LJN LAW JOURNAL NEWSLETTERS

The Insurance Coverage Law Bulletin™

Volume 2, Number 7 • August 2003

Aggregate Limits

Addressing Arguments Advanced by Policyholders in Asbestos Claims

By John C. Yang

Now entering its third decade, asbestos exposures threaten the financial stability of numerous commercial entities. Asbestos manufacturers, distributors and installers have been forced to declare bankruptcy because of these exposures. RAND Institute for Civil Justice, "Asbestos Litigation in the U.S.A.: A New Look at an Old Issue" (Aug. 2001). Even companies with only a peripheral connection to asbestos — *eg*, car manufacturers that used asbestos-lined brakes — have been sued. Asbestos claimants continue to aggressively pursue any entity that had any involvement with asbestos. Indeed, the backlog of asbestos suits in the federal and state courts doubled from about 100,000 in 1990 to 200,000 in 1999. Asbestos Compensation Act of 2000, H.R. Rep. No. 106-782, at 18 (2000). Quite simply, absent federal legislative relief, asbestos cases will continue to clog U.S. courts. Moreover, asbestos litigation has and will continue to bog down a large segment of the U.S. economy. Studies are now projecting that asbestos lawsuits will continue until at least 2030.

The costs associated with asbestos pose staggering exposures for their insurers as well. Many insurers have increased

continued on page 2

Use and Misuse of Insurance Experts

Surviving the Admissibility Challenge

By Stephen A. Klein

The use of expert testimony has dramatically increased over the past two decades, and insurance litigation has not been an exception. Experts have long been used in insurance cases to help the jury determine the facts surrounding the loss, such as in arson cases. But use of experts specializing in the field of insurance itself is becoming commonplace, as are challenges to the admissibility of their testimony.

The Touchstone of Admissibility: Will It Assist the Trier of Fact?

The rules of evidence in most jurisdictions, modeled after the federal rules, establish a fairly precise set of standards governing the scope and nature of allowable expert opinion testimony. Most states' versions of Rule 702, which establishes the fundamental standard for admissible expert testimony, provide something like the following:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

Thus, there are three elements of admissible expert testimony: 1) it must pertain to scientific, technical, or other specialized knowledge beyond the ken of the average juror; 2) it must assist the trier of fact; and 3) the expert must be appropriately qualified. But in the case of nonscientific testimony such as that relating to insurance, the test as a practical matter boils down to the fundamental question of whether the testimony will help the trier of fact sort through complex or specialized information, and whether the expert utilized some reasonable approach or methodology in reaching his or her conclusions. Given the broad latitude of trial courts to admit or reject nonscientific expert testimony as they see fit (the standard on appeal generally is an abuse of discretion), the most important task for the party sponsoring the insurance expert is to convince the court that the jury stands to benefit from hearing the testimony and that the testimony is more rigorous than the expert's *ipse dixit*.

continued on page 4

IN THIS ISSUE

Aggregate Limits

continued from page 1

reserves to respond to their potential asbestos liabilities. Several insurers — including Home Insurance Company, Reliance Insurance Company and Frontier Insurance Company — have been forced to declare insolvency because of such exposures. Nevertheless, policyholders are increasingly looking to their insurers to fund their asbestos-related liabilities.

Recently, policyholders have begun to pursue a novel argument in the attempt to shift the liability arising out of their use of asbestos-containing materials to their insurers. Specifically, many policies issued by insurers in the 1960s and 1970s included aggregate limits of liability for products hazards and completed operations, but did not include aggregate limits for other types of exposures. To avoid the application of aggregate policy limits, some policyholders seek to characterize asbestos-related claims against them as exposures that do not involve products/completed operations hazards. Most frequently, this argument is made when the policyholder is an asbestos installer or insulator.

Few courts have addressed this argument. The only decision that has squarely addressed this issue, however, recognized that asbestos insulators and installers cannot avoid straightforward policy terms in an effort to obtain limitless coverage. *In re Wallace & Gale Co.*, 275 B.R. 223 (Bankr. D. Md. 2002), *on appeal*, No. 02-2389 (4th Cir.). Rather, courts must give effect to the products/completed operations hazard and its applicable limits in any policy period after the policyholder's operations are completed. This article addresses that case law and some of the arguments that have been presented by policyholders and insurers on this issue.

The Language of General Liability Policies

Typically, claims involving a "products hazard" or "completed operations" are subject to limits for "each occurrence" and an aggregate limit. In contrast, claims that do not involve these exposures usually are subject to a limit for "each occurrence" but not aggregate limits. Accordingly, the classification of a claim as falling under the "products hazard" or the "completed operations" provisions is an important one.

Many of the policies issued in the 1960s and 1970s define "products hazard" as:

> "Products Hazard" includes bodily injury and property damage arising out of the named insured's products or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily injury or property damage occurs away from the premises owned by or rented to the named insured and after physical possession of such products has been relinquished to others.

The policies define "completed operations hazard" as:

> "Completed Operations Hazard" includes bodily injury and property damage arising out of operations or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily injury or property damage occurs after such operations have been completed or abandoned and occurs away from premises owned by or rented to the named insured. "Operations" include materials, parts or equipment furnished in connection therewith. Operations shall be deemed completed at the earliest of the following times:
> (1) when all operations to be performed by or on behalf of the named insured under the contract have been completed,

continued on page 6

John C. Yang is a partner in the litigation, insurance and appellate practices of the Washington, D.C. law firm of Wiley Rein & Fielding LLP (*www.wrf.com*) He has particular expertise in handling commercial, toxic tort and insurance law matters in appellate and trial court litigation. He can be contacted at *jyang@wrf.com*.

The Insurance Coverage Law Bulletin™

PUBLISHER ..... Marjorie A. Weiner
ASSOCIATE PUBLISHER ..... Sofia Pables
EDITOR-IN-CHIEF ..... Thomas O. Melvihill, Pringle, Quinn, Anzano, P.C., Morristown, NJ
MANAGING EDITOR ..... Julie Gromer
ART DIRECTOR ..... Claire C. O'Neill-Burke
GRAPHIC DESIGNER ..... Louis Bartella

The Insurance Coverage Law Bulletin™ (ISSN 1541-0773) is published by Law Journal Newsletters, a division of American Lawyer Media.
Telephone: (800) 999-1916 • Editorial e-mail: wendya@palawnet.com
Circulation e-mail: subs@palawnet.com

The Insurance Coverage Law Bulletin P0000-241
Periodicals Postage Pending at Philadelphia, PA
POSTMASTER: Send address changes to:
American Lawyer Media
1617 JFK Blvd., Suite 1750, Philadelphia, PA 19103
Annual Subscription: $249

Published by:
Law Journal Newsletters
1617 JFK Boulevard, Suite 1750, Philadelphia, Pa 19103

Unique Rules for Defending Surplus Carriers

By Ralph S. Hubbard III and Joseph P. Guichet

Part Two of a Two-Part Series

The first installment of this article, published in the July 2003 issue of ICLB, discussed the growth and regulation of the surplus lines industry.

In many respects, serving as coverage counsel for a surplus lines insurer is no different than representing any other admitted insurer. In either instance, the ultimate question that must be resolved is whether the facts of a particular case fall within the scope of coverage provided by the plain language of the applicable policy. However, just as surplus lines insurers are regulated differently than admitted insurers, many states also have different rules that apply to surplus lines insurers once they have been sued. The attorney representing a surplus lines insurer must be mindful of potential pitfalls (or at least obstacles) that are particular to representing the surplus lines insurer.

Perhaps the most significant distinction in the treatment of non-admitted insurers as compared to admitted insurers is the pre-answer bond requirement. Most states have passed statutes that require non-admitted insurers that have been named as defendants in a lawsuit to deposit security for the amount of their potential liability before they may file an Answer. Louisiana's statute, which is substantively similar to those of many other states, provides in relevant part as follows:

> Before any unauthorized insurer shall file or cause to be filed any pleading in any action, suit or proceeding instituted against it, such unauthorized insurer shall either (1) file with the clerk of the court in which such action, suit or proceeding is pending a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such action; or (2) procure a certificate of authority to transact the business of insurance in this state. La. Rev. Stat. Ann. §22:1255(A).

Such statutes appear to serve a dual purpose: they ensure both the state court's personal jurisdiction over, and the plaintiff's ability to recover against, insurers who may otherwise have no presence or assets in the state. But they also have a serious shortcoming. Most notably, in the event of a high-dollar claim, the posting of a bond to cover a potential judgment may amount to an impossible task for an insurer and may compel the entry of a default judgment against that insurer in spite of any valid defenses to the claim that it may possess. *See, e.g., Curiale v. Ardra Ins. Co., Ltd.*, 667 N.E.2d 313 (N.Y. 1996). Thus, an insurer could potentially be bankrupted by a claim for which it has no liability.

These pre-answer bond statutes clearly apply to rogue, unauthorized insurers who insure risks in states through neither the admitted or surplus lines market. However, because surplus lines insurers are technically "non-admitted" or "unauthorized" insurers, the question arises as to whether they too fall within the scope of, and must comply with, pre-answer bond statutes. At least a dozen states have expressly addressed the issue and have passed statutes excepting surplus lines insurers from pre-answer bond requirements. *See* Ala. Code §27-10-55 (Alabama); Ark. Code Ann. §23-65-204 (Arkansas); Colo. Rev. Stat. Ann. §10-3-1004(1)(b) (Colorado); 18 Del. C. §2106 (Delaware); F.S.A. §626.912 (Florida); Ga. Code Ann. §33-5-57 (Georgia); I.C. §41-1210 (Idaho); M.G.L.A. 175B §3A (Massachusetts); 24-A M.R.S.A. §2106 (Maine); MCA 33-1-614 (Montana); N.J.S.A. §17:51-3 (New Jersey); and W.S. 1977 §26-12-204 (Wyoming). On July 2, 2003, Louisiana became the latest state to pass such legislation to clarify its law. 2003 La. Act No. 994.

In those states that do not possess a specific exception for surplus lines insurers, the insurer possesses several arguments as to why pre-answer bond statutes should not be applied to surplus lines insurers. Specifically, the commonly stated purpose of these statutes — to establish personal jurisdiction over a company with no presence in the state — is rendered moot. By complying with the surplus lines laws discussed above and consenting to the oversight necessary to be included on states' approved surplus line insurers lists such as LESLI, insurers engage in more than sufficient minimum contacts with these states to subject themselves to personal jurisdiction. Moreover, the requirement imposed by states that surplus lines insurers maintain millions of dollars in surplus and capital also renders unnecessary the secondary purpose of pre-answer bond laws — ensuring that funds are available to cover the plaintiff's claims. The plain language of the state's statutes, like those in Louisiana, may also make this holding clear by distinguishing between surplus lines insurers and "non-admitted" or "unauthorized" insurers to which the pre-answer bond rule applies.

Another area in which surplus lines insurers may be subject to different rules than admitted insurers concerns service of process and delays for filing responsive pleadings. While admitted insurers may be

continued on page 8

Ralph S. Hubbard III is a partner and **Joseph P. Guichet** is a senior associate at Lugenbuhl, Wheaton, Peck, Rankin and Hubbard in New Orleans. Both attorneys specialize in insurance coverage litigation, with an emphasis on complex and environmental coverage litigation. Mr. Hubbard is a frequent lecturer in the areas of insurance law and environmental law and is a co-author of The Louisiana Environmental Handbook (Lawyers Cooperative Publishing).

Expert Testimony

continued from page 1

In applying the Supreme Court's interpretation of Rule 702 in *Daubert v. Merrel Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), to nontechnical expert testimony in a field of "specialized knowledge" like insurance, courts consider two questions: whether the testimony is (i) "relevant," *ie*, an appropriate "fit" with the issues of the case, and (ii) "reliable." *See Grinnell Mut. Reins. Co. v. Heritage Ins. Co.*, 2001 WL 902777 at *6 (D. Minn. Aug. 10, 2001) ("The objective ... is to ensure the reliability and relevancy of expert testimony."). These twin requirements apply to the field of insurance in a somewhat particularized way.

ASSISTING THE JURY: RELEVANCE

To be "relevant" under Rule 702, insurance expert testimony, first and foremost, must address a subject matter that can be characterized, convincingly, as "specialized knowledge." An examination of some of the subjects on which insurance expert testimony has been allowed is instructive.

Bad Faith. Many jurisdictions recognize that expert testimony is admissible in bad faith cases to provide factual evidence of industry custom, practice, and standards, which is probative of the standard of care owed by a reasonably prudent insurer. *See Groce v. Fidelity Gen. Ins. Co.*, 448 P.2d 554, 560 (Or. 1968) ("It can hardly be said that the average juror was ... well equipped ... to judge the good or bad faith of an insurer.") Indeed, expert testimony may be required in such cases to establish insurance industry standards. *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 788 N.E.2d 522, 536 (Mass. 2003) ("The standard of reasonable conduct for an insurer acting pursuant to its contractual obligation to defend any claim made against its insured is not a matter within the common knowledge of the ordinary lay person where that standard is not specifically set forth in the contract. Such a standard of care is analogous to the standard of care owed by other professionals to their clients and is elucidated by expert testimony.") Courts often permit the expert to go one step further and opine that the insurer's conduct in the case at hand met or fell short of such industry standards. *Rawlings v. Apodaca*, 726 P.2d 565, 574 (Ariz. 1986) (finding no error in allowing expert to testify about insurance industry custom and that the insurer breached such custom because "failure to comply may be relevant to the question of an insurer's alleged bad faith"); *cf.* Fed. R. Evid. 704 (opinion on ultimate issue not *per se* objectionable).

There certainly may be instances where the particular insurance industry custom, practice, or standard in question is a matter of common sense and not specialized knowledge. The Massachusetts high court acknowledged this possibility in *Herbert A. Sullivan, Inc.* 788 N.E.2d at 536 ("Only where professional negligence is so gross or obvious that jurors can rely on their common knowledge to recognize or infer negligence may the case be made without expert testimony."). For instance, a court may be reluctant to allow an expert to opine that an insurer violated industry standards by falsely reporting to its insured that it had opened an investigation into the claim. Lay jurors likely understand, based on common knowledge and experience, that insurers are not supposed to lie to their insureds, and expert testimony may not be necessary, *e.g., Weiss v. United Fire & Casualty Co.*, 541 N.W.2d 753 (Wis. 1995) (rejecting the need for expert testimony where the bad faith claim alleged incomplete and sloppy investigation, a matter within the average juror's knowledge, though admission of such evidence is unlikely to be reversible error.) But short of plain and obvious violations of nonspecialized duties, in most cases expert testimony regarding the insurer's compliance with industry custom, practice, and standards, will assist the jury.

Lost Policies. It is generally the insured's burden to establish the terms of lost or missing policies. In some cases, there is strong secondary evidence of what the policy terms were, such as binders or lists of form numbers. Piecing together the evidence into a coherent mosaic, which is what insurance archaeologists and policy reconstructionists do, has been recognized to be relevant testimony concerning a field of specialized knowledge that will assist the jury. *See Century Indem. Co. v. Aero-Motive Co.*, 254 F. Supp. 2d 670, 679 (W.D. Mich. 2003), (permitting testimony of policy reconstruction expert, though *Daubert* factors did not strictly apply, because that field of knowledge has gained general acceptance).

Policy Construction. Because insurance policies are standard-form contracts with specialized terms, there typically is an industry understanding or range of understandings as to the meaning of policy terms. *Playtex FP, Inc. v. Columbia Cas. Co.*, 622 A.2d 1074, 1076-77 (Del. Super. Ct. 1992). Many courts find that expert testimony explaining the industry's understanding of a policy term will assist the jury to determine whether the construction advocated by one side or the other is reasonable, which may bear on an insurer's bad faith, among other issues. *E.g., North River Ins. Co. v. Employers Reins. Corp.*, 197 F. Supp. 2d 972, 983 (S.D. Ohio 2002) (permitting expert to construe certificate of reinsurance to the extent it "constitutes a statement of fact concerning industry custom and practice"). *Cf. Iacobelli Constr., Inc. v. County of Monroe*, 32 F.3d 19, 25 (2d Cir. 1994) (finding expert affidavit to be competent summary judgment evidence where it "explained the approach by which reasonably prudent contractors would interpret the contract documents and enumerated the conclusions such reasonably prudent contractors would reach").

Expert testimony regarding policy construction often is attacked as irrelevant in that it amounts to the expert's opinion on a "legal conclusion" or merely tells the jury how to find. (Another common formulation of this attack is that the expert testimony "invades the province of the jury.") But this argument ignores the fact-bound nature of whether a policy construction is reasonable, which must be

continued on page 5

Stephen A. Klein is a partner with the Washington, D.C firm of Spriggs & Hollingsworth *(www.spriggs.com)*. Mr. Klein represents corporate policyholders seeking recovery for mass-product, asbestos, environmental, and employee dishonesty and other first-party exposures.

Expert Testimony

continued from page 4

assessed in the context of surrounding circumstances such as an industry-wide understanding of the meaning of a term and its application in context. *Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 682 P.2d 388, 398 (Ariz. 1984). So long as the testimony assists the jury by providing insight into a field of specialized knowledge beyond the jury's ken, the cry of "legal conclusion" alone no longer provides a proper basis for disallowing expert testimony, as Rule 704 especially confirms. *E.g., U.S.F.&G. v. Williams,* 676 F. Supp. 123, 126 (E.D. La. 1987) ("[T]he Court was seeking the testimony solely to determine what general understanding, if any, the insurance industry has as to the meaning of certain provisions in USF&G's policy. While resolution of this factual question affects the legal issues involved, the factual issue of industry custom is distinct from the legal issue of construction."). *Cf. North Am. Specialty Ins. Co. v. Myers*, 111 F.3d 1273 (6th Cir. 1997) (disallowing expert to construe policy terms that did not involve specialized or technical concepts beyond the jury's common experience).

Similarly, opponents of expert testimony may contend that any references to insurance statutes, standards, or other "legal obligations" impermissibly instruct the jury as to the law. But an expert's reference to a state's insurance code easily can be defended as providing the expert's basis for his or her opinions under Federal Rule of Evidence 703, which provides that the facts or data on which the expert relies need not be independently admissible so long as they are "of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject." Certainly, state insurance codes bear on proper insurance-industry practices, so an expert commits no transgression by relying on the law in explaining practice. *Peiffer v. State Farm Mut. Auto. Ins. Co.*, 940 P.2d 967, 970-71 (Colo. Ct. App. 1997) (admitting expert testimony that an insurer violated the Unfair Claims Settlement Practices Act as relevant to a bad faith claim).

ASSISTING THE JURY: RELIABILITY

The second element that determines whether expert testimony will help the jury is the reliability of the opinion. For nonscientific expert testimony, this question turns largely on whether (i) the expert is properly qualified, and (ii) whether the opinion is nonspeculative.

In order to be qualified, the insurance expert must have relevant training and experience. Insurance experts typically are members of the insurance industry, be they claims adjusters, underwriters, brokers, or state regulators. But the expert's experience must be tailored more narrowly than simply having general industry experience — courts will reject experts whose experience is too far afield. In *California Shoppers, Inc. v. Royal Globe Insurance Co.*, 221 Cal. Rptr. 171 (Cal. Ct. App. 1985), for instance, the court refused to find that a well-respected coverage lawyer was qualified to give expert testimony concerning insurance industry standards because he had never worked in the industry. Moreover, an expert who has spent her entire career with one insurance company may be vulnerable to the charge that her knowledge is limited to the particular procedures utilized by that company and not to *industry-wide* standards. *See, e.g., Sparks v. Republic Nat'l Life Ins. Co.*, 647 P.2d 1127, 1136-37 (Ariz. 1982) ("What other insurance companies would have done regarding payment of benefits under the circumstances of the present case would be irrelevant in view of the likelihood that each insurance company follows varying practices regarding the payment of doubtful claims.") However, this contention ignores the expert's ability to put the practices of her employer and the conduct of the insurer under scrutiny into the broader context of what constitutes good industry practice; that is, the expert is not limited to merely testifying that "this is what we did at Company X," but can state with authority that "we did it this way at Company X because that procedure represents a good insurance practice, for the following reasons ..."

The reliability requirement that expert opinions be nonspeculative is paid too little heed and, in fact, often is the real dynamic at work in cases where expert testimony is excluded as "invading the province of the jury" or "providing mere legal conclusions." For example, in *Alvarado v. Old Republic Insurance Co.*, 951 S.W.2d 254 (Tex. Ct. App. 1997), the court rejected the insured's expert testimony that an insurer committed bad faith, not because it stated a legal conclusion, but because the legal conclusion was unsupported. The court held that, "*In the absence of facts*, legal conclusions are inadequate to raise an issue of fact in response to a motion for summary judgment despite the affiant's qualifications.") *Id.* at 263 (emphasis added). Further underscoring the point, the court then *accepted* the insurer's expert testimony on the same subject, including the reasonableness of the policy interpretation, "because the factual basis of his expert opinion is clear." *Id.*

Similarly, in *Tapatio Springs Builders, Inc. v. Maryland Casualty Insurance Co.*, 82 F. Supp. 2d 633 (W.D. Tex. 1999), the court rejected the insurer's charge that the insured's expert testimony "set [ ] forth improper legal conclusions" and was "conclusory" where the expert based his testimony on (i) "twenty years of experience in the insurance industry" and (ii) "[the insurer's] own documents and his interpretation of them." *Id.* at 648-49. Also instructive is *North Star Mutual Insurance Co. v. Zurich Insurance Co.*, No. CIV.01-837 RLE, 2003 WL 21524543 (D. Minn. Apr. 22, 2003), in which the court rejected the testimony of an expert who failed to tie his opinions to any independent source of authority, such as industry codes or treatises. The court found unreliable testimony that merely amounts to "how one person who, admittedly, has been in the insurance industry for many years, views a series of communications between an insurance agent, and an insurance broker." *Id.* at *6.

In short, courts are far more amenable to expert testimony that touches upon an ultimate issue (Rule 704) if the testimony is well supported by a strong factual and experiential foundation.

continued on page 7

Aggregate Limits

continued from page 2

(2) when all operations to be performed by or on behalf of the named insured at the site of the operations have been completed, or

(3) when the portion of the work out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

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

These provisions are terms of coverage. *See Fibreboard Corp. v. Hartford Accident & Indem. Co.*, 20 Cal. Rptr. 2d 376 (Ct. App. 1993) (completed operations/products hazard clause was not "in the nature of an exclusion," by virtue of its aggregate limit, but rather was a term of coverage). It is black letter law that the policyholder has the burden of proving the existence of coverage. *See, e.g., New Castle County v. Hartford Accident & Indem. Co.*, 933 F.2d 1162, 1181 (3d Cir. 1991); *Rhone-Poulenc Basic Chems. Co. v. American Motorists Ins. Co.*, 616 A.2d 1192, 1198 (Del. 1992); *Miner v. Bray*, 513 N.E.2d 580, 582 (Ill. App. Ct. 1987); *John Hancock Mut. Life Ins. Co. v. Plummer*, 28 A.2d 856, 858 (Md. 1942); *Clark v. Hacker*, 76 N.W.2d 806 (Mich. 1956); *Munzer v. St. Paul Fire & Marine Ins. Co.*, 538 N.Y.S.2d 633, 636 (App. Div. 1989). Accordingly, the policyholder bears the burden of proving that its claims fall outside the scope of the completed operations/products hazard and are not subject to the aggregate limits applicable to them.

The policy language at issue clearly provides that injuries that occur after the policyholder's operations are complete are subject to an aggregate limit. Accordingly, a key question to be determined under each policy triggered in an asbestos claim is whether the policyholder was still undertaking operations at the time of the policy period. If the policyholder's operations were complete, then the claim would fall under the products/completed operations hazard.

Case Law and the Multiple Policies Trigger Theory

This issue has special importance when a court adopts a multiple trigger theory. Where there is a continuous injury that triggers multiple policies, courts are required to analyze the applicability of coverage anew under each policy. This is consistent with the plain language of the policy, the case law concerning continuous injury, the case law concerning the products/completed operations hazard, and fundamental principles of contract interpretation.

Most recently, a federal district court in Maryland addressed how to apply the terms of each policy to an asbestos claim against an installer where multiple policies were triggered over a period of years. Specifically, the court in *Wallace & Gale* held that any injury occurring after the policyholder completed its operations was subject to the completed operations hazard aggregate:

> [W]hatever injury — theoretical or real — is assumed to have occurred after [the policyholder's] operations were completed will always — by definition — be covered by the completed operations clause. The injury occurs after operations were completed. Nor does it matter whether an injury is viewed as occurring both upon initial exposure before operations are completed as well as thereafter. The portion of the injury extending beyond completion would still, by definition, occur post-operations and thus remain subject to the completed operations hazard aggregate limit. *Id.*

The court adopted a single, bright-line test for determining whether a claim fell under the products hazard provision of a particular policy:

> If a claimant's initial exposure occurred while [the policyholder] was still conducting operations, policies in effect at that time will not be subject to any aggregate limit. If, however, initial exposure is shown to have occurred after operations were concluded or if exposure that began during operations continued after operations were complete, then the aggregate limits of any policy that came into effect after operations were complete will apply. *Id.* at 241.

Other courts agree. In *Johnson v. Studyvin*, 828 F. Supp. 877 (D. Kan. 1993), which involved property damage arising from the policyholder's application of asbestos-containing ceiling texturing material, the court determined that the seven policies that were issued after the installation of the asbestos were triggered. Four of those seven policies contained exclusions for claims falling under the completed operations hazard. *Id.* at 884. The court concluded that those policies provided no coverage. Thus, rather than finding that all seven triggered policies provided coverage because injury first occurred during a policy that did not have an exclusion, the court concluded that it was appropriate to apply the products/completed operation hazard provision applicable to each individual policy at issue.

In sum, if "bodily injury" occurs after the policyholder has completed its operations, the products/completed operations hazard provision should apply regardless of the fact that "bodily injury" first occurred while the policyholder's operations were underway. This is consistent with any multiple trigger theory of liability, the policy language at issue, and the case law addressing bodily injury that is held to trigger multiple policies.

continued on page 8

CASE BRIEFS

Excess Insurer Not Obligated to Share in Defense Costs

In *Lexington Insurance Co. v. General Accident Insurance Co. of America*, ___ F.3d ___; 2003 WL 21782276 (1st Cir. 2003), the First Circuit considered the obligation of an excess liability insurer to contribute to the cost of defending an underlying insured. The insured was a law firm that placed a professional responsibility insurance contract with the primary insurer with a $10 million limit of liability and also placed coverage with excess insurers for liability exceeding the $10 million primary layer. The insured was later implicated in a securities fraud suit and the primary insurer paid $5.5 million toward defense costs. The primary insurer then demanded that the excess insurers share pro rata in these defense costs. While the primary insurer reached an accord with most of the excess insurers, it was unable to reach agreement with the first excess layer insurer.

The first excess insurer's contract provided that it would indemnify the insured "in accordance with the applicable insuring agreements, terms, conditions and exclusions of the Underlying Policy" except for "the obligation to ... defend and for costs and expenses incident to the same ... and any other provision inconsistent with" the excess contract. The court concluded that this language excused the excess insurer from any obligation to share in the underlying defense costs.

The court rejected several alternative positions proposed by the primary carrier. First, the primary carrier pointed to language in the primary insurance contract indicating that the primary carrier would only be responsible for the payment of "that proportion of claim expenses as the amount of damages paid by the [primary carrier] bears to the total amount of damages," suggesting that this language created a duty for the excess carriers to share in defense costs. However, the court concluded that the language in the excess contract disclaiming the obligation to pay defense costs was clear and that the clause in the primary insurance contract — which did "no more than disclaim any obligation on [the primary insurer's] part to pay more than its proportionate share of [the insured's] defense costs" — did not suggest an ambiguity in the excess wording.

The court also rejected the primary insurer's argument that the separate primary and excess insurance contracts must be read together as an integrated insurance program.

Finally, the court rejected the primary insurer's bid to impose an obligation based on the concept of "equitable contribution," which arises in some jurisdictions when "several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss ..."

Service of Suit Clause Trumps Arbitration Clause

In *Boghos v. Lloyd's of London*, 2003 LEXIS 980 (Cal. Ct. App. May 29, 2003, publication ordered June 30, 2003), a California Court of Appeal addressed whether an insured may arbitrate under a policy that contains a "binding arbitration" clause and a "service of suit" clause. The insured contended that certain underwriters at Lloyd's, London, had wrongfully refused to pay him disability benefits. He sued. In response, the underwriters contended that the policy required arbitration. The court disagreed. It noted that if the arbitration clause were enforced, it "would either render the service of suit clause surplusage or make it unlawful." The court observed that under the service of suit clause, the underwriters had agreed that, at the request of the insured, they would "submit to the jurisdiction of a court of competent jurisdiction within the United States." The court rejected the underwriters' argument that the service of suit clause should be construed to apply only to confirmation of arbitration awards based upon claims for failure to pay. The court also rejected the underwriters' argument that its view of the service of suit clause would mean that the arbitration clause would never apply. It reasoned that if the service of suit clause were "interpreted according to its plain terms, then it allows the insured to utilize the courts for claims involving the insurer's 'failure ... to pay any amount claimed to be due under the insurance. ... ' Other claims — not involving the insurer's failure to pay — would still be subject to the arbitration clause." The court also accepted the insured's argument that the arbitration clause was unconscionable because it required him to pay one-half of the costs of the arbitration. The court relied upon a line of cases recognizing that "arbitration costs can present significant barriers to vindication of statutory rights" and found that those cases would apply "where a disability claimant seeks to make the insurer pay disability benefits, and the insurer seeks to compel arbitration of those claims, and make the insured share the costs of arbitration." The court cited these cases for the proposition that an arbitration agreement "cannot generally require [the plaintiff] to bear any type of expense that [she] would not be required to [bear] if [she] were free to bring the action in court." Therefore, the court concluded that because the insured should not be forced to share in the cost of arbitration, the "Lloyd's arbitration clause, which requires that the parties split the costs, is unconscionable."

—❖—

Bryan Diederich of Ropes & Gray and **Kirk A. Pasich** of Pasich and Kornfeld contributed this month's case briefs.

Expert Testimony

continued from page 5

As evidentiary challenges to expert insurance testimony become a routine part of coverage litigation, insurers and insureds are well advised to understand how the fundamental principles underpinning Federal Rules of Evidence 702 through 705, as elucidated by *Daubert*, apply to nonscientific, nontechnical, fields of specialized knowledge like insurance, and to be guided by such principles in retaining insurance experts and crafting their testimony.

—❖—

Surplus Lines

continued from page 3

subject to service of process through multiple methods, many states allow service of process upon surplus lines insurers only by service upon that state's commissioner of insurance. *See, e.g.*, Colo. Rev. Stat. Ann. §10-5-114(2); Ga. Code Ann. §33-5-34(b); N.M. Stat. Ann. §59A-15-8. Many states also typically enlarge the number of days within which the surplus lines insurer must file responsive pleadings to any suit in which it has been named. In Louisiana, for example, a surplus lines insurer has 40 days to file responsive pleadings rather than the 15 provided to other corporate defendants such as admitted insurers. La. Rev. Stat. Ann. §1268.

The foregoing provide just a few examples of how surplus lines insurers may be subject to different procedural rules than admitted insurers. Depending upon the state in which the surplus lines insurer has been sued, other variations may exist. Coverage counsel representing a surplus lines insurer that has been sued should research the statutes of the applicable jurisdiction to evaluate whether its client has been served properly, when responsive pleadings are due, whether a pre-answer bond must be filed, and whether any other laws peculiar to surplus lines insurers are applicable to the claim. Without fully researching these issues, counsel should not proceed as if he or she were representing just any other admitted insurer.

—❖—

Aggregate Limits

continued from page 6

Policyholder Arguments Concerning the Continuous Nature of Asbestos Injuries

Policyholders also frequently argue that, when courts have held that asbestos injuries are continuous, they are likewise indivisible. Accordingly, policyholders contend that such injuries are incapable of simply being general liability claims under one policy and falling under the products/completed operations hazard under another. Through this argument, policyholders seek to categorize the claims as outside the products/completed operations hazard under all of the applicable policies, even though only a fraction of the bodily injury occurred while the policyholder was conducting its operations. The policyholders then argue that insurers are somehow "morphing" a claim to change it into one involving products/completed operations.

This argument fails to appreciate the relationship between the actual work done by the insulators and the trigger theories developed by courts. Typically, an insulator will complete its work within a short period of time — *eg*, one policy period. At the insistence of policyholders, courts have sometimes adopted a multiple trigger, whereby they conclude that a claimant suffers asbestos-related injuries not only during the first policy period, but for many years thereafter. Successive policies issued after the insulator has completed its work are then triggered.

The "morphing" arguments made by policyholders actually contradict their justification for a multiple trigger. Policyholders seek to recover under multiples policies on the basis that the injury occurs over multiple periods. At the same time, they seek to avoid the clear limits of coverage available under later policies by arguing that analysis of the injury should be frozen in time as one that takes place when operations are ongoing. If accepted, this argument would unjustly reward policyholders with unlimited coverage under each triggered policy, in spite of the fact that the policyholder had completed its operations by the time the subsequent policies were triggered and under those policies the aggregate limit for completed operations exposures should apply.

A policyholder cannot benefit from a multiple policy trigger without being subjected to the limitations on coverage that may appear in each applicable policy. To obtain a multiple trigger, the policyholder must argue that injury took place during successive policy periods. The logical corollary is that coverage for that injury must be analyzed independently under each triggered policy.

Conclusion

The products/completed operations hazard and the aggregate limits applicable to claims falling under them are important components of insurance policies and reflect limitations on which coverage is based. By seeking to evade the aggregate limits applicable to products/completed operations hazards, policyholders seek to make insurers' obligations for asbestos claims limitless. So far, courts have rejected the policyholders' arguments, but these theories will be tested in important cases in the upcoming months.

—❖—