of statutes

The difference between the two types of statutes can be of major significance to the insured. This was clearly the case in *Bell v. State Farm Fire & Casualty Co.*\(^ {49}\) In *Bell*, the plaintiff’s son, a resident of Louisiana, was killed when the car in which he was a passenger was struck from the rear. The driver who had struck the victim’s car carried liability insurance with limits of $35,000. The car in which the son was riding had underinsured motorist limits of $10,000 under a policy that was issued in Florida.

There was no dispute as to liability, and the wrongful death action easily exceeded the tortfeasor’s $35,000 limits. The question was whether the plaintiff was entitled to recover the $10,000 underinsured motorist coverage in addition to the $35,000 liability insurance recovered from the tortfeasor. The question was made

\(^{45}\) ILL. ANN. STAT. ch. 73, para. 755a-2(3) (Smith-Hurd Supp. 1989).


\(^{47}\) Id.

\(^{48}\) WIDISS, *supra* note 12, at § 35.2.

difficult by the fact that the Florida statute does not provide coverage where the tortfeasor's liability insurance exceeds the underinsured motorists limits.\textsuperscript{50} Louisiana law, however, compared the tortfeasor's liability coverage to the plaintiff's damages,\textsuperscript{51} and thus would have allowed the plaintiff to recover. The plaintiff was allowed to recover the $10,000 when the court determined that Louisiana law should apply.

2. Judicial Definitions

Courts have generally been presented with two distinct situations in which they were required to determine whether a tortfeasor was an underinsured driver. In the first instance, a remnant of uninsured litigation, the court was asked to determine whether two or more underinsured policies could be "stacked" to determine whether the tortfeasor was underinsured.

Generally, before the introduction of underinsured motorist coverage, courts rejected stacking of uninsured policies to determine whether a negligent driver was underinsured. However, with the passage of underinsured motorist statutes, courts have allowed stacking to determine whether a tortfeasor was underinsured. In \textit{Descoteaux v. Liberty Mut. Ins. Co.} \textsuperscript{52} the court stated that "[t]he purpose of the legislature in amending the uninsured motorist statute required us to find that the statute allowed an insured to recover to the extent that he had purchased uninsured motorist coverage exceeding the tortfeasor's liability insurance coverage."\textsuperscript{53}

The second dilemma involved situations where liability limits were reduced by multiple claims. As previously discussed, the Alaskan statute\textsuperscript{54} addressed this problem area. Although courts were initially reluctant to define a vehicle as uninsured where its liability limits were reduced by multiple claims, since the passage of underinsured motorist statutes, courts have generally held these to apply to multiple claims situations.\textsuperscript{55}

\textsuperscript{52} 125 N.H. 38, 480 A.2d 14 (1984).
\textsuperscript{53} \textit{Id.} at 44, 480 A.2d at 19.
\textsuperscript{54} \textsc{Alaska Stat.} § 28.20.445(h) (1984).
\textsuperscript{55} \textsc{Bender, supra} note 16, at § 30-40[4]. \textit{See supra} notes 47-51 and accompanying text.
III. Specific Issues Regarding Underinsured Motorist Coverage

A. Set-Offs for Tortfeasor’s Liability Payments

1. Overview

Following an accident, a claimant may be entitled to recover for damages from a number of sources including: (1) the tortfeasor's insurer; (2) the tortfeasor himself; (3) first-party coverages such as medical payment coverage, underinsured motorist coverage and some form of no-fault insurance; (4) other insurance coverages including health or medical insurance, disability insurance, and possibly worker's compensation.56

Because of the availability of these other coverages, two situations may arise with respect to the limits of liability provisions: (1) damages are such that despite various other coverages, a claimant is not fully indemnified; (2) other sources indemnify, and therefore, limits of liability prevent duplication.57 "The standard forms for the underinsured motorist coverage include numerous clauses that provide for both limits on liability and reductions of coverage as a consequence of indemnification from other sources of compensation."58 "However, in most states the underinsured motorist statutes do not make any references to such clauses or only appear to approve one or two of these provisions."59

Nineteen states have expressly allowed set-offs or reductions of liability on the part of the underinsured coverage provider for amounts paid by the tortfeasor’s liability carrier.60 Generally,

56. WIDISS, supra note 12, at § 41.1.
57. Id.
58. Id. at § 41.2.
59. Id.
these statutes provide that a set-off can be made for any amount that is recovered from the insured tortfeasor. The Kentucky statute states: "[t]he insurance company agrees to pay its own insured for such uncompensated damages as he may recover on account of injury due to a motor vehicle accident ...."61

The language of policies usually states that the limit of liability for underinsured motorist coverage set forth on the schedule pages of the insurance policy "shall be reduced by all sums paid because of the bodily injury by or on behalf of persons or organizations who may be legally responsible."62 When such a provision is present, insurers generally argue that the purpose of underinsured motorist coverage is to place the insured in the same position that would have existed if the tortfeasor had been covered by a liability insurance policy with limits of liability selected by the purchaser of the underinsured motorist coverage.63 Therefore, in order to assess the implications of a set-off provision, it is necessary to consider a number of questions:

(1) Does the underinsured motorist statute, either in its legislative provisions on set-off or its definition of underinsured motorist coverage, provide guidance about the goal of the statute in relation to such a set-off provision?

(2) If the statute gives guidance, are the coverage limits for underinsured motorist coverages to be computed by:

(a) A reduction from the damages sustained by the insured in the amount of the indemnification received from the tortfeasor (or the tortfeasor's insurer)?

(b) A reduction from the limit of liability for the claimant's underinsured motorist insurance of the actual amount of liability insurance paid to the claimant by the tortfeasor's insurer?

(c) A reduction from the limit of liability for the claimant's underinsured motorist insurance of the actual amount of liability insurance and any other payments made by the tortfeasor to the claimant?

(d) A reduction from the limit of liability for the claimant's underinsured motorist insurance in the amount of the tortfeasor's liability insurance regardless of whether any portion of that liability insurance was actually available for the payment or paid to the claimant?

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62. Widiss, supra note 12, at § 41.7.
63. Id. at § 41.7.
(e) Treating the claimant's underinsured motorist insurance as excess insurance which allows the insured to recover when the damages exceed the limits of the tortfeasor's insurance? 64

B. LaFrange v. United Services Automobile Association 65

In June 1982, Joseph LaFrange brought an action on behalf of his daughter, Laurie LaFrange, who was severely injured by an automobile driven by Gregory Richardson. Richardson's liability insurance carrier, Motorist Mutual, paid its policy limits of $25,000 and obtained a covenant not to sue which reserved to LaFrange any claims he had against his insurer, United Services Automobile Association. Motorist Mutual also paid LaFrange its maximum no-fault insurance of $10,000. 66

LaFrange's policy with USAA covered two vehicles. It contained an underinsured motorist endorsement with split limits in the amount of $25,000 per person and $50,000 for each accident. A separate premium was paid for each vehicle. 67

LaFrange brought a declaratory judgment action, asking the court to declare that USAA was liable to her for underinsured motorists coverage on each vehicle in the total sum of $50,000. The trial court dismissed the action on two grounds: (1) that there must be a judgment in favor of the plaintiff against the tortfeasor before making a claim for underinsured coverage; and (2) that the release of the tortfeasor by reason of the covenant not to sue had destroyed the insurance carrier's right of subrogation, which thus vitiated the coverage. 68

The court of appeals decided both of these issues in favor of the insured; however, it affirmed the trial court's dismissal based on its interpretation of the policy language. The court of appeals stated: "The policy limits liability to $25,000 less any sum paid because of bodily injury by persons legally responsible .... Since this amount is equivalent to the maximum liability under the underinsurer's policy, the appellant is not entitled to any payment from USAA in its status as underinsurer." 69

64. Id.
65. 700 S.W.2d 411 (Ky. 1985).
66. Id. at 412.
67. Id.
68. Id.
69. Id.
LaFrange's attorneys asked the Supreme Court of Kentucky to advise the Bench and Bar in the mechanics of applying this statute including:

1. Stacking of underinsured motorists insurance for coverage and recovery purposes;
2. Offset of tortfeasor's limits against injured-insured's underinsured limits, as offset against total damages;
3. Responsibility of an underinsured carrier once notice is given of an underinsured claim.  

The supreme court however addressed only the set-off issue. Affirming the decision of the court of appeals, the court specifically noted that the statute specified only that the authorized offset was for the amount paid by the liability insurer of the party recovered against, and that this was not co-extensive with the coverage terms which provide for an offset. The court concluded that since under the facts of the case all sums paid on behalf of the tortfeasor and the amount paid by the liability insurer are the same, it was not necessary to address the question of what would happen if they were different.

C. States that Do Not Provide for Set-offs

In states in which a set-off is neither required nor specifically authorized by underinsured motorist legislation, courts frequently favor maximizing the opportunity for the insured to be fully indemnified by invalidating any set-off provisions contained in the coverage terms. If an endorsement set-off is not to be enforced as set forth by insurers, there are several possible approaches regarding the effect payments from the tortfeasor will have on underinsured motorist coverage.

(1) Excess coverage — Under this theory the insured is allowed to recover from the underinsured motorist insurance when his

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70. Brief for movant at 14, LaFrange v. United Servs. Auto. Ass'n, 700 S.W.2d 411 (Ky. 1985) (No. 84-SC-1180-D).
71. LaFrange v. United Servs. Auto. Ass'n, 700 S.W.2d 411, 414 (Ky. 1985).
73. WIDISS, supra note 12, at § 41.7.
damages exceed the limit of liability of the tortfeasor's insurance.\footnote{434}

(2) Decreasing layer of excess coverage — This would provide that the amount of coverage would be decreased dollar-for-dollar by the amount that the tortfeasor’s liability insurer indemnifies the claimant.\footnote{74}

(3) Floating layer of excess coverage — Payment should be offset against the amount of damages sustained by the claimant, and the claimant is then entitled to recover — up to the amount of the underinsured motorist insurance limit of liability — all damages which have not been indemnified. The claimant is allowed to recover from the underinsured motorist insurance so long as some portion of damages sustained in the accident remains uncompensated.\footnote{75}

\section*{B. Stacking}

A person who has sustained injuries caused by an underinsured motorist may seek indemnification from more than one underinsured motorist coverage. “‘Stacking’ is the aggregation of coverage under different policies or on different vehicles to afford the injured party recovery up to the full amount of his damages.”\footnote{77}

The 1980 Standard Underinsured Motorist Insurance form is an example of how insurance companies have attempted to deal with the stacking of policies. It states:

\begin{quote}
If there is other applicable similar insurance we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide with respect to a vehicle you do not own shall be the excess over any other collectable insurance.\footnote{78}
\end{quote}

This language has resulted in two classes or types of coverage situations: (1) those where the policy provides proportional \textit{pro rata} coverage; and (2) those in which the policy provides excess coverage.\footnote{79}

\begin{footnotes}
\item[434] Id.
\item[74] Id.
\item[75] Id.
\item[76] Id.
\item[77] \textsc{Bender, supra} note 16, at § 30.60. \textit{See}, \textit{e.g.}, \textit{Nationwide Ins. Co. v. Gode}, 187 Conn. 386, 446 A.2d 1059 (1982).
\item[78] \textsc{Widiss, supra} note 12, at § 40.1.
\item[79] Id.
\end{footnotes}
Where the policy provides pro rata coverage, "the insurer agrees to pay a proportional amount of the loss as determined by combining all of the applicable coverages and then having each insurer pay a share of the loss as determined by the proportion the limit of each policy bears to the total of all applicable limits."

When an underinsured motorist policy contains an excess coverage clause, it is generally understood to mean that the underinsured motorist insurance of the policy in which this clause appears will be treated as excess coverage over any other collectible insurance coverage relating to a vehicle in which the insured is a passenger but not the owner.

Despite the presence of the pro rata and excess coverage clauses in a policy, several situations have arisen in litigation.

(1) Inter-policy stacking — When separate policies for several cars are purchased and each contains an underinsured motorist endorsement, courts have generally held that the pro rata aspect of the Other Insurance provision will be used. Inter-policy stacking may also be a problem when a claimant is covered as an insured by several underinsured motorists coverages acquired by members of her family; however, this situation is also covered by the pro rata clause.

(2) Intra-policy stacking — Where the insured acquires a single policy with coverages for several vehicles, the problem of stacking is not covered by the Other Insurance provision. But the Limits of Liability provision states that when this occurs, the most the insurer will pay will be the limit of liability as shown on the schedules of coverage regardless of the number of vehicles shown in the declaration. This appears to be an area where future litigation will often occur, since the insured would be better off to buy separate policies for each vehicle if he is not allowed to stack.

80. Id.
81. Id.
82. Id.
83. Id.
84. Id.
85. Note that in LaFrange, despite the movant's request for a decision on this very issue, the Supreme Court of Kentucky refused to decide this question.

On April 19, 1989, Circuit Judge L.T. Grant, from Fayette County, issued an opinion that Stephen Tritt could stack five (5) separate automobile policies with State Farm
(3) Class (b) insureds — When the insured is injured while occupying a vehicle owned by another person and the owner’s policy contains underinsured motorist coverage, the passenger (insured) would be covered on that policy as a class (b) insured. In this situation the insurance of the car is primary, and if the insured is a class (a) insured by other policies, these policies would be secondary and apply as excess coverage.\textsuperscript{86}

C. Exhaustion as a Precondition

Several states require an insured victim to exhaust the tort-feasor’s liability limits as a condition precedent to recovery of benefits under his underinsured motorist coverage. Kentucky is among these states since its underinsured motorists statute says: “[T]he insurance company agrees to pay for such uncompensated damages as he may recover on account of injury . . . because the judgment recovered against the owner of the other vehicle exceeds the liability policy limits thereon . . . .”\textsuperscript{87}

This language also makes it clear that the victim must actually obtain a judgment in excess of the tortfeasor’s liability limits. The exhaustion and judgment requirements were not decided in \textit{LaFrange}, but they have come under attack in other jurisdictions.

In \textit{Weinstein v. American Mut. Ins. Co.},\textsuperscript{88} a provision requiring the insured to exhaust all bodily injury liability bonds and policies applicable at the time of the accident before proceeding with arbitration against his own carrier was determined to violate the intent of the uninsured motorist statute and was therefore ineffective. “To require the insured to first obtain payment of a judgment or settlement is requiring more than the statutory intention and effectively limits the effect of this statute . . . .”\textsuperscript{89}

\textsuperscript{86} Widiss, supra note 12, at § 40.1.
\textsuperscript{88} 376 So. 2d 1219 (Fla. Dist. Ct. App. 1979).
\textsuperscript{89} Id. at 1220.
Kentucky's statutory requirement of a judgment prior to the activation of the underinsured coverage would seem to be open to attack on similar grounds, since it would seem to force an insured to go to trial where he would otherwise settle a claim. Two examples come readily to mind.

The first is where several persons are injured and the insurer works out a settlement with the individual claimant for less than the liability limits. To preclude the acceptance of the offer by a claimant would impose a result counter-productive to the interests of the claimant.

Second, liability insurers will often seek to settle claims for an amount less than the tortfeasor's insurance coverage. Claimants generally accept these offers in order to avoid the uncertainty, costs, and delays that a lawsuit would entail. Claimants should not forgo settlements and be forced to try a case in order to determine damages. This reasoning was confirmed in United States Fidelity & Guar. Co. v. Gordon when the court noted:

\[\text{The fact that [the insured] settled for an amount less than the full amount of liability insurance carried by [the tortfeasor] is not determinative of the amount of damages actually sustained.} \ldots \text{Settlements are often made for reasons which have little to do with the amount of damages sustained by the injured party. In this case, [the insured] decided to settle for $400 less than the policy limits because he was advised that the cost of continuing litigation would probably exceed the additional $400 he might receive.}\]

\[\text{D. Consent-to-Settle Clauses}\]

Some policies provide that the underinsured motorist insurance will not apply if the insured, a legal representative, or any person entitled to payment under the endorsement makes a settlement with any person or organization who may be legally liable, without the written consent of the insurer. Therefore, the insured could forfeit his rights under the endorsement if he settles without the insurer's consent.

How these consent-to-settle clauses and their accompanying notice requirements are handled by the courts varies from juris-

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90. 359 So. 2d 480 (Fla. Dist. Ct. App. 1978).
91. Id. at 482. See also Colonial Penn Ins. Co. v. Salti, 84 A.D.2d 350, 446 N.Y.S.2d 77 (1982).
diction to jurisdiction. However, the cases appear to fall into three categories: (1) the consent-to-settle clause is valid and enforceable; (2) the clause is valid, but breach will prevent recovery only if the defendant meets a two-part test; (3) the clause is void because it violates public policy.

In *March v. Mountain States Mut. Casualty Co.*, the New Mexico Supreme Court held that the subrogation and consent provisions of the applicable policy were valid and that release without the insurer's consent destroyed the insurer's subrogation rights, therefore relieving the insurer of any obligation to the plaintiff. Although the question was one of first impression in the area of underinsured provisions for this court, it noted that it had consistently recognized such rights as "legitimate contractual matters" that protected the insured's rights under the policy.

In *Starr v. Nationwide Mut. Ins. Co.*, a Delaware court noted that other courts were increasingly employing a two-part test when consent-to-settlement clauses were causing plaintiffs to forfeit their rights to recovery. The court held that despite the plaintiff's breach of the policy provisions, the insurer must show that the notice provisions were violated and that the insurer was thereby prejudiced. However, the court did not go on to explain what constituted a material breach. In Massachusetts, the Supreme Judicial Court set forth a detailed examination of what constituted a material breach in the case of *MacInnis v. Aetna Life & Casualty Co.* Determining when a material breach occurred, in this court's opinion, turned upon whether the insurer had a right to withhold consent to an agreement. Thus, if the tortfeasor has no substantial assets, the insurer cannot reasonably withhold its consent and must pay underinsured benefits since the tortfeasor has no remaining assets with which to reimburse the insurer. However, where the tortfeasor has substantial assets, the insurer may wish to withhold consent; therefore, failure to comply with such provisions may prejudice the insured.

93. Id. at 692, 687 P.2d at 1044.
94. Id. at 692, 687 P.2d at 1043.
95. 548 A.2d 22 (Del. Ch. 1988).
96. Id. at 26.
98. Id. at 227, 526 N.E.2d at 1260.
99. Id.
The court in *MacInnis* recognized, however, that such intervention by the insurer may hinder the plaintiff's immediate right to recover. Therefore, the insurer, in order to protect its rights, could: "(1) substitut[e] a payment to the policyholder in an amount equal to the tentative settlement, and (2) pay [ ] the policyholder the underinsurance benefit due under the policy prior to release of the tortfeasor."100 By requiring such a process, the court reasoned that the insurer bears the risk and the expense that follows such a cause of action.101

In *Bryant v. Federal Kemper Ins. Co.*,102 the Delaware Supreme Court also applied a two-part test similar to that adopted in *MacInnis*, but the court held that upon a showing of breach by the insured, a rebuttable presumption of prejudice arose. Thus, in *Bryant* the issue was moot and prejudice did not occur.

Despite what the *MacInnis* court recognized as a growing trend in this area, some courts simply rejected such provisions as violative of public policy.103 In *Longworth v. Van Houlen*, the court recognized the "limbo" in which an insured is placed by reason of the consent-to-settle clause. He cannot settle with the tortfeasor without a general release, and if the insurer refuses to consent, the insured must incur the expenses and risk of trial despite an adequate offer from the tortfeasor. The court in *Longworth* found that such a predicament totally frustrated the legislature's purpose of providing protection to victims of financially irresponsible drivers and the expectations of those who

100. *Id.* (citations omitted). The court expressly rejected the position that the insurer can protect its rights merely by paying the underinsurance benefits prior to release of the tortfeasor. *Id.* at n.14.
101. *Id.* at 228, 526 N.E.2d at 1261.

*See also* Bogan v. Progressive Casualty Ins. Co., 36 Ohio St. 3d 22, 521 N.E.2d 447 (1988), in which the court correctly held that the consent-to-settle clause violated public policy but incorrectly held that the insured could not destroy the right of the underinsured motorist's right to subrogation. This effectively allows the underinsured motorist carrier to control the litigation and cannot be allowed.
purchase the underinsured motorist coverage. The court, however, set out a number of suggestions that it believed would reconcile the purpose of the statute with the rights of all interested parties.

IV. CONCLUSION

The introduction of underinsured motorist coverage is a relatively new development, and numerous questions have yet to be settled. Therefore, practitioners must be very careful to examine the issues and applicable case law in their jurisdiction. If the case law is non-existent, or very limited, then analogies must be drawn from the uninsured case law of that jurisdiction and that of other states. The fact that Kentucky has only three reported cases dealing with underinsured motorist coverage makes this task very difficult for local practitioners and more so because of the limited holdings in each of the cases. The best advice to the practitioner, therefore, is to protect the client’s interest by keeping all parties informed and to ensure that unilateral decisions do not prejudice either the liability insurer of the defendant or the underinsured carrier of the client.

The courts must safeguard the rights of the citizens of the Commonwealth against restrictive language that may be contained in the insurance contract. The insured is purchasing, and the insurance company should be selling, an insurance contract that provides insurance for the insured that is in excess of the tortfeasor’s insurance contract. The underinsured motorist coverage should not be, coverage-wise, a mirror of the defendant’s contract. Where coverage is in doubt, the underinsured motorist carrier should not automatically deny coverage.

Take for example where the defendant intentionally runs down the plaintiff in a crosswalk. The defendant’s insurance company, which has limits of $100,000 per person, will deny coverage over

104. 223 N.J. Super. at 184, 538 A.2d at 419.
105. Id. at 194-95, 538 A.2d at 424-25.
106. For example, the Kentucky courts have routinely upheld “reasonable” exclusions in Uninsured Motorist Coverage. Jett v. Doe, 551 S.W.2d 221 (Ky. 1977) (physical contact); Commercial Union Ins. Co. v. Delany, 550 S.W.2d 499 (Ky. 1977) (governmental vehicle exclusion); Preferred Risk Mut. Ins. Co. v. Oliver, 551 S.W.2d 574 (Ky. 1977) (motorcycle exclusion).
the mandatory limit of $25,000. The underinsured motorist coverage must come into play and start at the $25,001 figure and not at the $100,001 or not at all. The reasonable expectation of the insured should be considered, and most certainly he would want and expect coverage from his insurance carrier to start where the defendant’s contract ended.

Finally, the most pressing need for change in the Kentucky statute is in the fact that the underinsured motorist insurer can “force” a trial between the plaintiff and defendant rather than negotiate. Since Kentucky has the “first-party bad faith” doctrine and an Unfair Claims Settlement Practices Act, a plaintiff may have some recourse to this “force” tactic. Until this issue is resolved by the courts or legislature, many lawyers and clients will be greatly harmed.

The plaintiff’s lawyer needs to consider in these cases whether or not to accept a complete release and indemnification. This probably will cut off the underinsured motorist’s right of subrogation against the tortfeasor and will preclude underinsured motorist coverage.

The defendant’s lawyer may want to rethink the “age old” tradition of getting a full release and indemnification. There is


111. The release could have a clause in it that says:

Same and except any and all claims that the (Plaintiff) has or may have against ___ Insurance Company for Underinsured Motorist Coverage.

This wording is preferable to either the tortfeasor or the underinsured motorist carrier taking a bulwark-like attitude in these cases. The underinsured motorist carrier will generally not assert its subrogation claim since the defendant could in almost all cases declare bankruptcy and eliminate its cause of action.

The North Carolina court interestingly has held that the underinsured motorist carrier must prove that the insured’s settlement prejudiced it when the insured settled without its consent. Silvers v. Horace Mann Ins. Co., 324 N.C. 289, 299, 378 S.E.2d 21, 28 (1989).
no reason that after full consent and disclosure with its insured, a proper release could not be entered into that will allow the plaintiff to pursue an underinsured motorist claim.

See also, McDonald v. Republic-Franklin Ins. Co., 45 Ohio St. 3d 27, 543 N.E.2d 456 (1987) (reasonable notice to underinsured motorist is enough to void subrogation right if not acted upon in a reasonable time).
COMMENTS

POLLUTION EXCLUSION CLAUSES: THE AGONY, THE ECSTASY, AND THE IRONY FOR INSURANCE COMPANIES

R. Stephen Burke

Millions of tons of hazardous waste generated yearly are stored, deposited, recycled or dumped, and eventually escape infusing lakes, streams and underground waters; this toxic material finally comes into contact with unprotected people who are its victims. When its source is identified, the question becomes who is to clean it up and who is to pay for the damages it caused. According to a recent study by the Rand Corporation, in the last eight years, only 34 of the 1,175 most egregious toxic waste dumps were cleaned — and of the dumps cleaned, polluters paid less than one-tenth of the cost...[1] This appeal confirms that the vast carelessness that created the conundrum of hazardous waste, which has continued for decades, will not be quickly or easily remedied.

—Circuit Judge Richard J. Cardamone in Avondale Indus. v. Travelers Indem. Co.²

I. INTRODUCTION

Whether the issue is the duty to defend a business or to provide coverage, the insurance industry is decidedly in the thick of hundreds of pollution-related claims across the country. Most of these claims have been filed under the longstanding Comprehensive General Liability Policy of 1973, but some are now being litigated under the newer version of that policy, known as the Commercial General Liability Policy of 1985.³ The 1973 policy

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2. 887 F.2d 1200 (2d Cir. 1989) (omitting citation).

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was altered for a number of reasons, and chief among them were problems with the so-called pollution exclusion clause.

Insurance companies had added the pollution exclusion to the 1973 Comprehensive Policy to limit coverage that they themselves had granted. The original Comprehensive General Liability Policy had contained broad language that covered all sorts of industrial pollution accidents. That language stated, basically, that the policy would cover all types of "occurrences," which the policy defined as an "accident(s), including continuous or repeated exposure to conditions." Insurers had intended the pollution exclusion clause to limit their liability by restricting coverage to pollution "occurrences" that were abrupt and unintended calamities. Yet, the courts — especially state courts — didn't read the pollution exclusion clause that way. Judges held insurers liable for the intentional acts of vandals, for pollution damage at landfills that had occurred over a number of years, and for industrial pollution that involved business practices that were certain to contaminate the environment.

The insurers fought back in court, and they found a considerable amount of support in scholarly reviews. Most commentators sided with the insurance companies in criticizing decisions that used the definition of an "occurrence" to negate the language of the pollution exclusion. The arguments were persuasive, and courts began siding with the insurers, particularly in cases that involved longstanding, continuous pollution. The turning point was in 1986, when the North Carolina Supreme Court issued a highly influential opinion that said continuous dumping at a

4. Explanatory Memorandum, supra note 3.
5. See infra notes 28-53 and accompanying text.
6. See infra notes 40-41 and accompanying text. See also Couch, supra note 3.
7. See infra note 50 and accompanying text.
8. See infra notes 60-78 and accompanying text.
12. See infra note 79 and accompanying text.
13. Id.
14. See infra notes 80-112 and accompanying text.
landfill could never qualify as sudden and accidental pollution, so
the insurer had no duty to defend. Many other courts have
followed suit, with the Sixth Circuit U.S. Court of Appeals
providing the most relief in favor of insurance companies.16

This resurrection of the pollution exclusion would normally be
considered a victory for insurers. Yet, in adopting the Commercial
General Liability Policy of 1985, the insurance industry killed
the old pollution exclusion and substituted a new, much longer
version.17 The new 1985 pollution exclusion may well eliminate
some of the coverage that was found under the 1973 clause,18 but
ambiguities arguably exist in the 1985 exclusion, just as they did
in the 1973 version.19

This article attempts to provide a nutshell guide to the pollu-
tion exclusion clauses — to explore their origins, to provide a
historical guide to the essential arguments that arise in almost
every pollution exclusion case, and to hypothesize on the court
trends based on a survey of ever-expanding case law.

If any sense can be made out of the chaotic condition of the
pollution exclusion rulings, perhaps it is this:

First, the rulings have become very fact-specific, with courts
concentrating on what the insured businesses expected or in-
tended, knew or should have known about the pollution alleged
against them.20 The most striking examples are found in the New
York courts, which have retreated from the forefront of finding

374 (1986), discussed infra at notes 83-97 and accompanying text.
16. See United States Fidelity & Guar. Co. v. Star Fire Coals, Inc., 856 F.2d 31 (6th
927 (S.D. Ohio 1987), aff'd, 865 F.2d 1267 (6th Cir. 1989); United States Fidelity & Guar.
Cir. 1989). See also infra note 108 and accompanying text, especially for circuits ruling
contra. Other circuits, however, have taken a more fact-specific approach and have ruled
against the insurers. See Avondale Indus. v. Travelers Indem. Co., 887 F.2d 1200 (2d Cir.
St. Paul Fire & Marine Ins. Co., 815 F.2d 1209 (8th Cir. 1987); Riehl v. Travelers Ins.
Co., 772 F.2d 19 (3d Cir. 1985).
17. See infra notes 113-118 and accompanying text.
18. Id. See also Explanatory Memorandum, supra note 2; Comment, Comparing the Old
and the New Pollution Exclusion Clauses in General Liability Insurance Policies: New
LanguageSame Results?, 14 B.C.L. ENVTL. AFF. L. REV. 601 (1987) [hereinafter Exclusion
Clauses].
19. See infra notes 119-137 and accompanying text.
20. See infra note 98 and accompanying text.
coverage or an insurer's duty to defend.\textsuperscript{21} Businesses with longstanding knowledge of pollution, or which are slow to abate it, are much more likely to be denied coverage,\textsuperscript{22} while coverage usually will be found for short-term discharges or for leaks from underground gasoline or chemical tanks.\textsuperscript{23}

Second, the majority rule seems to be that neither the 1973 exclusion nor the 1985 exclusion is ambiguous, thus favoring insurance companies. However, New Jersey and Ohio courts, clinging to the notion that the exclusions are ambiguous in light of other language in the policies, have remained particularly steadfast in finding coverage or a duty to defend.\textsuperscript{24}

Third, courts appear to be applying the same rules of contract construction in interpreting the 1985 exclusion as they applied in interpreting the old one.\textsuperscript{25} At least three courts have already addressed claims involving the new exclusion, with two denying coverage and one ruling that part of it was ambiguous.\textsuperscript{26} Thus, insurance companies and their clients may well have to endure more years of conflicting court decisions with the 1985 exclusion. The new, more restrictive language may eventually reduce the volume of pollution exclusion litigation, but by no means eliminate it.

II. ORIGINS OF THE POLLUTION EXCLUSION CLAUSE

The evolution of the 1973 pollution exclusion clause is important in understanding why it died in 1985, at least formally, and

\textsuperscript{21} See infra notes 98 & 101 and accompanying text.
\textsuperscript{22} See infra note 103 and accompanying text.
\textsuperscript{23} See infra note 104 and accompanying text.


\textsuperscript{25} See infra notes 108-140 and accompanying text.

why the 1985 exclusion already faces some of the same challenges.

The original exclusion grew out of the Comprehensive General Liability Policy — a title that suggests maximum coverage. The primary purpose of comprehensive general liability insurance was to protect businesses against liability for third-party damages that they were legally obligated to pay. The Comprehensive Policy also covered the costs of defending any third-party claims that could potentially result in liability. Such insurance was particularly attractive to businesses because it provided the broadest spectrum of indemnity for, and defense against, property damages and personal injury claims that arose out of day-to-day operations.

Yet, there were things that even the Comprehensive Policy did not cover. It did not cover "first-party losses," such as damage to the insured's own property that was caused by a fire or explosion. It did not cover certain employee and automobile liabilities. Such exclusions did not deprive the business of all coverage for such risks because other types of insurance were available. In fact, it has always been the availability and use of these other types of insurance (workmen's compensation, automobile insurance, casualty insurance) that account for most of the exclusions in the Comprehensive Policy.

27. See Couch, supra note 3. The policy was drafted by the Mutual Insurance Rating Bureau. Hourihan, Insurance Coverage for Environmental Damage Claims, 15 Forum 551 (1980). Its successor organization, the Insurance Services Office, is a private association of insurance companies that assists its members in drafting policies and assessing risks. Exclusion Clauses, supra note 18.


30. Id.

31. Judicial Interpretation, supra note 29 at 14-16.

32. Id.

33. Id.

34. Id.

35. Separate pollution coverage has been made available in the form of Environmental Impairment Liability policies, which also are known as Pollution Liability Insurance policies. However, these policies have had little market success, and there is no current case law interpreting them. See Exclusion Clauses, supra note 18 (citing Sparrow, Hazardous Waste Insurance Coverage: Unexpected Past, Uncertain Future, 84 Mich. B.J. 169, 171-173 (1985)).
Beyond these exclusions, the critical limitation in the Comprehensive Policy, and its offshoots, has always been that the covered risks must be “caused by an accident.” Since the first standardized liability policies were developed in the 1930s, it has always been clear that the insurance companies did not intend to cover risks that had been voluntarily assumed by the insured in conducting its business, nor risks that the insured knowingly or intentionally incurred. These first standardized policies were commonly called “accident-based” policies because of their crucial clause: “To pay, on behalf of the insured, all sums which the insured shall become legally obligated to pay as damages because of bodily injury, sickness or disease . . . sustained by any person, or because of injury to or destruction of property . . . caused by an accident.”

The demand for broader coverage led gradually to a revision in this standardized language. The crucial change came in 1966, when the “accident-based” Comprehensive Policy was changed to an “occurrence-based” Comprehensive Policy. The duty-to-pay clause was changed to read: “The Company will pay on behalf of the insured all sums which the insured shall become legally liable to pay as damages because of bodily injury or property damage . . . caused by an occurrence.” The 1966 Comprehensive Policy defined an “occurrence” as an “accident, including continued or repeated exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”

This “occurrence” clause was especially appealing to manufacturers, particularly those that dealt with hazardous chemicals or substances. Under a strict reading of the policy, a long and continuous release of pollution would qualify as an accident — and thus obligate the insurer — as long as the manufacturer did not intend the pollution’s resulting harm to third parties.

36. See infra notes 50-53 and accompanying text. See also Judicial Interpretation, supra note 29 at 14-16.
40. Judicial Interpretation, supra note 29 at 16.
41. COUCH, supra note 3.
42. Judicial Interpretation, supra note 29 at 31-35.
Insurance companies recognized the problem for them that was inherent in such an analysis. If they were obligated to pay for long, continuous occurrences of pollution, their liability might last for years, even decades. Another, and perhaps the primary, fear lay in Congress’ attempt to address a national concern with air and water pollution that had blossomed during the 1960s. Congress adopted the Clean Air Amendments in 1970, and President Nixon instituted a tough permit program to control pollution discharges into navigable waters. As a result of these environmental laws — and ones that states imposed soon thereafter — insurance companies could reasonably expect that pollution which occurred under a government permit was an intentional act. Nevertheless, the “occurrence” clause would obligate the insurer because it arguably allowed coverage for any unexpected harm, even if that harm was caused by an intentional act.

At the same time, massive environmental disasters, such as the oil spill that followed the sinking of the tanker Torrey Canyon, made insurers aware of the magnitude of their potential liability. That liability included not only the costs of damages to persons or property, but also the substantial costs in defending any claims made under the policy.

These realizations led the Mutual Insurance Ratings Bureau in 1970 to draft the original pollution exclusion clause:

This insurance does not apply ... (f) to bodily injury or property damage arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land, the atmosphere, or any water course or body of water; but this exclusion does not apply if such discharge, dispersal, release or escape is sudden and accidental.

43. Id.
45. Judicial Interpretation, supra note 29 at 34-38.
46. Id. at 35.
47. COUCH, supra note 3. The insurer’s obligation to defend, under standard policies, is separate and distinct from its obligation to indemnify. If a third party states a claim that can be construed as falling within policy coverage — no matter how remote or spurious the claim might be — the insurer is obligated to defend against the claim.
48. See supra note 27.
This wording was added to the Comprehensive General Liability Policy in 1973.\(^\text{49}\)

The clause seems straightforward enough: Pollution is excluded from coverage, unless the escape of the pollutant is sudden and accidental. If the escape is not sudden and was neither expected nor intended by the insured (using the policy definition of an accident), then the resulting harm is not covered.

Many insurers intended this to be the interpretation that the courts should apply. Charles K. Cox, president of the Insurance Company of North America, stated at the time:

INA will continue to cover pollution which results from an accidental discharge of effluents — the sort of thing that can occur when equipment breaks down. We will no longer insure the company which knowingly dumps its wastes. In our opinion, such repeated actions — especially in violation of specific laws — are not insurable exposures.\(^\text{50}\)

That interpretation was not so clearly stated by others, however, including the Insurance Ratings Bureau:

Coverage for pollution or contamination is not provided in most cases under present policies because the damages can be said to be expected or intended and thus are excluded by the definition of an occurrence. The above exclusion clarifies this situation so as to avoid any questions of intent. Coverage is continued for pollution or contamination caused injuries where the pollution or contamination results from an accident.\(^\text{51}\)

Applying this wording, businesses could argue that they were entitled to coverage because the pollution exclusion clause merely restates the wording of the "occurrence" clause. Thus, if the pollution met the definition of an occurrence — "an accident, which includes continued or repeated exposure to conditions"\(^\text{52}\) — then the business would be covered so long as it did not expect or intend the harm that followed the accident. This interpretation seemed to be supported by such scholars as Professor Long, who wrote that the clause "eliminates coverage for dam-

\(^{49}\) Id.

\(^{50}\) Soderstrom, The Role of Insurance in Environmental Litigation, 11 Forum 762, 767 (1976).


\(^{52}\) Couch, supra note 3.
ages arising out of pollution as contamination, where such dam-
ages appear to be expected or intended on the part of the insured
and hence are excluded by definition of occurrence."53

Thus, some insurers were saying one thing, the drafter of the
clause seemed to be saying another, and at least one leading
scholar in the field was supplying an extremely broad inter-
pretation. If the scholars and Ratings Bureau seemed confused, it
was easy enough, then, for the courts to become confused when
deciding cases involving the pollution exclusion clause.

III. THE 1973 POLLUTION EXCLUSION

The confusion surrounding the birth of the pollution exclusion
clause had not abated when the first cases involving it began
reaching state and federal courts. The issues and rationales in
these decisions are explored at some length here because almost
all of them recur in current pollution exclusion litigation.

A. Early Decisions by the Courts: Trouble for Insurers

A major factor in the courts' analysis was, and continues to
be, the generally accepted rules on construction for insurance
contracts:

1. Since standardized insurance policies are contracts of adhesion,
any ambiguities in wording are liberally interpreted against the
insurer, which drafted the policy, and in favor of the insured.
2. Policy limitations or exclusions are narrowly construed in favor
of coverage.
3. The burden of proving the policy exclusion is often placed on
the insurer.
4. Undefined policy terms are afforded their ordinary, common
sense meaning as they would generally be understood by a rea-
sonably intelligent purchaser of the particular type of insurance
coverage involved.54

Insurers soon found that these rules of construction worked
against them when courts began interpreting the "occurrence"
clause. In Grand River Lime Co. v. Ohio Casualty Ins. Co., the
Ohio Court of Appeals ruled that the emission of air pollutants

54. See Judicial Interpretation, supra note 29 at 16-20; Exclusion Clauses, supra note
18 at 610-614.
for seven years from quarrying and manufacturing operations triggered the insurer's duty to defend under an "occurrence" clause. The court said that the definition of an occurrence was broader than the term "accident": "As these words are generally understood, accident means something that must have come about or happened in a certain way, while occurrence means something that happened or came about in any way." It also cited a policy clause stating that injuries "arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence." Thus, even though Grand River Lime might have intended to emit at least some pollutants as a regular part of business, there was no evidence that it intended the emissions to harm people or property. This triggered the insurer's duty to defend.

Grand River Lime became a benchmark case for businesses seeking coverage or a duty to defend. Even though it did not deal with a pollution exclusion clause, it did decide that pollution over a seven-year event was "sudden" enough to trigger a duty to defend. It also broadly construed an "occurrence" to encompass many more situations than an "accident" encompassed. With Grand River Lime as a bedrock, businesses and municipalities successfully sought coverage and defense under policies that included the 1973 pollution exclusion. From 1977 to 1986, almost all state and federal court decisions obligated the insurance companies, even when they tried to invoke the pollution exclusion.

The first case that ruled expressly on the exclusion was Molten, Allen & Williams, Inc. v. St. Paul Fire & Marine Ins. Co. The Alabama Supreme Court decided that the dispersal of sand and dirt during the construction of a subdivision constituted an occurrence and, most importantly, that the pollution exclusion did not apply because it was ambiguous:

While a liberal construction of the "pollution exclusion" clause would include the damage allegedly caused by Molten, Allen and

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55. 32 Ohio App. 2d 178, 289 N.E.2d 360 (1972).
56. Id. at 184-85, 289 N.E.2d at 365.
57. Id.
58. Id.
59. See infra notes 77-78 and accompanying text.
60. 347 So. 2d 95 (Ala. 1977).
Williams, the clause is not free from ambiguity. It is believed that the intent of the "pollution exclusion" clause was to eliminate coverage for damages arising out of pollution or contamination by industry-related activities. The use of specific industry-related irritants, contaminants and pollutants seem to indicate this was the reason for the exclusion. The ambiguities, therefore, must be interpreted against the party drawing the contract. (omitting citations).

Thus, businesses had a two-prong attack on the pollution exclusion. They could use *Grand River Lime* to persuade a court to declare that pollution for a period of seven years was not sudden, thus triggering at least a duty to defend. Second, they could use *Molten, Allen & Williams* to attack the pollution exclusion as ambiguous. They succeeded in an important trio of state cases — *Allstate Ins. Co. v. Klock Oil Co.*, *Niagara County v. Utica Mut. Ins. Co.*, and *Travelers Indem. Co. v. Dingwell*. All were decided in a two-month period in 1980 — and it must have been a dark two months for the insurance industry.

*Klock* involved long-term percolation of gasoline from an underground storage tank, and the complaint alleged negligence in installing and maintaining the tank. The court decided that the word "sudden," as used in liability insurance, need not be limited to an instantaneous happening. It also defined an accident as an unexpected event. Thus, the escape of the gasoline could be "sudden and accidental," as defined by the pollution exclusion, even though it was not detected for a substantial period of time. "The relevant context to be considered is the fact that it is a term employed by an insurer in the contract and should be given the construction most favorable to the insured."

*Dingwell* was a class action seeking damages for the contamination of well water caused by Dingwell's operation of an indus-

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61. *Id.* at 99.
62. 73 A.D.2d 486, 426 N.Y.S.2d 603 (1980).
64. 414 A.2d 220 (Maine 1980).
65. *See supra* notes 62-64.
67. *Id.* at 488, 426 N.Y.S.2d at 605.
68. *Id.*
69. *Id.*
trial waste facility.\textsuperscript{70} The Maine court held that the insurers had a duty to defend even though the complaint against Dingwell did not allege whether the release of the pollutants was sudden and accidental.\textsuperscript{71}

\textit{Niagara County} was, perhaps, the most damaging case for the insurers. The county sought indemnification and defense against 65 claims alleging negligence in allowing the dumping of toxic chemicals at the infamous "Love Canal."\textsuperscript{72} The dumping had occurred for at least 20 years, but the court ruled in favor of the county.

First, the \textit{Niagara County} court discarded the conclusion in \textit{Molten, Allen & Williams} that the pollution exclusion applied only to industrial polluters. The exclusion, the court reasoned, applied only to active polluters without regard to their status.

This Court cannot perceive how the pollution exclusion can be applied to deprive a public corporation of coverage where it has been at most, accused in a complaint of nonfeasance, as opposed to misfeasance of the type here alleged. The legislative history of Insurance Law, § 46(13) and (14) and other sources indicates that the pollution exclusion was solely meant to deprive active polluters of coverage.\textsuperscript{73}

Second, the court simply chose to ignore whether the release of the chemicals was "sudden and accidental," within the meaning of the pollution exclusion. Instead, it focused on whether the harm from the pollution was sudden and accidental. "[I]t may be found that the pollution — from the County’s viewpoint at least, was ‘sudden and accidental,’ which did not occur until the discovery of the deleterious effects of the buried industrial toxic chemicals."\textsuperscript{74} Essentially, then, the court merged the pollution exclusion clause into the occurrence clause. A release can never be "sudden" until the insured learns of the harm that the release has caused. Under the definition of an accident in the occurrence clause, an accident is an incident that results in harm neither

\begin{itemize}
\item \textsuperscript{70} 414 A.2d 220, 222 (Maine 1980).
\item \textsuperscript{71} \textit{Id.} at 225. The court did offer insurers a ray of hope, however, by noting that a release of pollutants may be unexpected and unintended without being sudden and accidental.
\item \textsuperscript{72} 103 Misc. 2d 814, 815, 427 N.Y.S.2d 171, 172 (1980). For later case history, see \textit{supra} note 63.
\item \textsuperscript{73} \textit{Id.} at 818, 427 N.Y.S.2d at 174.
\item \textsuperscript{74} \textit{Id.} at 821, 427 N.Y.S.2d at 176.
\end{itemize}
expected nor intended by the insured.\textsuperscript{75} Therefore, according to the court’s rationale, a release of pollution that is neither expected nor intended by the insured entitles the insured to coverage and defense.\textsuperscript{76}

Thus, by 1980, the courts had ruled that the pollution exclusion (1) was ambiguous, (2) applied only to active polluters, and presumably not to passive acts, (3) did not apply where acts of pollution occurred during a period of (up to 20 years), and (4) was essentially superfluous by way of judicial merger into the occurrence clause.

With only a few exceptions, state and federal courts followed these precepts for six years in construing pollution exclusion clauses against insurance companies.\textsuperscript{77} Out of 35 pollution exclusion cases from 1981 through 1986, 27 were decided in favor of the insured business.\textsuperscript{78}

\textsuperscript{75} COUCH, supra note 3.
\textsuperscript{76} See supra note 71.
\textsuperscript{77} See Judicial Interpretation, supra note 29 at 39-53.
\textsuperscript{78} Rulings against the insurer:

\textbf{Alabama} — United States Fidelity & Guar. Co. v. Armstrong, 479 So. 2d 1164 (Ala. 1985) (overflow of sewage from construction was not the type of industrial pollution encompassed by the exclusion); Molten, Allen & Williams, Inc., v. St. Paul Fire & Marine Ins. Co., 347 So. 2d 95 (Ala. 1977) (only industrial pollution is excluded, not sand and dirt).


\textbf{Florida} — Payne v. United States Fidelity & Guar. Co., 625 F. Supp. 1189 (S.D. Fla. 1985) (refusal to control PCBs or to give EPA access to site was not enough to find harm was intended or expected).


\textbf{Louisiana} — Ashland Oil, Inc. v. Miller Oil Purchasing Co., 678 F.2d 1293 (5th Cir. 1985) (fire damages and contamination covered by insurance policy); Touchstone v. Land & Marine Applicators, Nos. 76-3364 & 86-2907 consolidated slip op., 1986 WESTLAW 12700 (E.D. La.) (refusal to reverse summary judgment against insurers); Bell v. Sediment Removers, Inc., 479 So. 2d 1078 (La. Ct. App. 1985) (non-toxic dumping for 14 days was not “sudden”); Sellers v. Seligman, 463 So. 2d 697 (La. Ct. App. 1985) (genuine issue whether inhalation of silica dust was encompassed by the pollution exclusion).

\textbf{Maine} — Travelers Indem. Co. v. Dingwell, 414 A.2d 220 (Me. 1980) (duty to defend in class action amid no allegation that operation of industrial waste facility was “sudden and accidental”).


Not everyone, however, was in agreement with these decisions. One by one, commentators argued that the proper analysis for a

N.E.2d 146 (1985) (leak from gas tank).

MICHIGAN — Jonesville Prod., Inc. v. Transamerica Ins. Group, 156 Mich. App. 508, 399 N.W.2d 156 (1986) (general complaint did not allege that discharge of chemical was expected or intended, even though it was continuous).

MISSOURI — United States v. Conservation Chem. Co., 653 F. Supp. 152 (W.D. Mo. 1986) (genuine issue as to whether waste disposal for 20 years was expected or intended to cause harm).


OREGON — A 1 Sandblasting & Steamcleaning Co. v. Baiden, 53 Or. App. 890, 632 P.2d 1377 (1981) (genuine issue whether paint that was oversprayed was a liquid).

PENNSYLVANIA — Riehl v. Travelers Ins. Co., 772 F.2d 19 (3d Cir. 1985) (genuine issue as to insured's knowledge of toxic substances on his property).


Rulings in favor of the insurer:

CALIFORNIA — Healy Tibbitts Const. Co. v. Foremost Ins. Co., 482 F. Supp. 830 (D. Cal. 1979) (sinking of oil barge excluded, but because it was not an insured peril).


NORTH CAROLINA — Waste Management of Carolinas, Inc. v. Peerless Ins. Co., 315 N.C. 688, 340 S.E.2d 374 (1986) (leaching of waste from a landfill may have been unintended, but was not abrupt or "sudden").

court was to examine first whether an “occurrence” had taken place, then to analyze whether the pollution occurrence was covered by applying the language of the exclusion clause. Thus, a court should analyze whether there had been an accident that had resulted in harm “neither expected nor intended by the insured.” If such an occurrence were found, then the court should focus on the release of the pollution, as mandated by the language of the exclusion clause. If the release were sudden, in a temporal sense, and accidental, then there would be no exclusion of coverage or the insurer would have a duty to defend.79

This analysis disregarded the passive-versus-active-polluter reasoning put forward by the Niagara County court. By focusing on the “release” language of the exclusion, it also rejected the holdings of some courts that the exclusion was merely a restatement of the “occurrence” clause. By giving “sudden” a temporal meaning, it also eliminated at least part of the ambiguity argument: that “sudden” actually means unexpected, and if pollution were unexpected according to the “occurrence” clause, then a duty to defend would follow.

Some courts did follow such an analysis, ruling that the discharge of industrial acid for two to ten years was not “sudden and accidental”80 and that the discharge of chemicals as a regular business practice was not covered.81 Yet, as far as the insurance industry was concerned, the damage had already been done. The ISO drafted a new Commercial General Liability Policy in 1985 to replace the Comprehensive General Liability Policy, and the old pollution exclusion was replaced with a much more restrictive exclusion.82 Even so, because of the many pollution incidents

82. See supra note 3 and accompanying text.
covered by the 1973 policies that still are being litigated today, insurance companies have continued to press the courts to reject the many broad interpretations of the 1973 exclusion.

B. The Most Recent Decisions: Victory for the Insurers

The turning point for the insurance companies came in 1986, and the leading case was *Waste Management of Carolinas, Inc. v. Peerless Ins. Co.* The case involved a landfill loaded with hazardous waste that had leached into the groundwater and contaminated several surrounding household wells. The landfill owner, Waste Management, filed a third-party complaint alleging that Trash Removal Services had misrepresented that the materials it dumped at the landfill were not hazardous. Trash Removal sought a declaratory judgment on the rights and obligations under its comprehensive general liability policy. The North Carolina Supreme Court adopted the position of the scholarly critics by construing the pollution exclusion clause in favor of Peerless Insurance.

First, the court rejected the ambiguity argument that had existed since *Grand River Lime*:

We do not perceive this provision to be either ambiguous or, except for the repeated appearance of "accident," redundant. In our view, this is an instance where nontechnical words (except for "occurrence," which is defined in the policy) can be given the same meaning they usually receive in ordinary speech.... Although it is possible to perceive ambiguity in the policy language, it strains at logic to do so. A commonsense reading of that language reveals that the exclusion narrows a virtually limitless class of events termed "occurrence," which can occur suddenly or over the course of time, to nonpolluting events or to polluting events that occur "suddenly and accidentally."

Indeed, the court conceded that the intentional dumping of waste by Trash Removal fell well within the policy definition of an occurrence. Trash Removal contended that it never expected

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83. 315 N.C. 688, 340 S.E.2d 374 (1986).
84. *Id.* at 690, 340 S.E.2d at 376.
85. *Id.* at 700, 340 S.E.2d at 383.
86. *Id.* at 694, 340 S.E.2d at 379.
87. *Id.* at 695, 340 S.E.2d at 380.
or intended that its dumping would pollute groundwater or well water, and the leaching of wastes certainly constituted continuous or repeated exposure to conditions. 88

Yet, the insurer prevailed under the pollution exclusion. Rejecting the analysis in Dingwell, 89 the court emphasized that “the focus of the exclusion is not upon the release but upon the fact that it pollutes or contaminates”: 90

The policy reasons for the pollution exclusion are obvious: If an insured knows that liability incurred by all manner of negligent or careless spills and releases is covered by his liability policy, he is tempted to diminish his precautions and relax his vigilance. Relaxed vigilance is even more likely where the insured knows that the intentional deposit of toxic material in his dumpsters, so long as it is unexpected, affords him coverage. In this case, it pays the insured to keep his head in the sand. 91

The court next took a slap at the result in the seminal landfill case, Niagara County. 92

From the insurer’s perspective, the practical reasons for the pollution exclusion are likewise clear: the lessons of Love Canal and sites like it have revealed the yawning extent of potential liability arising from the gradual or repeated discharge of hazardous substances into the environment. In addition, putting the financial responsibility for pollution that may occur over the course of time upon the insured places the responsibility to guard against such occurrences upon the party with the most control over the circumstances most likely to cause the pollution. 93

Finally, the court rejected the Klock court’s decision that gradual seepage of underground contaminants could be “sudden and accidental,” thus allowing coverage under the exclusion. 94 “Sudden” must be given its ordinary temporal meaning of connoting an instantaneous or precipitous event, it said, and not simply be construed as a synonym for “accidental.” 95 “Waste material that has leached into and contaminated groundwater is

88. Id. at 691, 340 S.E.2d at 376.
89. See supra notes 70-71 and accompanying text.
90. Waste Management at 697, 340 S.E.2d at 381.
91. Id.
92. See supra notes 63, 72-76 and accompanying text.
93. Waste Management at 698, 340 S.E.2d at 381.
94. Id. at 698-99, 340 S.E.2d at 381-382.
95. Id. at 699, 340 S.E.2d at 382.
clearly excluded by the plain terms of the pollution exclusion."

Nor would Trash Removal's sudden discovery of the contamination qualify: "The exception clearly comprehends the damaging act, not the act of discovery."[97]

The careful analysis of Waste Management, combined with the scholarly rejection of the early cases, has had a remarkable effect on other courts. Of the 51 pollution exclusion cases reported from 1987 through October 1989, 28 have been decided in favor of the insurance company.[98] Only the New Jersey and Ohio courts have

96. Id. at 700, 340 S.E.2d at 383.
97. Id.
98. Rulings for the insurance companies from 1987 through October 1989:

ALABAMA — Hicks v. American Resources Ins. Co., 544 So. 2d 952 (Ala. 1989) (not released for publication) (strip mining that fouled water is industrial pollution, which is expressly excluded).

COLORADO — New Hampshire Ins. Co. v. Hecla Mining Co., 1989 Colo. App. LEXIS 303 (statute provides continuous notice, so mining company knew or should have known that pollution from its operations would occur).


FLORIDA — Hayes v. Maryland Cas. Co., 688 F. Supp. 1513 (N.D. Fla. 1988) (dry-cleaning sludge was placed purposely on property for a number of years).


continued to grant coverage to businesses based on an analysis

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**South Dakota** - American Universal Ins. Co. v. Whitewood Custom Treaters, Inc., 707 F. Supp. 1140 (D.S.D. 1989) (a mixed ruling: discharge of chemicals from frozen pipes was "sudden and accidental," but damages caused afterward by failure to clean it up was not).


Rulings against the insurance company from 1987 through October 1989:


**Florida** - Pepper's Steel & Alloys, Inc. v. U.S. Fidelity & Guar. Co., 668 F. Supp. 1541 (S.D. Fla. 1987) (release of PCBs into aquifer was not a natural result of business practices and had been rectified).

**Georgia** - Claussen v. Aetna Casualty & Sur. Co., 259 Ga. 333, 380 S.E.2d 686 (1989) ("sudden" has more than one reasonable meaning, and landfill owner had no knowledge that City of Jacksonville, Fla., was dumping hazardous wastes on his property) (federal trial court ordered to make rulings consistent with this opinion, 888 F.2d 747 (11th Cir. 1989)).

that merges the pollution exclusion into the "occurrence" clause on grounds of vagueness. Thus, the *Waste Management* rejection or intended its hauler to dump waste illegally).


**NEW JERSEY** — American Motorists Ins. Co. v. Levolor Lorentzen, Inc., 879 F.2d 1165 (3d Cir. 1989) (genuine issue as to whether waste was deposited in Marylnd quarry, so Rule 54 interlocutory appeal of 57 U.S.L.W. 2270 was inappropriate); Gloucester Township v. Maryland Casualty Co., 668 F. Supp. 394 (D.N.J. 1987) (seepage from landfill, although state complaint alleged the township knew or should have known of pollution; Summit Assocs., Inc. v. Liberty Mut. Fire Ins. Co., 229 N.J. Super. 56, 550 A.2d 1235 (1988) (developer uncovered sludge pit); Broadwell Realty Servs. v. Fidelity & Casualty Co. of New York, 218 N.J. Super. 516, 528 A.2d 76 (1987) (genuine issue whether gasoline leak from underground tanks was "sudden").


**PENNSYLVANIA** — Scarcia v. Maryland Casualty Co., 1988 U.S. Dist. LEXIS 12946 (E.D. Pa.) (gasoline discharge of between one years and a few days from underground storage tank).


**WISCONSIN** — Wagner v. Milwaukee Mut. Ins. Co., 145 Wis. 2d 609, 427 N.W.2d 854 (Wis. Ct. App. 1988) (damage to gas pipe during a three-year period was "sudden").


of vagueness seems to be the majority rule today regarding the 1973 pollution exclusion.

Of all the state courts, the ones in New York have done the most dramatic turnabout — even rejecting the *Niagara County* finding that the exclusion did not apply to seepage from a landfill. The New York courts seem to have abandoned an across-the-board finding of vagueness for a much more fact-specific analysis that concentrates on what the insured business knew or should have known about the pollution it is accused of causing. Many other courts seem to have adopted this view as well, because the cases are almost evenly divided involving landfills and regarding businesses whose pollution was traced to their regular methods of doing business. Even rulings in-


102. The leading landfill case for the insurer remains *Waste Management of Carolinas, Inc. v. Peerless Ins. Co.*, 315 N.C. 688, 340 S.E.2d 374 (1986) (leaching of waste from a landfill may have been unintended, but was not abrupt or "sudden"). See also County of Broome v. Aetna Casualty & Sur. Co., 146 A.D. 337, 540 N.Y.S.2d 620 (1989); *Just v. Land Reclamation, Ltd.*, 445 N.W.2d 683 (Wis. Ct. App. 1989) (continuous dust, debris, and waste pollution from a landfill).

Landfill cases against the insurer include *Claussen v. Aetna Casualty & Sur. Co.*, 259 Ga. 333, 380 S.E.2d 686 (1989) ("sudden" has more than one reasonable meaning, and landfill owner had no knowledge that City of Jacksonville, Fla., was dumping hazardous wastes on his property) (federal trial court ordered to make rulings consistent with this opinion, 888 F.2d 747 (11th Cir. 1989); and several New Jersey opinions such as *Gloucester Township v. Maryland Casualty Co.*, 668 F. Supp. 394 (D.N.J. 1987) (seepage from landfill, although state complaint alleged the township knew or should have known of pollution).

volving underground leaks of gasoline or chemicals are split, although the majority view appears to be that the business will win. The only apparent uniform rules among the states are that insurers will have to cover non-toxic, non-industrial pollution, but not pollution that results from mining operations.

The federal courts have led the way in adopting the Waste Management analysis, ruling in favor of the insurance company

had charged dumping of waste for years); State v. Mauhe, 142 Wis. 2d 620, 419 N.W.2d 279 (1987) (repeated leaks of chromic acid for 16 years). See also cases cited supra notes 78 and 98.


105. See Bell v. Sediment Removers, Inc., 479 So. 2d 1078 (La. Ct. App. 1985) (non-toxic dumping for 14 days was not “sudden”); United States Fidelity & Guar. Co. v. Armstrong, 479 So. 2d 1164 (Ala. 1985) (overflow of sewage from construction was not the type of industrial pollution encompassed by the exclusion); Molten, Allen & Williams, Inc., v. St. Paul Fire & Marine Ins. Co., 347 So. 2d 95 (Ala. 1977) (only industrial pollution is excluded, not sand and dirt).

106. See United States Fidelity & Guar. Co. v. Star Fire Coals, Inc., 856 F.2d 31 (6th Cir. 1988) (continuous air pollution from a coal tipple); Hicks v. American Resources Ins. Co., 544 So. 2d 952 (Ala. 1989) (not released for publication) (strip mining that fouled water is industrial pollution, which is expressly excluded); New Hampshire Ins. Co. v. Hecla Mining Co., 1989 Colo. App. LEXIS 303 (statute provides continuous notice, so mining company knew or should have known that pollution from its operations would occur).
in 17 out of 29 cases between 1987 and October 1989.\textsuperscript{107} The Sixth Circuit has been in the forefront,\textsuperscript{108} and \textit{United States Fidelity & Guar. Co. v. Star Fire Coals, Inc.}, which applied Kentucky law,\textsuperscript{109} is illustrative. In \textit{Star Fire Coals}, the Sixth Circuit ruled that a tipple's continuous release of coal dust for more than seven years did not entitle the insured to defense or coverage.\textsuperscript{110} The court dismissed the coal company's argument that the "occurrence" clause and the pollution exclusion created a "circle of ambiguity," and it held that the "release of wastes and pollutants taking place on a regular basis or in the ordinary course of business" could not be "sudden and accidental."\textsuperscript{111}

Thus, even \textit{Grand River Lime}, the seminal case that granted occurrence-based coverage,\textsuperscript{112} has been discredited. The 1973 pollution exclusion has been resurrected — brought back from the dead by the persistence of the insurance industry, by the alarm of scholarly research, and by the discretion of the courts.

IV. THE 1985 POLLUTION EXCLUSION

Despite resurrecting the 1973 exclusion clause through its court battles, the insurance industry already is confronting different pollution coverage problems. The reason, as stated previously, is that the Insurance Services Office redrafted the 1973 pollution exclusion when it introduced the Commercial General Liability Policy in 1985.\textsuperscript{113}

The major changes in the new pollution exclusion are the elimination of the "sudden and accidental" language of the old

\textsuperscript{107} See cases listed supra note 98.


\textsuperscript{109} Id. at 32.

\textsuperscript{111} Id. at 35.

\textsuperscript{112} See supra notes 55-59 and accompanying text.

\textsuperscript{113} See supra note 3 and accompanying text.
exclusion, as well as the elimination of coverage for most environmental cleanup actions instituted by state and federal governments. The new clause reads:

This insurance does not apply to . . .
(1) "Bodily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, release or escape of pollutants:
   (a) At or from premises you own, rent or occupy.
   (b) At or from any site or location used by or for you or others for the handling, storage, disposal, processing or treatment of waste:
      (c) Which are at any time transported, handled, stored, treated, disposed of, or processed as waste by or for you or any person or organization for whom you may be legally responsible; or
      (d) At or from any site or location on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations:
         (i) if the pollutants are brought on or to the site or location in connection with such operations; or
         (ii) if the operations are to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize the pollutants.
(2) Any loss, cost, or expense arising out of any governmental direction or request that you test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants.
Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.114

Thus, the new exclusion represents a shift in focus — away from the issue of whether the release of the pollutant is "sudden and accidental" and toward the issue of whether there is exclusion regardless of the situs or the circumstances of the pollution release. The old exclusion required that the emission enter "into or upon land, the atmosphere or any water course or body of water."115 The new exclusion shifts the emphasis to industrial sites — excluding coverage when the pollution is released on site, excluding coverage if the pollution is in transit, excluding coverage no matter whether the polluted site is rented or owned by the responsible party, and excluding coverage regardless of

114. See Explanatory Memorandum, supra note 3.
115. See supra note 48 and accompanying text.
whether the pollutants are taken to a landfill or to a waste treatment center.\textsuperscript{116}

Another major change is that the new exclusion rules out reimbursements if the responsible party has to take remedial action at government direction to clean up the pollution.\textsuperscript{117} This clause was added not because of problems with the old pollution exclusion but because of problems with interpreting the definition of damages in the 1973 policy.\textsuperscript{118} The Insurance Services Office apparently felt that it was better to try to exclude coverage for all types of government remedial action than to redefine "damages" to exclude remedial costs.

Yet, despite its more restrictive language, even the new exclusion appears to have its own ambiguities that are just as open to attack as those in the 1973 exclusion.

\textbf{A. Industrial Pollution}

First, the exclusion concentrates heavily on industrial pollution. There is nothing in the exclusion that would prohibit coverage, for example, in instances of the erosion of soil caused by excavation — a problem that confronted the 	extit{Molten, Allen & Williams} court.\textsuperscript{119}

Also open to question is just what constitutes a pollutant. The policy defines pollutants as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste."\textsuperscript{120} This would appear to preclude coverage for industrial chemicals sent to a landfill or discharged as a regular business activity.\textsuperscript{121} However, the language might not cover the inadvertent spraying of paint, for example.\textsuperscript{122}

\textsuperscript{116} See Explanatory Memorandum, supra note 3, and supra note 114 with accompanying text.
\textsuperscript{117} \textit{Id}.
\textsuperscript{119} See supra notes 60-61 and accompanying text.
\textsuperscript{120} See supra note 114 and accompanying text.
\textsuperscript{121} See supra note 10.
B. Waste

The exclusion's definition of waste has proven the most problematic so far. The exclusion says, "Waste includes materials to be recycled, reconditioned or reclaimed." Thus, it apparently would exclude the coverage that the court granted in *Buckeye Union Ins.*, where the company was recycling or reprocessing chemical waste.

However, in one of only three reported cases involving the 1985 exclusion, a New Jersey federal court found that this definition of waste was "ambiguous." *In re Hub Recycling, Inc.*, concerned the insurance claim of a company that processed "scrap building material, mostly brick, wood and metal." The court said:

A contaminant has the effect of making something impure or dangerous.... An irritant induces inflammation.... In contrast... "waste" has no comparable implication.... [T]he mere presence of recyclable materials cannot preclude coverage under the insurance policy without further proof that the materials were also irritants or contaminants.

Yet, in *Hydro Systems, Inc. v. Continental Ins. Co.*, a California federal court rejected the argument of a manufacturer that the release of styrene gas was a "product" of its manufacturing process. The emission had to be waste because it was not "sold or marketed," the court said, and any contrary reading "would completely swallow the pollution exclusion."

The third case perhaps best illustrates the lengths to which businesses will go to challenge the new exclusion. *League of Minnesota Cities Ins. Trust v. City of Coon Rapids* involved people who said they suffered lung injuries that were caused by the buildup of nitrogen dioxide, a toxic by-product of Zamboni ice-cleaning machines, in the city ice arena. The city argued that it should be covered because the injuries arose out of the buildup

124. See supra note 114 and accompanying text.
125. 17 Ohio App. 3d 127, 477 N.E.2d 1227.
127. Id.
128. Id.
130. Id. at 703.
of the nitrogen dioxide, and not its mere release.\textsuperscript{132} However, the Minnesota Court of Appeals was not swayed. The term "arising out of" was not ambiguous, the court said, because it means "originating from" or "flowing from."\textsuperscript{133}

C. Decomposition of Waste

Also unclear is whether the 1985 exclusion would cover injuries or property damage resulting from the natural decomposition of waste at a landfill. For example, methane gas is naturally formed as some waste materials decompose at a landfill. Arguably, the policy language would not cover injuries or property damage if this methane gas were ignited because the methane was not the result of recycling, reconditioning, or reclamation. However, a case decided under the 1973 exclusion did find that the release of methane from a landfill, which did not ignite, still was a pollution occurrence.\textsuperscript{134}

D. "Cradle to Grave" Handling

Another ambiguity may be found in the exclusion's focus on "cradle to grave" handling of industrial pollutants.\textsuperscript{135} The language that excludes coverage for pollutants released on site, in transit, or at a third-party landfill or processor, might not cover an injury where the pollutant was not released. For example, one court found coverage under the 1973 exclusion where a worker was injured by fumes while cleaning a tank.\textsuperscript{136} The pollutants were never released, so the court found that there had been an occurrence that required coverage. Faced with a similar situation under the new exclusion, a court might reach the same result because the new exclusion covers only the "actual, alleged or threatened discharge, dispersal, release or escape of pollutants."\textsuperscript{137}

\textsuperscript{132} Id. at ___.
\textsuperscript{133} Id. at ___.
\textsuperscript{134} Lower Paxon Township v. United States Fidelity & Guar. Co., 383 Pa. Super. 558, 557 A.2d 393 (1989) (judgment N.O.V. because the escape of methane from a landfill was not abrupt).
\textsuperscript{135} See Exclusion Clauses, supra note 18 at 641.
\textsuperscript{137} See supra note 114 and accompanying text.
E. Expectation of the Insured

When ambiguities such as these are found in insurance contracts, the courts have not hesitated to construe them in favor of the insured — especially when taking the reasonable expectation of the insured into account. As with the 1973 Comprehensive General Liability Policy, it may well be the reasonable expectation of the insured that it will be covered for industrial accidents under the 1985 Commercial General Liability Policy. Some type of pollution is often involved in industrial accidents. For example, if the insured has a chemical tank that explodes, the release of some type of pollutant is inevitable. Such an explosion is precisely the type of accident that would be covered under the “sudden and accidental” requirement of the 1973 exclusion. The 1985 exclusion makes no such provision for an explosion, however, and the insurer could argue that there would be no coverage because a pollutant was released. Yet, the reasonable expectation of the insured would be that it would be covered for just such an accident — especially when the insured knew that it handled chemicals and that such an explosion was at least a possibility.

Another example is the leakage of an underground storage tank of gasoline. The insured who owns and operates a gas station, as was the case in Klock, would reasonably expect that a commercial liability policy would cover an accidental leak of gasoline. He also would expect that the accidental spilling of gasoline from a pump and a resulting fire would be covered. Yet, the insurer could argue that both instances are not covered because they involved the on-site discharge of a contaminant.

Thus, many of the same questions that confronted judges in interpreting the 1973 exclusion may well confront the courts that construe the 1985 exclusion, and history indicates that the insurers could lose their share of cases. Where the 1985 exclusion language is plain — regarding the reprocessing or recycling of industrial chemicals — the courts most likely will invoke the exclusion. However, where the language is not clear — as in what constitutes “waste” — the courts will most likely look to

138. See supra note 54 and accompanying text.
139. See supra notes 62, 66-69 and accompanying text.
140. See supra notes 54-82 and accompanying text.
the reasonable expectation of the insured, as well as to public-policy grounds such as who should bear the cost of cleanup and the burden of vigilance.

What may lie ahead, then, for the insurance industry and its clients is more decades of litigation to resolve the problems raised by the new pollution exclusion. The irony is that at least some of this litigation might have been needless if the insurance industry had remained steadfast in adhering to the 1973 pollution exclusion.

V. CONCLUSION

The history of pollution insurance has been marked with attempts to provide coverage, and then repeated attempts to severely limit that coverage. The 1973 pollution exclusion succeeded somewhat in restricting pollution coverage, but not until after 13 years of judicial interpretation did its restrictions begin to have some effect. The irony for the insurance industry is that it had ditched the 1973 pollution exclusion by the time most courts had begun giving it at least some of the force and effect that the insurers had sought from the beginning.

That effect, of course, has been mixed. Federal courts are much more likely to restrict coverage and a duty to defend under the 1973 pollution exclusion, but they also are following the majority rule of a fact-specific analysis of what the insured business intended or expected, or knew or should have known. The result has been cases almost evenly split regarding landfills, underground pipes and storage tanks, and pollution that was a continuous part of regular business practices. Coverage and a duty to defend are less likely to be granted for continuous industrial pollution, while insurers are more likely to lose cases involving leaks from underground tanks and pipes.

Given the millions of dollars at stake in hundreds of pollution cases across the country, it is uncertain whether the courts will give a restrictive reading to the 1985 pollution exclusion. Ample evidence exists, however, to support the thesis that insurance companies and their clients will endure the same sorting-out period with the new exclusion as they had to experience with the old one. The new exclusion proscribes many types of coverage, but enough ambiguities exist to provide at least several instances of coverage that the insurers may never have intended. Case law indicates that few courts will find the new exclusion
ambiguous, but most will rely on a fact-specific analysis and may even apply the reasonable expectation of the insured on close questions of granting millions of dollars in coverage or imposing a duty to defend on insurers.
A SURVEY OF KENTUCKY TORT REFORM

Robert R. Sparks

I. INTRODUCTION

The insurance crisis of 1986 has prompted state legislatures throughout the country to examine and modify their civil litigation systems and substantive tort law. The need to implement these modifications arises from the perception that the increase in jury verdicts (especially in products liability litigation) has caused insurance companies to pay out substantial sums to fulfill obligations to their insureds. The Kentucky General Assembly's response to tort reform is embodied in House Bill 551. This article will focus on the changes that have been enacted by the Kentucky General Assembly, the rationale for these changes, and their effects on existing Kentucky law.

House Bill 551 was primarily the result of the efforts of the Kentucky Insurance and Liability Task Force. The Task Force was composed of attorneys, state legislators, local officials, and representatives of groups ranging from insurance companies to the Kentucky Medical Association and the United Mine Workers. The Task Force was created to examine the liability insurance crisis of 1986 to report on its causes and to study and understand the reforms that had been advocated in other legislatures throughout the nation.

In its "General Findings," the Task Force noted that it found "no evidence" of a "litigation explosion" in Kentucky. However,

3. See LEGISLATIVE RESEARCH COMMISSION, supra note 1.
4. Id. at i-ii.
5. For a very useful table summarizing tort reform bills adopted by other states, see J. HENDERSON & A. TWERSKI, PRODUCTS LIABILITY 841-843 (1987).
6. LEGISLATIVE RESEARCH COMMISSION, supra note 1, at 15.

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it did believe that "some changes in the civil justice system [were] necessary to bring about a greater degree of efficiency, predictability and cost-effectiveness." While not purporting to provide an immediate answer to the liability insurance crisis, the proposals indicate an attempt to make the system "fairer"\(^8\) by weighing the interests of the potential victim of negligence against the interest of the availability of affordable insurance for everyone in the Commonwealth.

Given this backdrop, the General Assembly enacted, except where noted, the various reforms proposed by the Task Force regarding apportionment of damages, municipal corporation immunity, punitive damages, the collateral source rule, and the personal liability of corporate officers and directors. The major changes in these areas and the contents of the new legislation are discussed below.

II. APPORTIONMENT OF DAMAGES

Kentucky Revised Statutes (K.R.S.) § 411.182, entitled "Apportionment of Damages," provides in § 1:

In all tort actions, including products liability actions, involving fault of more than one party to the action, including third-party defendants and persons who have been released under [another section], the court, unless otherwise agreed by all parties, shall instruct the jury to answer interrogatories or, if there is no jury, shall make findings indicating:

(a) The amount of damages each claimant would be entitled to recover if contributory fault is disregarded; and
(b) The percentage of the total fault of all the parties to each claim that is allocated to each claimant, defendant, third-party defendant, and person who has been released from liability under [another section].\(^9\)

This dispute surrounding this section arises from the fact that it may be interpreted in two entirely different and competing ways. First, it can be interpreted as statutorily enacting a comparative negligence scheme. Second, it can be interpreted as only

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7. Id.
8. Id. at 18.
eliminating joint and several liability. This dispute is most clearly illustrated, and possibly solved, when its effect on products liability actions is considered.

The Kentucky Product Liability Act provides for a contributory negligence defense.\(^\text{10}\) K.R.S. 411.182 was made applicable to products cases by the General Assembly's insertion of the phrase "including products liability actions" into § 2 of the text of the Uniform Comparative Fault Act (UCFA).\(^\text{11}\) If the General Assembly only intended to enact a comparative negligence scheme, then K.R.S. 411.182 would impliedly repeal the contributory negligence defense in the Product Liability Act. However, if the General Assembly intended to eliminate joint and several liability and to replace it with a mandatory apportionment scheme, then there would be no conflict with the Product Liability Act because the only effect would be to mandate apportionment in products cases.

The intent of the Task Force in including Bill Draft 1 in its recommendations to the General Assembly appears in its issue statement relating to that section. Issue Statement 1, entitled "Joint and Several Liability," provides in full:

Joint and several liability is at the top of the list of "tort reform" issues debated in other states. Under joint liability, if one or more defendants are unable to pay their share of a damage award, the responsibility for the entire award falls to the remaining defendant or defendants. The doctrine can be abused with plaintiff's lawyers naming defendants in lawsuits based upon their financial resources, so-called "deep-pockets," rather than their liability based on fault.

The law in Kentucky, K.R.S. 454.040, as interpreted by court decisions, allows the jury to apportion damages among joint tortfeasors; however, there remains a question to what extent apportionment applies to third party defendants and settling parties. The Task Force believes it would be well to mandate apportionment, thereby assuring consistency in the future. The language in draft #1 requires juries be instructed to determine "a percentage of fault to each claimant, defendant, third party defendant" and defendants settling out of court and then determine each party's "equitable share . . . in accordance with the respective percentages


\(^{11}\) Uniform Comparative Fault Act § 2 (1987).
of fault."\textsuperscript{12}

The Task Force's intent to "mandate apportionment" in proposing this section clearly appears from the above-quoted Issue Statement. Furthermore, as will be demonstrated below, this section should be interpreted in accordance with the Task Force's expressed intent because if not, there will have been no change effected in Kentucky law, only a codification of existing law.

In the usual case — that is, one which does not involve a products liability claim — there is no conflict between comparative negligence and joint and several liability. However, for the doctrine of comparative negligence to be consistent with the policy considerations advanced to justify its adoption, some modification of the doctrine of joint and several liability is required.

The Kentucky Supreme Court adopted the "pure form" of comparative negligence in \textit{Hilen v. Hayes}.\textsuperscript{13} The \textit{Hilen} court specifically adopted § 2 of the (UCFA), substantially the same standard codified at K.R.S. 411.182. Under \textit{Hilen}, joint and several liability remained as it does under the UCFA.\textsuperscript{14}

Prior to the adoption of House Bill 551, the only instance where joint and several liability could be eliminated in Kentucky was where the apportionment statute, K.R.S. 454.040, was invoked. It simply states that "the jury may assess joint or several damages against the defendant."\textsuperscript{15} This statute was later interpreted to mandate apportionment where a joint tortfeasor has settled out of the case.\textsuperscript{16} After the adoption of House Bill 551, the Kentucky Supreme Court mandated apportionment in cases involving non-party defendants and third party defendants without reliance on the apportionment statute of the Tort Reform Act in \textit{Floyd v. Carlisle Constr. Co., Ind.}\textsuperscript{17} Before, \textit{Floyd}, unless

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\textsuperscript{12} Legislative Research Commission, supra note 1, at 19 (emphasis added). Despite this clear expression of intent, a recent Kentucky Court of Appeals decision held, in \textit{dictum}, that K.R.S. 411.182 repealed K.R.S. 411.320(3). The court stated: "we are further confounded by KRS 411.182 (effective July 15, 1988) which adopts comparative negligence in products liability cases, thus overruling K.R.S. 411.320(3), land which statutorily overrules Reda Pump Co., supra." Ingersoll-Rand Co. v. Rice, 775 S.W.2d 924, 930 (Ky. App. 1989).

\textsuperscript{13} 673 S.W.2d 713, 719 (Ky. 1984).

\textsuperscript{14} Uniform Comparative Fault Act, supra note 11.


\textsuperscript{16} Orr v. Coleman, 455 S.W.2d 59, 61 (Ky. 1970).

\textsuperscript{17} Floyd v. Carlisle Constr. Co., 758 S.W.2d 430 (Ky. 1988).
\end{flushright}
at least one joint tortfeasor had removed himself from the case through settlement, it was the jury's choice whether to apportion damages and eliminate joint and several liability. The Task Force intended to extend this "choice" one step further—to mandate apportionment in all cases involving joint tortfeasors.

This extension is consistent with the purpose of comparative fault and the intent of the Task Force. In *Hilen*, the Supreme Court stated that pure comparative negligence is "100% fair" for both the plaintiff and defendant when "liability for any particular injury [is] in direct proportion to fault." As stated in the introduction to this article, the Task Force sought to make the civil litigation system "fairer" through its proposals. If the Kentucky courts interpret K.R.S. 411.182 as only legislatively enacting a pure comparative negligence system and not as mandating apportionment, then the potential for liability in excess of fault will remain where the jury has not chosen apportionment, or has not been required to choose. This would hardly be "fair" and certainly would not be a "reform" of the law.

Those in support of the interpretation that K.R.S. 411.182 was intended only to make comparative negligence applicable to products liability actions cite the General Assembly's insertion of "including products liability actions" into § 2 of the UCFA. As stated above, joint and several liability remains under the UCFA. Assuming the General Assembly was aware of the UCFA and its interpretation, this argument is significant in that it impliedly expresses the intent of the General Assembly to repeal the contributory negligence defense in products liability cases.

A fairness argument similar to that advanced for the interpretation eliminating joint and several liability can also be advanced in favor of the view that K.R.S. 411.182 only legislatively enacts comparative negligence. This arises from the fact that the Task Force did not propose, and the General Assembly did not enact, § 2(d) of the UCFA which provides for reallocation of damages among all parties, including a plaintiff at fault, if the judgment is uncollectable from any defendant. Therefore, under K.R.S.

18. *Hilen*, 673 S.W.2d at 718.
21. Id. at § 2(d).
411.182, a successful plaintiff must forgo recovery from a judgment-proof defendant if one construes the act as eliminating joint and several damages. This result also would hardly be "fair" under the Hilen rationale.

However, if K.R.S. 411.182 is interpreted as only legislatively enacting a comparative negligence scheme and made applicable to products liability cases, the courts would have to overcome several legal and theoretical obstacles before such an interpretation could validly be applied to repeal the contributory negligence defense in the Product Liability Act by implication.

A. Repeals by Implication are Not Favored

The first legal obstacle that courts must overcome in applying K.R.S. 411.182 to products liability cases is the "well settled" principle in Kentucky that repeals by implication are not favored. For one statute to repeal another by implication the intent to do so must be clearly expressed or the statutes must be so repugnant to each other that one cannot continue to operate in the face of the other.

The provisions relating to apportionment of damages and contributory negligence in products cases can co-exist without any conflict if K.R.S. 411.182 is construed to mandate apportionment. In a hypothetical products liability case, if a plaintiff is found to be at fault, to any degree, her claim will be barred under K.R.S. 411.320(3) and the apportionment statute will not operate nor conflict with K.R.S. 411.320(3). However, if the plaintiff is adjudged to be free from fault and there are multiple defendants, then K.R.S. 411.320(3) will not enter into the determination. In this case, the apportionment of damages statute will operate to apportion the responsibility for plaintiff's injuries among all defendants as well as those released from liability. Once this has been accomplished, the respective percentages will become fixed. This result will accomplish the declared intentions of the Task

22. Dreidel v. City of Louisville, 268 Ky. 659, 662, 105 S.W.2d 807, 809 (1937); Louisville & N.R. Co. v. Jarvis, 27 Ky. L. Rptr. 986, 990, 87 S.W. 759, 761 (1905). In Jarvis, the court stated, "It is a well-settled principle of statutory construction that repeals by implication are not favored by the courts and will not be declared except it be impossible to permit both statutes to stand." Id. at 761.

Force and will not require the courts to find a repeal by implication where one is clearly not warranted.

If the courts interpret K.R.S. 411.182 to require a comparative negligence analysis in products liability cases, that section and K.R.S. 411.320(3) will clearly conflict. In this case a repeal by implication can be found. However, for this to occur the intent to do so must be clearly expressed and free from doubt. Such a clear intent cannot be found either on the face of the legislation or in its legislative history.24

B. Section 51 of the Kentucky Constitution

The second legal obstacle encountered in applying a comparative negligence interpretation of K.R.S. 411.182 to products liability cases is a possible constitutional bar under § 51 of the Kentucky Constitution. It states in full:

No law enacted by the General Assembly shall relate to more than one subject, and that shall be expressed in the title, and no law shall be revised, amended, or the provisions thereof extended or conferred by reference to its title only, but so much thereof as is revised, amended, extended, or conferred, shall be re-enacted and published at length.25

One major difficulty when this section is applied to legislation which arguably violates it, is that the case law interpreting § 51 is confused and conflicting.26 However, a meaningful analysis can be conducted if one proceeds through a two-step analysis of the major considerations supporting the section.

The first logical step involved in an analysis of § 51 is a consideration of its stated purpose. The framers included this section to prevent the enactment of surreptitious legislation that has the effect of “surprising” the members of the General As-

26. Mills v. Dawson, 197 Ky. 518, 523-524, 247 S.W. 764, 766-767 (1926) (intent to repeal must be expressed in title of statute); Price v. Vox, 220 Ky. 373, 376, 295 S.W. 433, 434-435 (1926) (repeal by implication allowed where intent was merely to amend); Barnett v. Caldwell, 231 Ky. 514, 517, 21 S.W.2d 838, 839 (1929) (amendment or repeal effected only by reference to amended or repealed section in title of new act); Board of Trustees of Policeman’s & Fireman’s Fund v. City of Paducah, 333 S.W.2d 515, 521 (Ky. 1960) (need not republish where repeal by implication is effected).
sembly and those affected by and relying on the legislation.27 When this consideration is analyzed it is clear that K.R.S. 411.182 was not intended to surprise the General Assembly. To the contrary, it was the General Assembly that made K.R.S. 411.182 applicable to products liability actions. Furthermore, the General Assembly is presumed to know the law and therefore the enacted legislation's effect on existing law.28 The legislation also does not surprise those affected by or relying on it. Such a result would be effected if K.R.S. 411.182 impliedly repealed K.R.S. 411.320(3). In this instance, one could not rely upon an analysis of the plain meaning of each statute.

The second step involved in an analysis of § 51 is a consideration of its attendant rules of construction. Although § 51 has been liberally interpreted in modern times to avoid the perceived harshness of its requirements, it "is not a lifeless anachronism."29 Section 51 has been applied in recent years to invalidate portions of statutes that did not relate to the title of the act.30 K.R.S. 411.182, entitled "Apportionment of Damages," may also violate the requirement in § 51 that any act which is amended by a subsequent act must be republished at length as it will appear after the amendment.31 If K.R.S. 411.182 were interpreted to repeal the statutory contributory negligence defense in products cases, it would clearly relate to more than one subject. K.R.S. 411.182 did not republish the "repealed" section of the Product Liability Act. The Kentucky courts should find that K.R.S. 411.182 is in violation of § 51 if that section is to continue to have force and not become a mere "legal anachronism."

C. Applicability of Negligence Principles in Strict Products Liability

The application of negligence principles in strict products liability actions is theoretically impermissible. If K.R.S. 411.182 is interpreted to apply comparative negligence to products liability actions, such a theoretical conflict will be presented. Therefore, this is an obstacle which warrants consideration.

30. Lewis v. Captain's Quarters, Inc., 655 S.W.2d 26, 28 (Ky. 1983).
The majority position on this issue permits the application of comparative negligence principles in strict products liability actions to assess the plaintiff's degree of fault despite their obvious theoretical conflict. Kentucky is among the minority of states making the contributory negligence of a plaintiff a defense in products cases. This departure from the majority however, is not due to the doctrinal conflict between the negligence and strict liability theories of recovery. As will be demonstrated below, the Kentucky law on products liability is replete with the application of negligence principles in strict products liability actions. Therefore, the Kentucky courts are not likely to have difficulty in this regard if K.R.S. 411.182 is interpreted to apply comparative fault principles to products liability actions.

In Jones v. Hutchinson Manufacturing, Inc., the Kentucky Supreme Court candidly declared its position on the doctrinal differences between negligence and strict liability principles at least insofar as they affect defective design cases. The court stated:

We think it apparent that when the claim asserted is against a manufacturer for deficient design of its product the distinction between the so-called strict liability principle and negligence is of no practical significance so far as the standard of conduct required of the defendant is concerned. In either event the standard required is reasonable care.

The Kentucky Supreme Court has taken a similar approach in fashioning a test for whether a product is unreasonably dangerous under the Restatement (Second) of Torts § 402A. In Nichols v. Union Underwear Co., the court articulated its test in a model jury instruction, stating that the jury should find for the plaintiff only if "an ordinarily prudent [manufacturer], being fully aware of the risk, would not have put [the product] on the market." Therefore, the court has formulated an imputed knowledge/negligence standard to determine whether the product is unreasonably dangerous. This willingness of the Kentucky courts to accept

33. See Reda Pump, 713 S.W.2d 818, 820 (Ky. 1986).
34. 502 S.W.2d 66 (Ky. 1973).
35. Id. at 69-70.
36. 602 S.W.2d 429 (Ky. 1980)
37. Id. at 433.
negligence principles in strict liability cases indicates that this
theoretical obstacle will not pose a hurdle as substantial as the
legal obstacles.

K.R.S. 411.182 faces two possibly insurmountable legal obsta-
cles before it can be interpreted to repeal the contributory
negligence defense in the Product Liability Act. These obstacles
are even greater when one considers that the only available
legislative history indicates a contrary intent.

III. MUNICIPAL TORT CLAIMS ACT

At common law, a municipal corporation possessed unqualified
immunity from suit.\(^{38}\) This immunity was derived from the ancient
concept of the divine right of kings.\(^{39}\) The law in Kentucky on
this issue was first articulated in the case of Haney v. City of
Lexington.\(^{40}\) In Haney, the court abrogated the traditional rule of
sovereign immunity in favor of holding cities liable for “ordinary
torts”\(^ {41}\) with one exception. That exception afforded limited im-
munity for municipal governments where the cause of action
arose out of some non-feasance or misfeasance associated with
the city’s “exercise of legislative or judicial or quasi-legislative
or quasi-judicial function.”\(^ {42}\)

Although Haney intended to eliminate the “legal anachronism
of municipal immunity from liability for tort,”\(^ {43}\) it nevertheless
retained that “anachronism” in a limited form without clearly
defining the scope of the new exception. By not defining what
exactly was meant by the distinction between legislative/judicial
and quasi-legislative/quasi-judicial functions, it left their devel-
opment to interpretation in subsequent cases. The subsequent
cases, however, blurred this distinction to such a degree that the
exception was beyond logical and consistent application.\(^ {44}\) In Gas
Service Co. v. City of London,\(^ {45}\) the court finally redefined its
position on the municipal immunity doctrine and clarified 21 years

\(^{39}\) Id.
\(^{40}\) 386 S.W.2d 738 (Ky. 1968).
\(^{41}\) Id. at 742.
\(^{42}\) Id.
\(^{43}\) Id. at 743.
\(^{45}\) 687 S.W.2d 144 (Ky. 1985).
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of confusion. The court returned to its holding in Haney, again favoring limited immunity in cases involving the exercise of a legislative/judicial or quasi-legislative/quasi-judicial function. The court expressly overruled all cases, with two exceptions, subsequent to Haney applying the municipal immunity doctrine because the functions involved were not within the legislative/judicial or quasi-legislative/quasi-judicial exception.

Although the Gas Service court re-affirmed the Haney exception, it, too, failed to clearly delineate and define the exception, thereby possibly condemning the Kentucky courts and cities to a new period of confusion. As will be discussed below, the legislation proposed by the Task Force and enacted by the General Assembly affecting claims against local governments seeks to avoid this problem by attempting to clearly define the exception by example as well as enacting several other substantive provisions on limitations of recoverable damages, and periodic payment of damages.

A. Limitation on Claims

K.R.S. 65.2003 makes a municipal corporation immune from actions resulting from any claim covered by the workers' compensation law, or connected with the collection or assessment of taxes and for any claim arising from the exercise of a legislative/judicial or quasi-legislative/quasi-judicial function.

The statute includes, by way of illustration, several examples of what constitutes a legislative/judicial or quasi-legislative/quasi-judicial function:

(a) The adoption or failure to adopt any ordinance, resolution, order regulation, or rule;
(b) The failure to enforce any law;
(c) The issuance, denial, suspension, revocation of, or failure or refusal to issue, deny, suspend, or revoke any permit, license, certificate, approval, order or similar authorization;

46. Id. at 150.
47. Commonwealth Dept. of Banking and Sec. v. Brown, 605 S.W.2d 497 (Ky. 1980); Grogan v. Commonwealth, 577 S.W.2d 4 (Ky. 1979).
48. Gas Service, 687 S.W.2d at 149.
49. Id. at 149-150.
51. Id. § 65.2003(2).
52. Id. § 65.2003(3).
(d) The exercise of discretion when in the face of competing demands, the local government determines whether and how to utilize or apply existing resources; or,
(e) Failure to make an inspection.53

Whether these examples will prevent the confusion prevalent after Haney remains to be seen. However, the legislature's action in this area is a welcome development and one that was clearly warranted and invited.54

B. Limitation on Recoverable Damages

K.R.S. 65.2002 limits the total damages awardable in any action not barred by the limited immunity doctrine against a city to the "total damages suffered by the plaintiff, reduced by the percentage of fault including contributory fault, attributed by the trier of fact to other parties."55

This cap on liability promises to be the most controversial aspect of this section and will undoubtedly be challenged as an unconstitutional limitation on recoverable damages under §§ 14 and 54 of the Kentucky Constitution. Section 14 guarantees that "every person for an injury done him in his lands, goods, person or reputation, shall have remedy by due course of law."56 Section 54 provides that the General Assembly "shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property."57 Both provisions prohibit the limitation of actions or damages from actions that existed prior to the 1891 enactment of the Constitution.

In Rooks v. University of Louisville,58 the Kentucky Court of Appeals allowed a limitation of governmental liability pursuant to § 231 of the Kentucky Constitution. Section 231 provides that the General Assembly has the power to regulate "in what manner and in what court suit may be brought against the Commonwealth."59 Rooks, however, involved a statute that limited recovery and provided recourse against an otherwise immune institution

53. Id.
54. See Snell, supra note 44.
57. Id. § 54.
58. 574 S.W.2d 923 (Ky. 1978).
59. Ky. Const. § 231.
through the Board of Claims. The creation of this alternative forum in which suits could be brought against the Commonwealth was a significant factor in the court's decision.\textsuperscript{60} K.R.S. 65.2002, however, provides no alternative forum that can be construed to constitute any regulation of the manner or where suit can be brought against a municipal government. It simply places a cap on how much can be recovered.\textsuperscript{61}

The Task Force noted the difficulties that \S\ 231 could pose. In Issue Statement 18 the Task Force unsuccessfully recommended that \S\ 231 be amended to state:

The General Assembly may, by law, direct in what manner, to what extent and in what courts or other tribunals, suits may be brought against the Commonwealth, its counties, cities and other governmental entities.\textsuperscript{62}

As stated, however, this section may withstand constitutional challenge on two separate grounds. First, sovereign immunity was the rule rather than the exception when the Constitution was adopted; thus, there were very few suits that could be brought against a municipal government.\textsuperscript{63} Therefore, the limitation may not affect a cause of action in existence before the Constitution was adopted. Second, in \textit{Galloway v. City of Winchester},\textsuperscript{64} the court stated that "since the right to sue a municipal corporation for tortious acts may be conferred or withheld at the pleasure of the Legislature, the latter may attach such conditions to the right to recover as it deems proper or expedient."\textsuperscript{65} This may serve as precedent for allowing a limitation on the liability of a municipal corporation.

\textbf{C. Periodic Payment of Damages}

K.R.S. 65.2004 permits a local government to pay any final judgment rendered against it under K.R.S. 65.200 to 65.2006 in whole or in part by periodic payments.\textsuperscript{66} This section can be invoked only upon motion of a local government,\textsuperscript{67} and the pay-

\begin{itemize}
\item \textsuperscript{60} \textit{Rooks}, 574 S.W.2d at 924-925.
\item \textsuperscript{62} \textit{Legislative Research Commission}, \textit{supra} note 1, at 46.
\item \textsuperscript{63} \textit{Wood v. Board of Educ. of Danville}, 412 S.W.2d 877 (Ky. 1967).
\item \textsuperscript{64} 299 Ky. 87, 89, 184 S.W.2d 890, 891 (1944).
\item \textsuperscript{65} \textit{Id.} at 89, 184 S.W.2d 891 (1944).
\item \textsuperscript{67} \textit{Id.}
The legislation enacts two limitations that must be considered by the court before it permits a final judgment to be satisfied by periodic payments. First, the payment of the judgment cannot be totally covered by insurance. Second, the funds allocated by the local government to pay judgments in the current year must be insufficient to "finance both the adopted budget of expenditures for the year and the payment of that portion of the judgment not covered by insurance."

As it is evident from the above, the General Assembly has attempted to relieve the burden that civil judgments can impose on a municipality. It has done so by limiting the claims for which damages can be sought, by limiting the amount which can be recovered, and by extending the time for payment of that judgment. Whether these provisions are valid and can, in fact, relieve the burden must still be determined by the Kentucky courts.

IV. PUNITIVE DAMAGES

The Task Force also proposed a substantial change in the conduct that justifies punitive damages, as well as in the manner in which they are awarded. In doing so, it rejected the responses made by other legislatures throughout the country. In Issue Statement 3, the Task Force states that it:

considered and rejected: abolishing punitive damages; prohibiting insurability of punitive damages and requiring punitive damage coverage to be added to rather than included in insurance policies (and priced separately); and mandating that punitive damages be awarded to the benefit of the Commonwealth rather than the individual.

Instead, the Task Force proposed a bill that defines three types of conduct for which punitive damages may be awarded and develops a five-factor approach for the trier of fact to utilize in assessing the amount of punitive damages to be awarded.
Punitive damages may be awarded for conduct that is "oppressive," "fraudulent," or "malicious." These terms are defined as follows:

(a) "Oppressive" means conduct which is specifically intended by the defendant to subject the plaintiff to cruel and unjust hardship.
(b) "Fraud" means an intentional misrepresentation, deceit, or concealment of material fact known to the defendant and made with the intention of causing injury to the plaintiff.
(c) "Malice" means either conduct which is specifically intended by the defendant to cause tangible or intangible injury to the plaintiff or conduct that is carried out by the defendant both with a flagrant indifference to the rights of the plaintiff and with a subjective awareness that such conduct will result in human death or bodily harm. (emphasis added).

This section is consistent in many respects with existing Kentucky law on punitive damages. The definitions of each of the above types of conduct require intent. The only exception is the second definition of "malice," which can be found from what is arguably grossly negligent conduct. The Kentucky courts have permitted punitive damages to be assessed for grossly negligent conduct. The gravamen of the punitive damages claim in Kentucky is not whether the conduct was intentional but whether it was outrageous. Previously, intentional conduct alone was insufficient. Therefore, this definition is not inconsistent with existing Kentucky law and may, in fact, lessen the existing Kentucky standard by not requiring "outrageousness." This standard was set forth in *Horton v. Union Light, Heat & Power Co.*, where the Supreme Court adopted § 908 of the Restatement (Second) of Torts and held punitive damages could be awarded because of the defendant's "reckless indifference to the rights of others." Therefore, in *Horton*, punitive damages were allowed for grossly negligent conduct.

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75. Id.
77. Id. at 389.
78. Id.
79. Id.
81. In *Horton*, the court stated at 690 S.W.2d at 38990: In order to justify punitive damages there must be first a finding of failure to
The Act does depart from existing Kentucky law in two other respects.

First, it requires that the plaintiff prove by clear and convincing evidence that the defendant acted toward him with "oppression," "fraud," or "malice."\(^8\)\(^2\) In *Horton*, the Kentucky Supreme Court articulated the existing rule regarding proof of the requisite conduct as follows: "Just as malice need not be expressed and may be *implied* from outrageous conduct, so too may wanton or reckless disregard for the lives and safety of others be *implied* from the nature of the misconduct."\(^8\)\(^3\)

It is clear that the new Act would not permit the requisite conduct to be implied. Rather, the defendant's conduct must be proven by clear and convincing evidence before punitive damages can be assessed.\(^8\)\(^4\)

Second, the Act departs from existing Kentucky law in that it does not allow punitive damages to be assessed against an employer for the acts of its employee under the doctrine of vicarious liability. Previously, Kentucky followed the "broad rule," which holds an employer vicariously liable for punitive damages assessed against an employee arising from conduct while acting within the scope of his employment.\(^8\)\(^5\) The new statute allows punitive damages to be assessed against an employer only where the employer authorized, ratified, or "should have anticipated" the conduct of the employee.\(^8\)\(^6\)

The new statutory provision is in accord with the "complicity" rule of the Restatement of Torts, which provides that punitive damages may be assessed against a principal only under certain conditions.\(^8\)\(^7\)

If a plaintiff is successful in proving that punitive damages are warranted under the Act, then K.R.S. 411.186(2) provides the


\(^{83}\) *Horton*, 690 S.W.2d at 389 (emphasis added).

\(^{84}\) In a recent case, however, the Kentucky Court of Appeals permitted a plaintiff to recover punitive damages where "malice" could only be implied. *Radcliff Homes, Inc. v. Jackson and Jackson*, 36 K.L.S. 3, 7 (March 17, 1989).

\(^{85}\) Continental Ins. Co. v. Hancock, 507 S.W.2d 146 (Ky. 1973).


\(^{87}\) RESTATEMENT (SECOND) OF TORTS § 909 (1979). Note, however, that the RESTATEMENT contains more exceptions than the Kentucky statute.
five-factor approach for determining the amount of punitive damages to be assessed. If the trier of fact determines that punitive damages are warranted, it is required to consider the following factors in assessing the amount to be awarded:

(a) The likelihood at the relevant time that serious harm would arise from the defendant's misconduct;
(b) The degree of the defendant's awareness of that likelihood;
(c) The profitability of the misconduct to the defendant;
(d) The duration of the misconduct and any concealment of it by the defendant; and
(e) Any actions by the defendant to remedy the misconduct once it became known to the defendant.\footnote{88}

K.R.S. 411.186(3) makes this section applicable to "all cases in which punitive damages are sought," not just to actions filed after the effective date of the tort reform legislation as in the Apportionment of Damages provision.\footnote{89}

V. ABROGATION OF THE COLLATERAL SOURCE RULE

Traditionally, the collateral source rule excluded all evidence of payment to the plaintiff of collateral benefits as well as the existence of subrogation benefits.

The policy reasons underlying this rule are clearly and succinctly stated in the landmark California case of Helfend v. Southern California Transit District.\footnote{90} The California Supreme Court noted that:

The collateral source rule expresses a policy in favor of encouraging citizens to purchase and maintain insurance for personal injuries and for other eventualities [and that the] defendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance.\footnote{91}

The counter-argument propounded to this policy justification is that the collateral source rule permits a "double recovery."\footnote{92} The plaintiff can recover not only his judgment from the defendant but also collateral benefits from insurance policies that

\footnotesize{\begin{itemize}
\item \footnote{90. 2 Cal. 3d 1, 465 P.2d 61, 84 Cal. Rptr. 173 (1970).}
\item \footnote{91. Id. at 10, 465 P.2d at 66-67, 84 Cal. Rptr. at 178-79.}
\item \footnote{92. Id. at 10, 465 P.2d at 67, 84 Cal. Rptr. at 179.}
\end{itemize}}
frequently overlap with jury awards. This rewards the plaintiff and punishes the defendant by requiring him to pay amounts over and above the compensation due the plaintiff for his injury. Under K.R.S. 411.188, evidence of collateral benefits and the existence of subrogated benefits is admissible. Evidence of collateral benefits from life insurance policies, however, are not admissible. 93

The Kentucky legislation in this regard is a restrained response. Other states have enacted more radical approaches that more severely impact a plaintiff’s recovery. For example, Ohio has also recently abrogated the collateral source rule in its Tort Reform Act. 94 In Ohio, however, the defendant is entitled to a setoff. 95 The amount of the setoff is determined after the jury finds liability and an award is rendered. The setoff is determined by subtracting the non-subrogated collateral benefits that the plaintiff has received, or is likely to receive during the next five years, from the jury’s award. 96 The plaintiff has the responsibility to report these benefits to the court when the setoff phase begins. Next, the court adds to the jury award the amount of premiums paid by the plaintiff or his immediate family in the preceding three years. 97 The amount remaining is the award plaintiff can recover. 98

The new Kentucky rule is similar in operation and effect to the Georgia rule. 99 Under the Kentucky and Georgia statutes, evidence of the payment of collateral benefits is admissible only for the trier of fact to “consider.” 100 The jury is not required to reduce the award by the amount of benefits received.

The Kentucky statute therefore reduces the risk of a “double recovery” somewhat by making the existence of collateral and subrogated benefits admissible facts at trial. It avoids the harshness of other responses by not requiring an automatic setoff of

95. Id. § 2317.45(B)(2).
96. Id. § 2317.45(B)(2)(c)(ii).
97. Id. § 2317.45(B)(2)(c)(ii).
99. GA. CODE ANN. § 51-12-1(b) (Supp. 1988).
100. Id.
the benefits received. It does not, however, provide any induce-
ment to maintain insurance because no credit is given for prem-
iums paid by the plaintiff. The end result under the Kentucky
legislation appears to be that the jury may attach whatever
importance it wishes to evidence of collateral source payments.

The abrogation of the collateral source rule is applicable to all
actions for damages commenced after July 15, 1988, the effective
date of the act. The insertion of this provision is an attempt
to eliminate any retroactivity arguments regarding the applica-
bility of this rule.

K.R.S. 411.188 also requires the plaintiff to notify, at the
commencement of the action, those persons who he believes hold
subrogation rights to any award received by him. If the person
holding such a right does not assert it through intervention in
the action, the right is lost.

VI. REVISED MODEL BUSINESS CORPORATION ACT

Included in Kentucky's Tort Reform Act is a provision limiting
the liability of the directors and officers of profit and non-profit
corporations. Although not considered as an area of "tort reform"
by other legislatures, the General Assembly agreed with the
Task Force that the increasing insurance premiums and decreas-
ing coverage experienced by corporate officers and directors
warranted attention. A chief problem noted by the Task Force
was articulated in Issue Statement 15 as follows:

Some smaller corporations faced the dilemma of whether they
could afford directors and officers insurance. In what is perceived
to be an atmosphere created by recent case law of increased
uncertainty over the personal liability of directors and officers,
companies without directors and officers coverage are finding it
difficult to recruit and retain qualified directors. It is tough enough
to find good people to serve on boards without asking them to put
their personal assets at risk in order to serve.

The Revised Model Business Corporation Act (RMBCA) is the
model for the Kentucky legislation. The provisions enacted by

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102. Id. § 411.188(2).
103. Id.
104. LEGISLATIVE RESEARCH COMMISSION, supra note 1, at 40.
the General Assembly are very similar to the RMBCA in many respects but depart from it in several very important respects. The Task Force also concluded that a "Delaware provision," which allows the corporation to assume more responsibility for the liability of its directors, would be beneficial in making insurance policies more affordable.106

The Task Force concluded in Issue Statement 16 that similar provisions were warranted for the directors of non-profit corporations.107 Given the similarity in the treatment of the directors and officers of profit and non-profit corporations, each will be discussed together below under the major categories in which reforms were made. Where appropriate, the differences in treatment will be noted. Due to the comprehensive nature of the legislation in this area and the lack of prior Kentucky case law, a significant portion of this analysis will be devoted to a summary of the important provisions of this legislation.

A. Liability of Corporate Directors and Officers with Discretionary Authority

With regard to directors of profit and non-profit corporations, the articles of incorporation may set forth "a provision eliminating or limiting the personal liability of a director to the corporation or its shareholders for monetary damages for breach of his duties as a director."108 However, the provision may not eliminate or limit the liability of a corporation for profit:

1. For any transaction in which the director's personal financial interest is in conflict with the financial interests of the corporation or its shareholders;
2. For acts or omissions not in good faith or which involve intentional misconduct or are known to the director to be a violation of law;
3. For any vote or assent to an unlawful distribution to shareholders as prohibited by [Kentucky law];
4. For any transaction from which the director derived an improper personal benefit.109

This provision changes existing Kentucky law by allowing a corporation to limit or even eliminate the liability of its directors,

106. LEGISLATIVE RESEARCH COMMISSION, supra note 1, at 41.
107. Id. at 42-43.
109. Id. All of the above apply to the directors of non-profit corporations, with the exception of No. 3 which is omitted.
with certain specified exceptions, for monetary damages arising from the breach of the director's duties. The only analogous provision under prior Kentucky law was the indemnification provision of K.R.S. 271A.026.

B. Standards of Conduct

Directors and officers with discretionary authority in both profit and non-profit organizations must discharge their duties:

a. In good faith;

b. On an informed basis; and,

c. In a manner he honestly believes to be in the best interests of the corporation.\(^{110}\)

A director or officer is not acting in good faith “if he has knowledge concerning the matter in question that makes reliance otherwise permitted by [the above] unwarranted.”\(^{111}\) Also inherent in the concept of good faith is the requirement that the director read or otherwise be familiar with the content of the report, statement, or other document which is the basis of his or her decision.\(^{112}\)

A duty is discharged on an informed basis if the officer or director makes, “with the care an ordinarily prudent person in a like position would exercise under similar circumstances, inquiry into the business and affairs of the corporation, or into a particular action to be taken or decision to be made.”\(^{113}\) In discharging his duties, a director in a profit or non-profit organization is entitled to rely on “information, opinions, reports, or statements, including financial statements and other data, if prepared or presented by:"

a. One (1) or more officers or employees of the corporation whom the director honestly believes to be reliable and competent in the matters presented;

b. Legal counsel, public accountants, or other persons as to matters the director honestly believes are within the person’s professional or expert confidence; or,

c. A committee of the board of directors of which he is not a member, if the director honestly believes the committee merits

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111. Id. § 271B.8-300(4).
confidence.\textsuperscript{114}

The most important deviation from the text of the RMBCA is found in part (c), which requires the director to "act in a manner he honestly believes to be in the best interests of the corporation."\textsuperscript{115} The RMBCA requires that the director "act in a manner he reasonably believes to be in the best interests of the corporation."\textsuperscript{116} The effect of the Kentucky Act is to eliminate the application of a negligence standard in determining the director's liability. Such an analysis is inconsistent with the business judgment rule.\textsuperscript{117} Although the comment to the RMBCA states this was not the intended effect of this language, courts have nonetheless interpreted it as such.\textsuperscript{118}

All of the above applies to officers in profit and non-profit organizations, with the exception of allowing reliance on a committee of the board of directors, which is omitted.\textsuperscript{119} The effect of this provision, according to the Official Comment to the RMBCA, is to make non-director officers meet the same standards of conduct as required of directors.\textsuperscript{120} However, the officer's "ability to rely on information, reports, or statements, may, depending upon the circumstances of the particular case, be more limited than in the case of a director."\textsuperscript{121}

C. Director Conflicts of Interest

Regarding directors of profit and non-profit organizations, a conflict of interest is a "transaction with the corporation in which a director of the corporation has a direct or indirect interest."\textsuperscript{122} A director has an indirect interest in a transaction if:

a. Another entity in which he has a material financial interest or in which he is a general partner is a party to the transaction; or,

\begin{itemize}
  \item \textsuperscript{114} Id. § 271B.8-300(3).
  \item \textsuperscript{115} Id. § 271B.8-300.
  \item \textsuperscript{116} MODEL BUSINESS CORP. ACT ANN., supra note 105, at 8.30.
  \item \textsuperscript{117} Veasey & Manning, Codified Standard — Safe Harbour or Uncharted Reef?, 35 BUS. LAW 919 (1980).
  \item \textsuperscript{118} Smith v. Van Gorkum, 488 A.2d 858 (Del. 1985).
  \item \textsuperscript{119} KY. REV. STAT. ANN. § 271.B.8.420 (Michie/Bobbs-Merrill Supp. 1988).
  \item \textsuperscript{120} MODEL BUSINESS CORP. ACT ANN., supra note 105, at 8.42.
  \item \textsuperscript{121} Id. at 8.41, comment (1987).
  \item \textsuperscript{122} KY. REV. STAT. ANN. § 271.B.8-310 (Michie/Bobbs-Merrill Supp. 1988).
\end{itemize}
b. Another entity of which he is a director, officer, or trustee is a party to the transaction and the transaction is or should be considered by the board of directors of the corporation.123

A conflict-of-interest transaction is not voidable by a corporation solely because of a director's interest in the transaction if the material facts of the transaction and the director's interest were disclosed or known to the board or shareholders entitled to vote, and if either body authorized, approved, or ratified the transaction.124 A conflict-of-interest transaction is also not voidable by the corporation solely because of a director's interest in the transaction if the transaction was fair to the corporation.125

This section retains most of the conflict-of-interest rules previously found in K.R.S. 271A.205 but defines an indirect interest more clearly. This section also was made applicable to directors of non-profit corporations, whereas previously there were no such standards.

D. Limitation of Remedy

K.R.S. 271B8-300 also limits the obtaining of monetary damages and injunctive relief against a director or officer by disallowing such relief unless:

a. [The director or officer] has breached or failed to perform the duties of [his] office; and,

b. In the case of an action for monetary damages, the breach or failure to perform constitutes willful misconduct or wanton or reckless disregard for the best interests of the corporation and its shareholders.126

A person seeking monetary damages must prove, by clear and convincing evidence, both (a) and (b) above and that the breach or failure to perform was the legal cause of the damages suffered by the corporation.127

VII. Conclusion

The Kentucky Tort Reform Act, as described above, appears to be a genuine attempt to make the civil litigation system fairer.

123. Id. § 271.B.8-310(2).
124. Id. § 271.B.8-310(1).
125. Id.
126. Id. § 271.B.8-300(5).
127. Id. § 271.B.8-300(6).
The Act represents a restrained response to the insurance "crisis" that other states rushed to eliminate with radical alterations of their state's procedural and substantive laws. The Kentucky legislation seems more inclined to use this "crisis" as a justification to clarify and reform various areas that were in need of attention. This can be most clearly seen in the Municipal Tort Claims Act, which primarily attempts to clarify decades of confusion in the courts. At the same time, the Task Force and the General Assembly took the opportunity to enact various reforms with a more concrete impact on the plaintiff's cause of action.

In the final analysis, the Kentucky legislation did not extensively alter existing Kentucky law. The reforms with the most immediate impact, like the apportionment of damages statute and the cap on recoverable damages in the Municipal Tort Claims Act, will undoubtedly face challenges to their effect and validity. This will give the Kentucky courts an opportunity to concur with the General Assembly or to restrict the reform's operation. Whatever the result, the foundation has been laid for the legal community to question and debate the civil litigation system in place in Kentucky. This result may be the most beneficial "reform."
NOTE

BROWNING-FERRIS INDUSTRIES v. KELCO DISPOSAL, INC.: THE CONSTITUTION AND "EXCESSIVE" PUNITIVE DAMAGES

Bruce Joel Hillman

I. INTRODUCTION

This is an era in which punitive damage awards levied by juries in civil actions are soaring, reaching into the millions and even the billions of dollars. The consequences of this trend are enormous for all segments of commerce, but especially so for the insurance industry, where unpredictably large punitive damage awards levied against insureds may be payable under the insurance policy, and in an increasing number of cases where punitive damages are assessed against insurance companies themselves.

Cases in the latter category arise out of these basic facts: An insured presents a claim payable under an insurance policy to his or her insurance company; the insurer, acting for good or bad purpose, delays in payment of the claim; the insured sues the insurance company for bad-faith dealing and includes a punitive damage prayer arising out of willful misconduct on the part of the insurer. Where the insured prevails, the punitive damages can exceed the original claim hundreds of times over.

Some defendants facing large punitive damage awards have looked to the United States Constitution, particularly the Eighth Amendment's Excessive Fines Clause and the Fourteenth Amendment.

1. See, e.g., Texaco Must Pay $11 Billion Award, Texas Court Rules, N.Y. Times, Dec. 11, 1985, at 1, col. 1 ($3 billion in punitive damages). See also Bankers Life & Casualty Co. v. Crenshaw, 486 U.S. 71, 108 S. Ct. 1645 (1988) ($20,000 compensatory damages, $1.6 million punitive damages); Aetna Life Ins. Co. v. Lavoie, 475 U.S. 813 (1986) ($1,500 compensatory damages, $3.5 million punitive damages.)
3. Id. at n.1.
4. U.S. CONST. Amend. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.")

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Amendment's Due Process provision, in order to obtain a judicial check on civil punitive damages. The arguments advanced in these cases are (1) that the Eighth Amendment's proscription against excessive fines can be applied to punitive damages awarded in civil actions and (2) that there are Fourteenth Amendment Due Process violations in denying defendants in civil trials protections that are routinely afforded criminal defendants, namely the constitutional protection against the infliction of excessive fines.

In *Browning-Ferris Indus. v. Kelco Disposal, Inc.*, the Supreme Court closed off to defendants one of these legal avenues regarding the constitutionality of the manner in which punitive damages are awarded in civil lawsuits. In doing so, the court held the Excessive Fines Clause not to be applicable to punitive damages in civil lawsuits, but specifically declined to decide the Due Process argument. At the time of this writing, the Supreme Court is said to be seeking an appropriate case to hear on this issue.

II. BACKGROUND

The Supreme Court was asked twice before *Kelco* to rule on the applicability of the Eighth Amendment to the imposition of punitive damages in civil lawsuits. In both cases the Court avoided the issue on grounds not related to the merits.

The first case, *Aetna Life Ins. Co. v. Lavoie*, reached the Court on appeal from Alabama state courts in 1986, and it arose out of a claim for the recently recognized tort of "bad faith in first party insurance actions." In *Lavoie*, the jury assessed compensatory damages of $1,500 and punitive damages of $3.5 million against the insurance company defendant. The Alabama Supreme Court affirmed, rejecting the insurance company's argument that the punitive damages award was so excessive that it

5. U.S. CONST. Amend. XIV ("...nor shall any State deprive any person of life, liberty, or property without due process of law...")
7. Id. at 2921.
8. 475 U.S. 813.
10. 475 U.S. at 816.
must be set aside. The defendant appealed to the United States Supreme Court. Though it granted certiorari, the Court provided no guidance on the applicability of the Excessive Fines Clause because it did not reach that issue in its opinion. It remanded the case on another appealed issue, recusal-for-bias, because a justice on the Alabama Supreme Court was involved in a similar action against an insurance company at the time the case came before the court. The Eighth and Fourteenth Amendments arguments had been briefed, however, and Chief Justice Burger’s statement on the issue announced the Court’s willingness for another case on the question to be sent before it: “These arguments raise important issues which, in an appropriate setting, must be resolved; however, our disposition of the recusal-for-bias issue makes it unnecessary to reach them.”

In 1988, the Court was faced with similar facts and arguments in Bankers Life & Casualty Co. v. Crenshaw. A Mississippi jury had awarded a plaintiff $20,000 compensatory damages (the maximum policy limit on the denied claim) and $1.6 million in punitive damages against an insurance company defendant arising out of a bad-faith refusal to pay a claim. The Mississippi Supreme Court affirmed the jury verdict and concluded that the punitive damages award was not excessive in light of the defendant’s financial worth and the degree of its wrongdoing.

In its appeal to the Mississippi Supreme Court, the insurance company did not raise the specific federal constitutional questions put before the United States Supreme Court. Instead, it had argued in the petition that “the punitive damage verdict was clearly excessive, not reasonably related to any legitimate purpose, constitutes excessive fine, and violates constitutional principles.” The Supreme Court declined to rule on the Eighth and Fourteenth Amendment arguments raised by the insurance com-

12. 475 U.S. at 828.
13. Id. at 829-30.
pany and affirmed the award. 17 As in Lavoie, the decision was on procedural grounds, the Court holding that its "not raised or passed on below" rule precluded the issue's review. 18 The Court concluded that the petition stated a "vague appeal to constitutional principles" 19 and that "[a] party may not preserve a constitutional challenge by generally invoking the Constitution...." 20 The Court held that the defendant's failure to raise the federal constitutional question in state court was "particularly problematic" because the Mississippi Constitution contains its own Excessive Fines Clause. 21

It is interesting to note the Court's promotion of legislative and lower judicial development that is found in Banker's Life. 22 The Court indicates that an early review of the federal constitutional claims might chill more appropriate action in the individual jurisdictions. 23 For example, legislatures might enact laws dealing specifically with punitive damages in insurance company bad-faith refusal-to-pay cases, as has been done by states in other areas such as the fraudulent filing of mechanics' liens, 24 malicious harassment, 25 and credit consumer denial. 26 Further, lower courts would be able to decide the question of federal law in the first instance, and the Court would "gain the benefit of a well-developed record and a reasoned opinion on the merits." 27

The record and reasoned opinion that developed prior to the 1989 decision in Kelco indicated that punitive damages would be held beyond the scope of the Eighth Amendment. 28 This is because almost every court that has addressed this question, with the exception of the Georgia Supreme Court, as will be discussed,
begins its analysis of the excessive fines issue with an examination of *Ingraham v. Wright.*

This 1977 Florida case involved the corporal punishment of public school students. Parents of students who had been paddled in school as punishment for misbehavior brought a civil action against school authorities. They alleged, among other things, that the paddling was in violation of the children's right against cruel and unusual punishment guaranteed by the Eighth Amendment of the Constitution. In *Ingraham,* the Court held Eighth Amendment provisions — specifically the cruel and unusual punishment clause — not applicable outside the criminal process.

The Court noted in *Ingraham* that the Eighth Amendment traditionally has been limited to the criminal area. Tracing the history of the clause to what it views as its English antecedents, the Court found the clause to have been taken from a provision of the Virginia Declaration of Rights of 1776, which itself had been adopted from the English Bill of Rights of 1689. The Court found the ultimate source of the Eighth Amendment was either Parliament’s reaction to the “Bloody Assize” in 1685 or to the perjury prosecution of Titus Oates in the same year. In either case, the Court concluded that “the exclusive concern of the English version was the conduct of judges in enforcing the criminal law.”

The Court decided that in light of the provision’s legal history, it was “not surprising to find that every decision of this Court considering whether a punishment is ‘cruel and unusual’ within the meaning of the Eighth and Fourteenth Amendments has dealt with a criminal punishment.” Further, in broad language the court said that “[i]n the few cases where the Court has had occasion to confront claims that impositions outside the criminal process constituted cruel and unusual punishment, it has had no difficulty finding the Eighth Amendment inapplicable.”

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30. *Id.* at 653.
31. *Id.* at 667-68.
32. *Id.*
33. *Id.* at 664.
34. *Id.*
35. *Id.* at 665.
36. *Id.* at 666.
37. *Id.* at 667-68.
amples, the court cited *Fong Yue Ting v. United States* 38 (Eighth Amendment not applicable to deportation of aliens because deportation is not punishment for a crime) and *Uphaus v. Wyman* 39 (Eighth Amendment not applicable to civil contempt order because such order is essentially a civil remedy designed for the benefit of other parties exercised to secure compliance with judicial decrees).

For the most part, lower courts that considered the Excessive Fines Clause of the Eighth Amendment in the context of punitive damages prior to *Kelco* relied on the *Ingraham* holding and denied the applicability of the clause in civil lawsuits. 40 The Court of Appeals of Texas dispensed with the Eighth Amendment argument in *Underwriters Life Ins. Co. v. Cobb* 41 in one brief paragraph. “[T]he Eighth Amendment has traditionally been held to apply solely to the criminal process and not to matters out of the realm of punishment assessed for the conviction of crimes.... We hold the Eighth Amendment to the Federal Constitution not to apply to an award of exemplary damages.” 42 The Supreme Court of Alabama was equally succinct in *Industrial Chem. & Fiberglass Corp. v. Chandler*. 43

Wisconsin has a statutory setup that allows for a stronger argument in favor of Eighth Amendment protection for certain punitive damages, but it’s courts have ruled to the contrary. In that state, some punitive damages have been adjudged to be penal in nature, the law calling for a statutory multiplication of damages in certain circumstances. 44 It could be argued that the statutory imposition of punitive damages in jurisdictions with such statutory schemes gives the award an element of penal, or criminal quality. However, when the matter was put before a

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38. 149 U.S. 698 (1893).
42. *Id.* at 817.
43. 547 So. 2d 812 (1988). After quoting *Ingraham* at length, the court holds that punitive damages awarded in a civil proceeding are not subject to the constitutional restrictions of the Eighth Amendment, which applies to criminal proceedings only. *Id.* at 818.
44. See *John Mohr & Sons, Inc. v. Jahnke*, 55 Wis. 2d 402, 198 N.W.2d 363 (1972).
United States District Court in Wisconsin Truck Center v. Volvo White Truck Corp., the court held otherwise. Based on language in Cieslewicz v. Mutual Serv. Casualty Co., holding that multiple damages awards are not to be considered the equivalent of punitive damages “for all purposes and in all contexts,” the district court found the Eighth Amendment not to be applicable to a punitive damages award in a civil lawsuit. The court made a distinction between strictly penal actions and an overall non-penal action having penal overtones. The court clearly stated where it stood on the issue:

Although the award is designed to be in part a deterrent, like RICO and anti-trust awards, this penal aspect cannot transform this civil action into a criminal proceeding governed by the Eighth Amendment. No court has held the excessive fines clause applicable to such an award and this court will not be the first to do so.

The Ingraham holding that civil actions lie beyond the protection of the Eighth Amendment was cited by the U.S. Supreme Court in at least one other 1988 decision. In Spallone v. United States, officials of the City of Yonkers, N.Y., had been assessed penalties of $1 million per day for noncompliance with a civil contempt order. The officials appealed to the Supreme Court for a stay and included an argument under the Excessive Fines Clause. The Court recognized the constitutional question, quoting a phrase from Bankers Life & Casualty that “the Court has indicated that the applicability of this Clause to punitive damages in civil cases is ‘a question of some moment and difficulty.’” The Court again was able to avoid directly addressing the Excessive Fines Clause issue, without providing direction on the stand it would eventually adopt, as it found the question immaterial to the case at hand:

[Even if the Clause applies to punitive damages, the City offers no compelling reason why we should extend its reach to civil contempt sanctions. Indeed, it appears settled that the Cruel and
Unusual Punishment Clause does not apply to civil contempt sanctions.... This is not surprising since the Cruel and Unusual Punishment Clause, like the Excessive Fines Clause, applies to punishments for past conduct, while civil contempt sanctions are designed to secure future compliance with judicial decrees.\textsuperscript{53}

Prior to the decision in \textit{Kelco}, one state had decided contra to the trend and found punitive damages awards subject to the Excessive Fines Clause. In 1988, the Georgia Supreme Court performed its own analysis of the Eighth Amendment issue in \textit{Colonial Pipeline Co. v. Brown}.\textsuperscript{54} The court ruled that the Excessive Fines Clause of the Georgia Constitution\textsuperscript{55} does apply to punitive damages awarded in civil lawsuits. One of the reasons behind its decision was that "the Eighth Amendment Excessive Fines Clause of the United States Constitution was intended as a protection from all excessive monetary penalties."\textsuperscript{56} In \textit{Colonial Pipeline}, the plaintiff had been awarded $52,000 actual damages, $300 consequential damages, and $5 million in punitive damages.

The Georgia Supreme Court also began its analysis with \textit{Ingraham}, but then made an immediate and sharp turn from the traditional reasoning:\textsuperscript{57}

\textit{Ingraham} dealt only with the cruel and unusual punishment clause of the Eighth Amendment, it did not concern the Excessive Fines Clause. It cannot be viewed as excluding punitive damages from scrutiny under the Excessive Fines Clause of the Eighth Amendment.\textsuperscript{58}

The court in \textit{Colonial Pipeline} also found a different historic origin of the provision that has become the Eight Amendment’s Excessive Fines Clause. The court disagreed that this provision, as originally drafted, was limited to criminal cases.\textsuperscript{59} Instead, the origin is traced to a clause in the Magna Carta, drafted to protect individuals from abuses of the practice of “amercement.”\textsuperscript{60}

\textsuperscript{53} 109 S. Ct. at 18.
\textsuperscript{54} 258 Ga. 115, 365 S.E.2d 827 (1988).
\textsuperscript{55} GA. CONST., Art. I, § 1, para. XVII. (1983)
\textsuperscript{56} 258 Ga. at 120, 365 S.E.2d at 831.
\textsuperscript{57} Id. at 118, 365 S.E.2d at 829.
\textsuperscript{58} Id.
\textsuperscript{59} Id. at 119, 365 S.E.2d at 830 (citing Jeffries, \textit{A Comment on the Constitutionality of Punitive Damages}, 72 VA. L. REV. 139 (1986); Massey, \textit{The Excessive Fines Clause and Punitive Damages: Some Lessons from History}, 40 VAND. L. REV. 1233 (1987)).
\textsuperscript{60} Id.
fore, the protections of the clause were not necessarily limited to criminal actions in the development of the law.

Further, the Georgia court held that even if Ingraham did limit the United States Constitution’s Excessive Fines Clause to criminal cases, nothing prevented it from applying the state constitution’s own provision to the issue, “thereby affording greater protection under state law.”61 Of course, the holding in Kelco overturns this state court decision.

III. BROWNING-FERRIS INDUSTRIES v. KELCO DISPOSAL, INC.62

As noted by Justice Blackmun, who authored the majority opinion, the “weighty questions” of constitutional law posed in this case “arise from an unlikely source: the waste-disposal business in Burlington, Vt.”63 Kelco Disposal, Inc., sued Browning-Ferris Industries, Inc. (BFI), in federal district court alleging antitrust and business tort violations arising from BFI’s efforts to drive Kelco from the waste-disposal business in Burlington. The jury found for Kelco and awarded $51,146 in compensatory damages and $6 million in punitive damages. BFI appealed, asking that the punitive damages awarded be held in violation of the Eighth Amendment’s Excessive Fines Clause. The Court of Appeals for the Second Circuit affirmed the lower court’s decision,64 and BFI appealed to the United States Supreme Court.65

The opinion opens with the statement that the United States Supreme Court “has never held, or even intimated, that the Eighth Amendment serves as a check on the power of a jury to award damages in a civil case.”66 The Court then states its holding, that “on the basis of the history and purpose of the Eighth Amendment, . . . its Excessive Fines Clause does not apply to awards of punitive damages in cases between private parties.”67

Prior to turning to its interpretation of the history and scope of the Eighth’s Amendment’s Excessive Fines Clause, the Court

61. Id.
63. Id. at 2912.
66. Kelco, 109 S. Ct. at 2912
67. Id.
defines the parameters of this decision. The holding is not a blanket statement that the Excessive Fines Clause cannot be applied to punitive damages, but that there must be more active governmental participation in the prosecution of a case involving punitive damages before the Constitution’s Eighth Amendment protections can be invoked.

We need not go so far as to hold that the Excessive Fines Clause applies just to criminal cases. Whatever the outer confines of the Clause’s reach may be, we now decide only that it does not constrain an award of money damages in a civil suit when the government neither has prosecuted the action nor has any right to receive a share of the damages awarded.68

In framing its decision, the Court first looked for the drafters’ original intent behind the Eighth Amendment, and particularly the Excessive Fines Clause. The Court found that the term "fines" was not specifically debated at the time, and decided it "significant that at the time of the drafting and ratification of the Amendment, the word ‘fine’ was understood to mean a payment to a sovereign as punishment for some offense."69 The Court’s analysis of the intent behind the Eighth Amendment leaves no room for applying the Excessive Fines Clause to civil punitive damages, holding instead that the provision had nothing to do with civil matters. “Simply put, the primary focus of the Eighth Amendment was the potential for governmental abuse of its ‘prosecutorial’ powers, not concern with the extent or purposes of civil damages.”70

The Court adopts the history of the Excessive Fines Clause as stated in Ingraham.71 that the clause was taken from the Virginia Declaration of Rights, which in turn has its basis in the English version adopted after the accession of William and Mary with the intention of curbing the excesses of English judges under the reign of James II.72

In short, nothing in English history suggests that the Excessive Fines Clause of the 1689 Bill of Rights, the direct ancestor of our Eighth Amendment, was intended to apply to damages awarded

68. Id. at 2914.
69. Id. at 2915.
70. Id.
71. Ingraham, 430 U.S. at 664-66.
in disputes between private parties. Instead, the history of the Eighth Amendment convinces us that the Excessive Fines Clause was intended to limit only those fines directly imposed by, and payable to, the government. 73

The defendants had briefed the argument that the history of the Excessive Fines Clause is older than that adopted by Ingraham and “derives from limitations in English law on monetary penalties exacted in private civil cases to punish and deter misconduct.” 74 In support of this argument, the defendants relied upon English history prior to Magna Carta and the use and abuse of “amercements.” The defendant argued that amercements were essentially civil damages, “and the limits Magna Carta placed on the use of amercements were the forerunners of the 1689 Bill of Rights' prohibition on excessive fines.” 75 By this interpretation of the provision's development, the English Bill of Rights and the Eighth Amendment must reach beyond criminal actions, because Magna Carta did. Punitive damages are analogized as a modern-day version of 13th-century amercements. 76

While the Court found this argument “somewhat intriguing,” 77 it rejected it, hesitating “to place great emphasis on the particulars of 13th century English practice, particularly when the interpretation ... appears to conflict with the lessons of more recent history.” 78 Further, the Court disagreed that amercements and modern-day punitive damages awards share a common origin:

Amercements were payments to the Crown, and were required of individuals who were 'in the King's mercy,' because of some act offensive to the Crown. Those acts ranged from what we today would consider minor criminal offenses ... to 'civil' wrongs against the King.... Amercements were an 'all-purpose' royal penalty.... Petitioners, and some commentators, find in this history a basis for concluding that the Excessive Fines Clause operates to limit the ability of a civil jury to award punitive damages. We do not agree. Whatever uncertainties surround the use of amercements prior to Magna Carta, the compact signed at Runnymede was aimed at putting limits on the power of the King ... whether that

73. Id.
74. Id.
75. Id. at 2916-17.
76. Id. at 2917.
77. Id.
78. Id.
power be exercised for purposes of oppressing political opponents, for raising revenue in unfair ways, or for any other improper use. These concerns are clearly inapposite in a case where a private party receives exemplary damages from another party, and the government has no share in the recovery.\textsuperscript{79}

The Court recognizes in its opinion that law is not static and that Eighth Amendment jurisprudence has not been inflexible.\textsuperscript{80} However, the Court clearly opposes the idea that the Excessive Fines Clause should be extended to civil punitive damages:

[E]ven if we were prepared to extend the scope of the Excessive Fines Clause beyond the context where the Framers clearly intended it to apply, we would not be persuaded to do so with respect to cases of punitive damages awarded in private civil cases, because they are too far afield from the concerns that animate the Eighth Amendment. We think it clear ... that the Eighth Amendment places limits on the steps a government may take against an individual, whether it be keeping him in prison, imposing excessive monetary sanctions, or using cruel and unusual punishments. The fact that punitive damages are imposed through the aegis of courts and serve to advance governmental interests is insufficient to support the step petitioners ask us to take. While we agree with petitioners that punitive damages advance the interests of punishment and deterrence, which are also among the interests advanced by the criminal law, we fail to see how this overlap requires us to apply the Excessive Fines Clause in a case between private parties.\textsuperscript{81}

The Court deferred a decision as to the Fourteenth Amendment Due Process Clause's applicability to punitive damages awards.\textsuperscript{82} The Court notes the parties' agreement that Due Process considerations impose some limit on punitive damages awarded by juries and reiterates that a jury award may not be upheld if it was the product of bias or passion or was reached in proceedings lacking the basic elements of fairness.\textsuperscript{83} However, the Court states it has never answered the precise question asked by defendant's brief: "whether due process acts as a check on undue jury discretion to award punitive damages in the absence of any

\textsuperscript{79} Id. at 2917-18 (emphasis added) (citation omitted).
\textsuperscript{80} Id. at 2919.
\textsuperscript{81} Id. at 2920.
\textsuperscript{82} Id. at 2921.
\textsuperscript{83} Id.
express statutory limit." The Court refused to consider this question, because of the failure of the defendant to raise the Due Process argument before either the district court or the court of appeals, or to specifically mention the issue in its petition for certiorari to the Supreme Court.

Justices Brennan and Marshall, writing in a concurring opinion, joined the majority holding "on the understanding that it leaves the door open for a holding that the Due Process Clause constrains the imposition of punitive damages in civil cases brought by private parties" and, as is discussed in the Analysis and Conclusion section, below, Justice O'Connor dissented to the majority opinion, joined by Justice Stevens.

IV. ANALYSIS AND CONCLUSION

The Georgia Supreme Court, in Colonial Pipeline and Justice O'Connor's dissent in Kelco make legal points regarding the desirability of applying the Excessive Fines Clause to civil punitive damages that the majority opinion seemingly disregards. The Georgia Supreme Court phrased the issue in this manner: "Punitive damages, although civil in nature, nonetheless serve the criminal law goal of deterrence rather than the traditional compensatory goal of civil law." This echoes the reasoning of Justice White, dissenting in Ingraham v. Wright: "The relevant inquiry is not whether the offense for which a punishment is inflicted has been labeled as criminal, but whether the purpose of the deprivation is among those ordinarily associated with punishment, such as retribution, rehabilitation, or deterrence." Therefore, a good case can be made that the appropriate approach to this issue would be to examine the purposes of punitive damages awards in order to assess the applicability of the Excessive Fines Clause.

In her dissent in Kelco, Justice O'Connor focuses on two issues: the historical development of the Eighth Amendment's Excessive Fines Clause.

84. Id.
85. Id.
86. Id. at 2923.
87. Id. at 2924.
88. 258 Ga. 115, 365 S.E.2d 827.
89. Id. at 118-19, 365 S.E.2d at 830.
90. Ingraham, 430 U.S. at 686-87 (White, J., dissenting).
Fines Clause and the current usage of the word "fine." Justice O'Connor notes with agreement several legal commentators who have traced the history of the clause and have adopted the theory regarding the historical use of amercements as early versions of punitive damages. "[A] chronological account of the Clause and its antecedents demonstrates that the Clause derives from limitations in English law on monetary penalties exacted in civil and criminal cases to punish and deter misconduct." Justice O'Connor also makes the sweeping statement that, "History aside, this Court's cases leave no doubt that punitive damages serve the same purposes — punishment and deterrence — as the criminal law, and that excessive punitive damages present precisely the evil of exorbitant monetary penalties that the Clause was designed to prevent."

Justice O'Connor's dissent makes the point that in current usage, "the word 'fine' comprehends a forfeiture or penalty recoverable in a civil action." This position is buttressed with a quotation from International Brotherhood of Electrical Workers v. Foust: "Punitive damages ... are private fines levied by civil juries...." Her dissent notes a number of recent cases recognizing the penal nature of punitive damages. Justice O'Connor then cites with approval the "Mendoza-Martinez factors" applicable to determining whether a sanction is penal in nature. These factors include: (1) whether it involves an affirmative disability; (2) whether it has historically been regarded as punishment; (3) whether it comes into play upon a finding of scienter; (4) whether its operation will promote retribution and deterrence; (5) whether the behavior to which it applies is already a crime;

92. Id. at 2931-32.
94. Kelco, 109 S. Ct. at 2926.
95. Id.
96. Id. at 2931-32 (quoting BLACK'S LAW DICTIONARY, 569 (5th ed. 1979)).
98. Kelco, 109 S. Ct. at 2932.
whether there is an alternative purpose for it; and (7) whether it is excessive in relation to the alternative purpose assigned.100

The dissent also disagrees with the majority opinion that the Excessive Fines Clause becomes relevant only when some governmental entity is seeking to reap the benefits of a monetary sanction. "A governmental entity can abuse its power by allowing civil juries to impose ruinous punitive damages as a way of furthering the purposes of its criminal law."101

By leaving civil punitive damages awards beyond the protection of the Constitution, the Court has left defendants subject to arbitrary and perhaps capricious action on the part of juries. Justice White's dissent in Ingraham makes the point that "[b]y holding that the Eighth Amendment protects only criminals, the majority adopts the view that one is entitled to the protections afforded by the Eighth Amendment only if he is punished for acts that are sufficiently opprobrious for society to make them 'criminal.' This is a curious holding..."102

Further, by not taking the constitutional opportunity for judicial review of punitive damages levied by juries in civil trials, the Court is inviting legislative action under the umbrella of tort reform, as has been done by various states. For example, the Alabama legislature has enacted a law limiting punitive damages to the amount of compensatory damages or $250,000, whichever is less.103 In Delaware, legislation has been proposed capping punitive damages at three times the amount of actual damages.104 Other jurisdictions have adopted, or have considered, such limiting measures. Such legislative action may prove inflexible in fashioning the appropriate award in individual cases. A constitutional review, under a court-mandated formula, of the "excessiveness" of any particular punitive damages award would be preferable.

A ruling applying the Eighth Amendment's Excessive Fines Clause in Kelco would have provided that individuals and businesses in the position of having disproportionate punitive dam-

101. Id. at 2932.
102. 430 U.S. at 691.
ages assessed against them be afforded the broad range of protection offered by the Constitution. The Court could then develop appropriate elements to ascertain an “excessive” punitive damages award. This would include the factors of retribution, rehabilitation, and deterrence — the traditional purposes of a punitive damages award — and also allow a reviewing court to look at a civil punitive damages award in terms of proportionality between award and offense, the financial worth of the defendant, and other factors.

The Supreme Court will, in a near-future term, have the opportunity to again pass on constitutional provisions in relation to punitive damages awards, this time in the form of a Fourteenth Amendment Due Process Clause question. As Justice O'Connor wrote in her dissent in *Kelco*: “Awards of punitive damages are skyrocketing.... The threat of such enormous awards has a detrimental effect on the research and development of new products.”

The uncertainty and unpredictability of jury-awarded punitive damages, unchecked by constitutional constraints, has an adverse effect on individuals and commerce. The dissenting opinion of Justices O'Connor and Stevens, and the concurring opinion of Justice Brennan, provide hope that the Supreme Court will give close consideration to placing punitive damages awards under Due Process Clause protection.

Nothing in the Court’s opinion [in *Kelco*] forecloses a due process challenge to awards of punitive damages or the method by which they are imposed, and I adhere to my comments in *Bankers Life & Casualty Co. v. Crenshaw* regarding the vagueness and procedural due process problems presented by juries given unbridled discretion to impose punitive damages.

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105. *Colonial Pipeline*, 258 Ga at 121, 365 S.E.2d at 831.

106. 109 S. Ct. 2924.

107. 108 S. Ct at 1654-56 (O'Conner, J., concurring in part).