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Case Summaries And Insights

Staying up to Date on Insurance Policy Law Is Critical. Here Are a Few Significant Insurance Cases Decided Recently.

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California Supreme Court Hands Policyholders Big Win by Adopting Vertical Exhaustion Rule

Montrose Chemical Corporation v. Superior Court of Los Angeles County (2020) 460 P.3d 1201 (Cal. 2020)

The California Supreme Court's recent decision in *Montrose Chemical Corp. v. Superior Court* has limited the ability of excess insurers to use their "other insurance" clauses to put off or avoid indemnifying their insureds. The case involves the application of the dueling insurance concepts of "horizontal exhaustion" and "vertical exhaustion" in long-tail insurance claims under primary and excess Commercial General Liability (CGL) policies – that is, claims involving continuous property damage or bodily injury occurring over several successive policy periods.

"Horizontal exhaustion" is the concept that, before a given excess carrier has any obligation to pay under its policy, all underlying insurance from *all* policy periods must be exhausted first. In contrast, "vertical exhaustion" is the competing concept that an excess insurer's obligations are triggered as soon as the limits of the underlying policies below the excess policy in the same tower have been exhausted, without regard to policies issued for other policy periods. In a win for policyholders, the court in *Montrose* adopted the vertical exhaustion rule and rejected the horizontal exhaustion rule for purposes of triggering excess CGL policies in the context of long-tail claims.

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Montrose was sued for environmental damages caused by its production of insecticide for a number of decades.

It sought to recoup its losses under certain excess CGL policies after having exhausted underlying policies covering the same policy period. Montrose's excess carriers pushed back, arguing that the "other insurance" provisions in their respective policies required the insured to exhaust the limits of all "other policies with lower attachment points from every policy period" in which the long-tail damage occurred before coverage under that excess policy incepted. *Id*. at 1206 (emphasis original).

The court determined that "the 'other insurance' clauses at issue clearly require exhaustion of underlying insurance, but none clearly or explicitly states that Montrose must exhaust insurance with lower attachment points purchased for *different policy periods*." *Id*. at 1210 (emphasis original). The court also held that "the policies are most naturally read to mean that Montrose may access its excess insurance whenever it has exhausted the other directly underlying excess insurance policies that were purchased for the same policy period." *Id*. at 1212-13. The court noted that, historically, "other insurance" clauses were designed to prevent multiple recoveries when more than one policy provided coverage for a loss, and not to "dictat[e] a particular exhaustion rule for policyholders seeking to access successive excess insurance policies in cases of long-tail injury." *Id*. at 1211.

This decision is a significant victory for policyholders seeking coverage of long-tail injury claims under California law. It permits many policyholders to use the principles of vertical exhaustion to target those insurance towers containing policies with the most favorable and consistent terms in an effort to streamline their litigation resources, or to concentrate on carriers that are more likely to settle. It also shifts the responsibility for allocating coverage for long-tail claims among excess policies issued over multiple policy periods from the policyholder to the insurers, by requiring excess insurers to indemnify the insured and sue other carriers on the risk for equitable contribution.

Ohio Supreme Court Rejects All Sums Approach When Damage, Though Spanning Multiple Years, Occurred at Discernible Times

Lubrizol Advanced Materials, Inc. v. National Union Fire Insurance Company of Pittsburgh, Pa., 2020 WL 1943212 (Ohio Apr. 23, 2020)

The Ohio Supreme Court recently attempted to further refine the state's law surrounding the question of how to allocate coverage for long-tail claims under successive CGL policies. In *Lubrizol Advanced Materials, Inc. v. National Union Fire Insurance Company of Pittsburgh, Pa.*, 2020 WL 1943212, the court addressed the following certified question from the Northern District of Ohio: "Whether an insured is permitted to seek full and complete indemnity, under a single policy providing coverage for 'those sums' that the insured becomes legally obligated to pay because of property damage that takes place during the policy period, when the property damage occurred over multiple policy periods." In a win for policyholders, it concluded that policies with "those sums" language – as with policies with "all sums" language – may be held liable for all damage taking place over time, even if outside the policy period. This clarifies a significant source of uncertainty for

many policyholders with “those sums” policies – but it comes with an important caveat.

Between 2001 and 2008, the insured, Lubrizol, sold resin to IPEX, Inc., who used it in the production of pipes that were sold to consumers in the U.S. and Canada. After facing numerous claims arising out of the failure of many of these pipes, IPEX sued Lubrizol for indemnification, alleging that the failures had been caused by allegedly unfit resin supplied by Lubrizol. Lubrizol eventually settled with IPEX and sued one of its CGL carriers, National Union, which had issued a policy in effect during one of the relevant years. Although other carriers were on the risk at other times during this period, coverage under their respective policies was not at issue in the coverage litigation.

Lubrizol argued that under Ohio law, “all of its triggered policies should be treated as establishing joint and several liability,” allowing Lubrizol to recover under the policy of its choice. Id. at *1 In other words, Lubrizol urged the court to adopt the “all sums” allocation method under which any policy on the risk at the time of the injury or damage should cover the entire loss up to policy limits, regardless of how many other policies offered coverage. Lubrizol bolstered its argument by pointing out that the court had adopted the “all sums” method in a 2002 decision involving an insured’s efforts to secure coverage for extensive environmental cleanup costs.

National Union argued that its policy and the nature of the damages at issue were distinct from the environmental cases, such that the “all sums” approach should not be adopted for its policy. First, the carrier pointed out that its policy only provided coverage for “those sums” – and not “all sums” –Lubrizol must pay for damage occurring during the policy period. On this basis, it advocated for application of the “pro rata” allocation method, which apportions coverage proportionally among all triggered policies. The court agreed with the policyholder on this argument, stating that it “refuse[d] to engage in a hypertechnical grammar analysis to determine whether the phrase ‘those sums’ is always more limited than ‘all sums’ and would always lead to a different allocation.” *Id*. at *3. At the same time, the court cautioned against using its decision as a blanket rule for all policies containing the “those sums” language, noting that the contract terms and underlying facts control. *Id*. at *1

Second, the carrier argued that an “all sums” approach – regardless of the specific terminology at issue – was unwarranted under the facts of that case. It argued that, unlike the environmental cases in which that approach had been applied, the underlying harm at issue in the matter before the court involved discrete episodes of pipe failures that could be segregated by policy periods, and not indivisible injury taking place over a period of time. On this decisive argument, the court sided with the insurer, noting that “it should be ascertainable . . . how much resin was sold to IPEX . . . when [the] plumbing was sold and installed, and when it failed.” *Id*. at *4 It determined that, in such circumstances, “the operative contract language is not the reference to policy coverage for ‘those sums’ but rather to injury or damage ‘that takes place during the Policy Period.’” *Id*.

This case presents a mixed bag for Ohio policyholders. On one hand, the court clarified that CGL policies with “those sums” language may be held to cover the entirety of harm under a long-tail claim – even harm that occurs outside the policy period. This greatly expands the application of the “all sums” approach to covering long-tail claims. On the other hand, this approach applies where the nature of the injury is indivisible, and not

comprised of discrete, readily discernable episodes of harm.

Ninth Circuit Distinguishes Between "Written Demand" and "Suit" and Holds "Claims First Made" Provision is Ambiguous

National Union Fire Insurance Company of Pittsburgh, Pa. v. Zillow, Inc., 802 Fed. Appx. 265 (9th Cir. 2020)

The distinguishing characteristic of a "claims-made" policy is that coverage applies only if a claim is deemed first made while the policy was in effect. Whether this requirement has been satisfied depends on what constitutes a "Claim," and when that "Claim" is deemed first made. Because the wording of claims-made policies vary considerably from one carrier to the next, there is no guarantee that one policy will operate the same way as another.

The Ninth Circuit was recently tasked with weighing in on a dispute over a very general, but important, policy clause. Online real estate database company Zillow's professional liability policy provided coverage for "Claims first made against an Insured during the Policy Period . . . " The policy defined "Claim" as either "(1) a written demand for money . . . or (2) a Suit." Prior to the policy period, Zillow received a demand letter from a third party for alleged copyright infringement. The third party subsequently filed suit against Zillow during the policy period. The carrier denied coverage on the grounds that the letter and the suit together comprised "a single Claim that was first made" prior to the policy period. The district court agreed with the carrier and dismissed Zillow's claims.

On appeal, Zillow emphasized that a "Claim" could be considered a written demand or a suit, and the third-party action against Zillow fit the definition of "Suit" under the policy. It argued that because the "Suit" was initiated during the policy period, it constituted a "Claim" first made during the policy period – even if the demand letter also may have been a "Claim" in a prior policy period. In response, the carrier argued that the "Claims first made" provision implicitly required that the demand letter and the suit be treated as a single "Claim" since they were based on the same wrongful conduct. Because that wrongful conduct was "first" raised in a demand letter outside the policy period, the carrier argued that coverage was barred.

The Ninth Circuit held that Zillow's interpretation of the policy as separately covering different types of "Claims" was reasonable, 802 Fed. Appx 265 at 266. The court observed that the insurer easily could have drafted the policy to require that factually similar claims be integrated under the policy's coverage provision but did not do so. See Id. It also noted that other provisions in Zillow's policy, such as an exclusion for claims arising out of "wrongful acts" that had been alleged in a claim reported in a prior policy period, underscored that the insurer did not intend for factually similar claims to be integrated. See *Id*. at 267. The court found that the exclusion would be rendered meaningless "because any Claim involving the same Wrongful Act as that alleged in an earlier Claim made under a prior policy would already fall outside of the Policy's coverage." *Id*.

At the same time, the court also concluded that the carrier's interpretation was reasonable, saying, the policy's use of the phrase "Claims first made" may suggest that the lawsuit against Zillow "might be the reassertion of a prior unreported Claim." *Id*. Ignoring this possibility would render the inclusion

of the word “first” superfluous, which is contrary to general contract interpretation principles. See *Id*.

In light of the two reasonable meanings that could be attributed to the “Claims first made” provision, the court held that the provision was ambiguous and remanded the case for further proceedings. See *Id*. It noted, however, that, if any ambiguity still remained after reviewing the extrinsic evidence, such ambiguity should be resolved in Zillow’s favor. See *Id*.

This case amply demonstrates that there is no uniform industry approach to what constitutes a “Claim” first made under a claims-made policy. This variation carries significant implications. Claims-made policies generally also require that a claim be reported to the carrier during the policy period in which it is deemed first made, or within a specific period of time thereafter. Courts generally strictly enforce these reporting provisions – reporting a claim even a day late may defeat the policyholder’s right to coverage under the policy. Accordingly, satisfying critical reporting conditions under a policy requires a solid understanding of what is a claim and when it is deemed made under the policy. Policyholders should carefully review their policies with coverage counsel to better understand how they are structured, and to ensure that their risk managers implement claims-reporting procedures consistent with policy requirements.

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