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The “Non-Cumulation Clause”: An “Other Insurance” Clause by Another Name

Christopher C. French*

I. INTRODUCTION

Imagine a corporate policyholder that is facing tens of millions or even hundreds of millions of dollars in liabilities for events and injuries that occurred years, if not decades, in the past. These liabilities threaten the very financial solvency and future of the company. Imagine further that, although the policyholder has dozens of insurers and insurance policies to cover the liabilities, none of its insurers agrees to pay anything. Instead, in addition to a litany of defenses that the policyholder is forced to defeat through years of litigation, at the end of that long fight each insurer contends that it nonetheless should have no liability because insurers other than itself should pay instead. Now, imagine being the judge who must decide which of the dozens of insurers should pay and how much each one should pay. The scenario described above is not fictional. It is a scenario that plays out regularly in the world of insurance coverage litigation regarding long-tail liability claims.

One of the most factually and legally complex issues courts are asked to resolve in insurance coverage disputes that involve long-tail claims such as asbestos bodily injury claims and environmental claims, which have damage processes that span multiple policy years, is how the liabilities associated with the claims should be allocated among the numerous policy years that often are triggered by such losses. The courts’ resolution of this critical issue may shift responsibility for millions or tens of millions of dollars of liabilities from one party to another.

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Because insurance companies are in the business of making money—that is, their goal is to pay out less money in claims payments and costs of doing business than they receive in premiums and investment income—they continuously are looking for ways to minimize or eliminate their obligations to pay long-tail claims even after it has been determined that their policies have been triggered by a loss. To that end, certain insurers have turned to a provision often found in commercial general liability (CGL) policies—the “Prior Insurance and Non-Cumulation of Liability Clause,” referred to herein simply as the “non-cumulation clause”—as a linguistic vehicle they attempt to use to minimize or eliminate their payment obligations after a court or jury has determined that their policies have been triggered by a loss.

The non-cumulation clause commonly found in historical London market umbrella liability policies, for example, states as follows:

It is agreed that if any loss covered hereunder is also covered in whole or in part under any other excess policy issued to the Assured prior to the inception date hereof the limit of liability hereon . . . shall be reduced by any amounts due to the Assured on account of such loss under such prior insurance.

In essence, the insurers’ argument is that the non-cumulation clause shifts the responsibility for paying for losses that trigger multiple policy years to any and all triggered insurance policies that were issued prior to their own policy year. Thus, even after it has been determined that the loss triggers their policy year, these insurers point to the non-cumulation clause and then attempt to reduce, or completely eliminate, their payment obligations on the grounds that all of the liabilities associated with the loss should be reallocated to only policy years that predate their own (invariably another insurer’s policy year). Under the insurers’ argument, if the policies in the earlier triggered policy years have unpaid limits, then the limits of those policies should pay until their limits are exhausted. If the limits of the policies in the earlier triggered policy years have been exhausted by settlements or prior payments of unrelated claims, then, according to these insurers, the policyholder becomes self-insured for the remaining amount of the loss—that is, the policyholder receives nothing from the insurers, even though the policyholder paid a

premium for the policies, the policies have been triggered, and the policies’ limits have not been exhausted.

This Article explains that non-cumulation clauses were never intended to apply to long-tail claims in the manner certain insurers now contend they should. When the clauses were first drafted, the original drafters of the clauses did not intend for the clauses to apply to long-tail claims—like asbestos bodily injury and environmental property damage—because such claims were not even recognized as such, and the allocation schemes developed to address such claims had not yet been adopted by the courts.

Indeed, non-cumulation clauses such as the London version quoted above are hopelessly ambiguous when applied to long-tail claims. This ambiguity is revealed when one attempts to apply the clause literally to long-tail claims by considering questions such as the following: How does one determine whether a loss is “covered” under a prior-incepting policy when the prior-incepting policy has not been included in the case because of settlements, exhaustion, or some other reason? Must the issuer of the prior-incepting policy admit, which is unlikely, that its policy “covers” the loss? How can amounts be “due” from insurers from which the policyholder is not even seeking to recover? To whom would the amount be “due” in such circumstances? Is an adjudication required regarding the responsibilities of the prior-incepting policies before amounts are “due” from them? Would such a result even be legally binding on insurers that issued the prior-incepting policies if they are not parties in the case? These are just a few of the questions that reveal the ambiguity of non-cumulation clauses when they are applied to long-tail claims.

This ambiguity is further highlighted by the fact that the courts that have attempted to apply such clauses cannot agree on the clauses’ meaning or application. Stated differently, it is hornbook insurance law that a non-cumulation clause must be “unambiguous”—have only one reasonable meaning—when applied to long-tail claims before the insurer’s argument seeking to defeat coverage can be accepted. Yet, if the numerous courts that have considered such clauses—including the courts that have held such clauses are “unambiguous”—cannot even agree on the meaning and application of such clauses, how can such clauses be “unambiguous”?

In addition to this introduction and a conclusion, this Article examines the interpretation and application of non-cumulation clauses with respect to long-tail claims in four parts. Part II sets forth the factual background necessary to discuss the issue, which includes the typical
structure of commercial insurance programs, the nature of long-tail claims, the various trigger and allocation schemes that have been adopted by the courts, and the history of the drafting of one of the most common versions of the clause—the London version. Part III examines the courts’ inconsistent interpretations and applications of non-cumulation clauses. Part IV discusses the principles of insurance policy interpretation—such as the doctrines of \textit{contra proferentem} and “reasonable expectations”—and how such principles apply to the interpretation and application of non-cumulation clauses to long-tail claims. Finally, Part V suggests the proper interpretation and application of non-cumulation clauses in the context of long-tail claims. This Article concludes that non-cumulation clauses, using the London version as an example, are ambiguous when applied to long-tail claims. Consequently, courts should construe the clauses in favor of the policyholder such that the policyholder can and should recover the full amount of its covered liabilities to the extent the triggered policies’ limits are sufficient. Because non-cumulation clauses purport to shift liability for a loss from one insurer to another insurer, they essentially are variations of “other insurance” clauses. Thus, after the policyholder has been paid in full for its covered liabilities, the non-cumulation clause should apply, if at all, in contribution claims between insurers to determine their respective obligations in the same manner as “other insurance” clauses.

II. THE FACTUAL AND LEGAL BACKGROUND IN WHICH NON-CUMULATION CLAUSES ARE INTERPRETED AND APPLIED

A. Typical Insurance Programs

Historically, many commercial policyholders have purchased “occurrence”-based liability insurance annually to ensure that they have seamless coverage for losses that span multiple policy periods. Such programs typically have multiple layers of coverage with primary insurance at the lowest level and excess insurance above the primary insurance, with the total limits of insurance in each policy year increasing as time moves forward. The policy language in all of the policies in the various policy years often is the same or similar because commercial liability insurance policies are drafted by the insurance

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2. See infra Figure 1.
industry and used by most insurers. A graphic depiction of a typical insurance program of a commercial policyholder appears in Figure 1.

Figure 1: Typical Insurance Program of a Commercial Policyholder

Under the hypothetical insurance program reflected in Figure 1, if a covered liability in the amount of $18 million triggered only the 1984 policy year, then Insurer H would pay the first $5 million, Insurer D would pay the next $5 million, Insurer E would pay the next $5 million, and Insurer F would pay the final $3 million. In long-tail claims where a covered liability implicates multiple years and layers of coverage, the determination of each insurer’s liability is more complex. For example, assume that a covered loss totals $30 million and it has been determined that the damage process giving rise to the liability began in 1980 and ended in 1986. What is Insurer E’s coverage obligation? As one might suspect, answering that question is a more difficult task.

Policy Period

Under the hypothetical insurance program reflected in Figure 1, if a covered liability in the amount of $18 million triggered only the 1984 policy year, then Insurer H would pay the first $5 million, Insurer D would pay the next $5 million, Insurer E would pay the next $5 million, and Insurer F would pay the final $3 million. In long-tail claims where a covered liability implicates multiple years and layers of coverage, the determination of each insurer’s liability is more complex. For example, assume that a covered loss totals $30 million and it has been determined that the damage process giving rise to the liability began in 1980 and ended in 1986. What is Insurer E’s coverage obligation? As one might suspect, answering that question is a more difficult task.

3. See, e.g., Holmes’ Appleman on Insurance § 129.1 (2d ed. 2010) (noting that the “insurance industry voluntarily set about to standardize CGL insurance contract language”); Nancy Ballard & Peter M. Manus, Clearing Muddy Waters: Anatomy of the Comprehensive General Liability Pollution Exclusion, 75 Cornell L. Rev. 610, 622–23 (1990) (noting that in the 1940s, “the National Bureau of Casualty Underwriters (‘NBCU’), consisting of employee-representatives of stock insurance companies, and the Mutual Insurance Rating Bureau (‘MIRB’), consisting of employee-representatives of mutual insurance companies,” jointly drafted the basic provisions of the CGL policy to be used on an industry-wide basis).
B. Typical Long-Tail Claims: Asbestos Bodily Injury and Environmental Property Damage

Asbestos bodily injury and environmental property damage claims are typical long-tail claims. Asbestos was used in numerous products—from gloves to insulation—because of its heat-retardant qualities. Consequently, an individual’s exposure to asbestos historically may have occurred in numerous places over the course of many years. Once asbestos fibers enter an individual’s lungs, a progressive disease process can begin that progresses over many years and ultimately can result in deadly diseases such as mesothelioma and lung cancer.

4. Jeffrey W. Stempel, Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute, 12 CONN. INS. L.J. 349, 375 (2006) (“Because injury continues to be inflicted anew by asbestos fibers in the lungs, consecutive liability policies are triggered.”). For a detailed discussion of insurance and asbestos liability, see, for example, id.

5. See BellSouth Telecomms., Inc. v. W.R. Grace & Co.-Conn., 77 F.3d 603, 606 (2d Cir. 1996) (“Asbestos is a flame-retardant and heat-resistant fibrous mineral that was commonly used in fireproofing in buildings, ships, and protective fireproof garments at least as early as the nineteenth century.”); Johns-Manville Corp. v. United States, 855 F.2d 1571, 1571 (Fed. Cir. 1988) (per curiam) (“Due to the heat resistant and fire retardant properties of asbestos it was used in insulating ships’ boilers, steam pipes, pumps, and other equipment.”); Borel v. Fibreboard Paper Prods. Corp., 493 F.2d 1076, 1083 n.3 (5th Cir. 1973) (“[Asbestos] was used as an insulator against heat as early as 1866, and asbestos cement was introduced about 1870.”); STEPHEN G. CARROLL, ET AL., RAND INST. FOR CIVIL JUSTICE, ASBESTOS LITIGATION 11 (2005) (noting the wide use of asbestos because the product is “strong, durable, and has excellent fire-retardant capability”), available at http://www.rand.org/content/dam/rand/pubs/monographs/2005/RAND_MG162.pdf.

6. See CARROLL ET AL., supra note 5, at 11–12.

7. See, e.g., Norfolk & W. Ry. Co. v. Ayers, 538 U.S. 135, 168 (2003) (Kennedy, J., concurring in part and dissenting in part) (“Cancers caused by asbestos have long periods of latency. Their symptoms do not become manifest for decades after exposure.”); Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1198 (2d Cir. 1995) (“[T]here is a period of time prior to the point at which asbestosis and pleural plaques are clinically diagnosable when the condition is evolving cumulatively or incrementally. This period when the asbestosis or pleural plaques develop undetected is the latency period, which is normally 15 years and may be as long as 40 years. The latency period begins at the time of initial exposure to asbestos and ends with the onset of symptoms and diagnosis. From the time of exposure, asbestos fibers are readily inhaled into the lungs and can immediately injure the cells by causing inflammation and scarring. The disease process for a person who develops asbestosis begins within days of initial exposure to asbestos and continues for decades. How far this disease process progresses depends upon the quantity of asbestos inhaled and deposited in the lungs.”); Borel, 493 F.2d at 1083 (noting the progressive nature of asbestos-related diseases following asbestos exposure); Pack v. Artuz, 348 F. Supp. 2d 63, 79 (S.D.N.Y. 2004) (“Exposure to friable asbestos poses a significant health risk because airborne particles or fibers can become lodged in a person’s lungs and in his respiratory tract. Over time this can lead to asbestosis, a nonmalignant scarring of the lungs that causes extreme shortness of breath and often death; lung cancer; gastrointestinal cancer; and mesothelioma, a cancer of the lung lining or abdomen lining that develops as long as thirty years after the first exposure to asbestos and that, once developed, invariably and rapidly causes death.” (citing Env'tl. Encapsulating Corp. v. City of New York, 855 F.2d 48, 50 (2d Cir. 1988))).
Similarly, a typical environmental property damage claim arises as follows: a policyholder operated a manufacturing plant for decades that resulted in the release of contaminants at and around the plant site itself or in waste sites such as landfills. Once the contaminants entered the soil or groundwater, they continuously spread through the soil and groundwater over many years until they were discovered and remediated. The policyholder then faces liability to a governmental entity or a private party for the cleanup of the contaminated property.

Thus, two key questions face policyholders, liability insurers, and courts when determining insurers’ coverage responsibility for these types of long-tail claims. One, which policy years are implicated or “triggered” by the covered loss? Two, how much of the covered loss should each insurer whose policy has been triggered pay?

C. Trigger of Coverage

Courts’ answer to the first question—which policy year or years are triggered by the liability—has varied from jurisdiction to jurisdiction. Some courts hold that coverage is triggered continuously throughout the entire time period from exposure to manifestation. Other courts have determined the trigger-of-coverage issue by ascertaining the time of actual damage or injury-in-fact. In some jurisdictions . . . the issue appears undecided, at least as a general rule.” (citations omitted)). For a general discussion of coverage triggers in various claim situations, see, for example, Kenneth S. Abraham, Essay, The Rise and Fall of Commercial Liability Insurance, 87 VA. L. REV. 85, 95–96 (2001) (noting the advent of long-tail coverage); Mark W. Dykes, Occurrences, Accidents, and Expectations: A Primer of These (and Some Other) Insurance-Law Concepts, 2003 UTAH L. REV. 831, 838–40 (2003) (discussing policy language and claims used to trigger coverage); James M. Fischer, Insurance Coverage for Mass Exposure Tort Claims: The Debate over the Appropriate Trigger Rule, 45 DRAKE L. REV. 625 (1997) (describing triggers in mass tort litigation claims); Jamie A. Grodsky, Genomics and Toxic Torts: Dismantling the Risk–Injury Divide, 59 STAN. L. REV. 1671, 1700–01 (2007) (distinguishing “exposure,” “injury-in-fact,” and “exposure in residence” triggers for progressive diseases); Jeffrey W. Stempel, The Insurance Policy as Social Instrument and Social Institution, 51 WM. & MARY L. REV. 1489, 1563–69 (2010) (discussing asbestos cases and application of the continuous trigger); Nicolas R. Andrea, Comment, Exposure, Manifestation of Loss, Injury-in-Fact, Continuous Trigger: The Insurance Coverage
Some courts have adopted an “exposure” trigger, which means those insurers whose policies provided coverage at the time of exposure are triggered. Other courts have adopted an “injury in fact” trigger, which means the liability policies on the risk when the injury actually occurs are triggered. Other courts have adopted a “manifestation” trigger,


11. See, e.g., Gulf Chem. & Metallurgical Corp. v. Associated Metals & Minerals Corp., 1 F.3d 365, 372 (5th Cir. 1993) (apportioning cost of policyholder’s defense among insurers on risk and finding that the policyholder must bear its share of defense costs determined by fraction of time it lacked coverage); Cont’l Ins. Cos. v. Ne. Phar. & Chem. Co., Inc., 811 F.2d 1180, 1189 (8th Cir. 1987) (“Environmental damage occurs at the moment that hazardous wastes are improperly released into the environment[,] and the liability policy in effect at the time this damage is caused provides coverage.”) (footnote omitted), aff’d in part, 842 F.2d 977 (8th Cir. 1988) (en banc); Cletmetal, Inc. v. Se. Fid. Ins. Co., 807 F.2d 1271, 1276 (5th Cir. 1987) (finding that tissue damage takes place upon initial inhalation of asbestos); Hancock Labs., Inc. v. Admiral Ins. Co., 777 F.2d 520, 524 (9th Cir. 1985) (“[T]he California Supreme Court would adopt the exposure theory to determine when bodily injury occurs.”); Commercial Union Ins. Co. v. Sepco Corp., 765 F.2d 1543, 1546 (11th Cir. 1985) (endorsing exposure theory where “it is impossible practically to determine the point at which the fibers actually imbed themselves in the victim’s lungs”); Dacre v. Exec. Officers of Halter Marine, Inc., 752 F.2d 976, 992 (5th Cir. 1985) (applying exposure theory to insurance coverage for asbestosis); TBB, Inc. v. Commercial Union Ins. Co., 806 F. Supp. 1444, 1452–53 (N.D. Cal. 1990) (applying exposure trigger theory where each release of the hazardous substance triggered the policy); B.F. Goodrich Co. v. Am. Motorists Ins. Co., No. C84-1224A, 1986 WL 191786, at *12 (N.D. Ohio May 22, 1986) (“The trigger of coverage is the exposure which causes personal injury regardless of the time of the injury.”); Burroughs Wellcome Co. v. Commercial Union Ins. Co., 632 F. Supp. 1213, 1222 (S.D.N.Y. 1986) (holding that insurance duty to defend triggered at ingestion of harmful substance from which such claims arise); Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 451 F. Supp. 1230, 1239 (E.D. Mich. 1978) (“[E]ach insurer on the risk when a currently deceased plaintiff was allegedly exposed is obligated to acknowledge coverage and to provide a defense and possibly indemnification.”), aff’d, 635 F.2d 1212 (6th Cir. 1980), clarified, 657 F.2d 814 (6th Cir. 1981); Cole v. Celotex Corp., 599 So. 2d 1058, 1076–77 (La. 1992) (applying exposure trigger).

which means the policies on the risk when the injury or disease manifests—that is, when a medical diagnosis is made or adverse health symptoms first appear—are triggered.\textsuperscript{13} Finally, other courts have adopted a “continuous” trigger, which means all of the policyholder’s liability policies on the risk from the time of initial exposure until the injury or disease manifests are triggered.\textsuperscript{14}


D. Allocation

Similarly, courts’ answers to the second question—the amount of liability paid by each triggered policy—also has varied by jurisdiction. Because long-tail claims may trigger numerous policies, some courts, relying upon the “all sums” language in commercial general liability policies that provides that the insurer agrees to pay “all sums” for which the policyholder is liable, have held that the policyholder can select which of the triggered policy years will cover the liability subject only to the limits of coverage provided by the policies selected. Other jurisdictions have adopted pro rata allocation, which essentially divides the liability equally among the policy years triggered. Finally, New

502, 507 (Pa. 1993) (concluding that the policies of each insurer that was on the risk during the development of an asbestosis-related disease are triggered); Wis. Elec. Power Co. v. Cal. Union Ins. Co., 419 N.W.2d 255, 258–59 (Wis. Ct. App. 1987) (finding that the occurrence was active and continuing during the terms of the policies).

15. In “manifestation” trigger jurisdictions, the allocation issue is straightforward because only a single policy year is triggered by each claim. Thus, the loss does not need to be allocated among multiple triggered policy years. For a discussion of insurance allocation law generally, see Jeffrey W. Stempel, Domtar Baby: Misplaced Notions of Equitable Apportionment Create a Thicket of Potential Unfairness for Insurance Policyholders, 25 WM. MITCHELL L. REV. 769, 807–23 (1999). For a discussion of allocation issues in the context of environmental-coverage cases, see Christopher R. Hermann et al., The Unanswered Question of Environmental Insurance Allocation in Oregon Law, 39 WILLAMETTE L. REV. 1131 (2003); Thomas M. Jones & Jon D. Hurwitz, An Introduction to Insurance Allocation Issues in Multiple-Trigger Cases, 10 VILL. ENVTL. L.J. 25 (1999).

16. See, e.g., AC&S, 764 F.2d at 974 (“[T]here is no proration of losses under a policy once coverage is triggered.”); Keene Corp., 667 F.2d at 1050 (policyholder may “collect from any insurer whose coverage is triggered, the full amount of indemnity that it is due, subject only to the provisions in the policies that govern the allocation of liability when more than one policy covers an injury”); New Castle, 725 F. Supp. at 817 n.28 (finding insufficient evidence for proration); Reading Co. v. Travelers Indem. Co., No. 87-2021, 1988 WL 13242, at *3 (E.D. Pa. Feb. 18, 1988) (holding each insurer jointly and severally liable for the injuries that occurred during its policy period); Hercules, Inc. v. AIU Ins. Co., 784 A.2d 481, 491 (Del. 2001) (finding “all sums” language in policy to be inconsistent with pro rata allocation); Owens-Ill., 597 F. Supp. at 1524 (holding that once triggered, policy provided coverage without any proration); Owens-Corning Fiberglas Corp. v. Am. Centennial Ins. Co., 660 N.E.2d 770, 788 (Ohio Com. Pl. 1995) (noting that under “continuous injury trigger of coverage,” bodily injury occurs from the first exposure to asbestos and ends with diagnosis; and any policy in force may be triggered); J.H. France, 626 A.2d at 506–07 (finding each insurer that issued a CGL policy to manufacturer of asbestos-containing products liable for entire loss subject to policy limits); Am. Nat. Fire Ins. Co. v. B & L Trucking & Constr. Co., 951 P.2d 250, 254 (Wash. 1998) (en banc) (holding that all insurers on risk during time of ongoing damage have joint and several obligation to provide coverage of all damages, regardless of amount that occurred during their policy period).

17. See, e.g., Soc’y of the Roman Catholic Church of the Diocese of Lafayette & Lake Charles, Inc. v. Interstate Fire & Cas. Co., 26 F.3d 1359, 1367–68 (5th Cir. 1994) (dividing liability for damages based on each insurer’s share of coverage); Commercial Union Ins. Co. v. Sepco Corp., 765 F.2d 1543, 1544 (11th Cir. 1985) (requiring all insurers that provided coverage to asbestos manufacturer during periods of exposure to participate in defense and settlement on prorated basis); Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1225 (6th Cir. 1980) (holding
Jersey applies a variation of pro rata allocation that divides the liability among the triggered insurance policies based upon the percentage amount of the limits of each policy issued in relation to all of the insurance triggered by the claim.18

E. Non-Cumulation Clauses

1. The Wording of Non-Cumulation Clauses

Adding to the complexity of the analysis are non-cumulation clauses, which often were included in historical liability policies. One common version of the non-cumulation clause, which is used in London umbrella liability policies, contains the following language:

\[
\text{It is agreed that if any loss covered hereunder is also covered in whole or in part under any other excess policy issued to the Assured prior to the inception date hereof the limit of liability hereon . . . shall be reduced by any amounts due to the Assured on account of such loss under such prior insurance.}^{19}
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In a typical liability-insurance program, many of the policies issued in the program may contain a non-cumulation clause with this language or similar language.20

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18. Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d 1116, 1124 (N.J. 1998) (allocating coverage among multiple liability insurers in proportion to the degree of the risks transferred or retained during the years of exposure); see Owens-Ill., 650 A.2d at 995 ("When progressive indivisible injury or damage results from exposure to injurious conditions for which civil liability may be imposed, courts may reasonably treat the progressive injury or damage as an occurrence within each of the years of a CGL policy.").


2. The Drafting of the London Version of the Non-Cumulation Clause

The London market version of the non-cumulation clause was first drafted in 1960 by the underwriters at Lloyd’s of London in connection with the development of a new umbrella liability form known as the “LRD 60” form.21 The LRD 60 form was named after the initials of the principal draftsman, Leslie R. Dew, who was then the chief underwriter for the Merrett Syndicate at Lloyd’s of London.22 Dew was assisted in the drafting of the LRD 60 form by the then-senior underwriter in the Merrett Syndicate, Henry S. Weavers.23

When the LRD 60 form was originally drafted in 1960, it contained two paragraphs worded as follows:

C. PRIOR INSURANCE AND NON CUMULATION OF LIABILITY

It is agreed that if any loss covered hereunder is also covered in whole or in part under any other policy issued to the Assured prior to the inception date hereof the limit of liability hereon as stated in item 2 of the Declarations shall be reduced by any amounts due to the Assured on account of such loss under such prior policy insurance.

Subject to the foregoing paragraph and to all the other terms and conditions of this policy in the event that personal injury or property damage arising out of an occurrence covered hereunder is continuing at the time of termination of this policy Underwriters will continue to protect the Assured for liability in respect of such personal injury or property damage without payment of additional premium.24

22. *Id.*
23. *Id.*
According to at least one London underwriter, the drafters included the non-cumulation clause in the new LRD 60 policy form to prevent a policyholder from obtaining a double recovery on a coverage claim only in the limited circumstance that the policy using the LRD 60 form covered the claim and a prior-incepting policy using a different form also covered the same claim. The reason for this was that the LRD 60 form, which was an “occurrence”-based form, significantly changed the standard “accident”-based Price Forbes umbrella liability form that previously had been used by insurers in the London market. For example, in a situation in which an insured manufactured defective machinery in 1958 that resulted in an injury in 1961, a claim could trigger both a Price Forbes form policy issued in 1958—when the “accident” of the defective manufacture arguably took place—and a 1961 policy using the LRD 60 form—when the injury arguably “occurred.” The drafters designed the non-cumulation clause to thwart the policyholder’s attempt at obtaining twice as much coverage as the amount of the liability by pursuing coverage under both policies for the same liability.

Significantly, at the time the non-cumulation clause was drafted in 1960, the drafters did not contemplate the later developments in insurance law that occurred in the United States. Specifically, concepts such as continuous trigger, in which a single claim can trigger multiple, consecutive policies, and “all sums” allocations, which allows the policyholder to “pick and choose” which policy year would provide coverage for the liability, were unknown and undeveloped in 1960. Thus, the drafters did not design or intend the non-cumulation clause to apply in the modern-day coverage schemes of continuous trigger and “all sums” coverage responsibility that now exists under state law in jurisdictions such as California, Delaware, Illinois, Indiana.

26. See Wilson Deposition I, supra note 21, at 98–100.
27. Wilson Deposition I, supra note 21, at 158. See also Wilson Deposition II, supra note 25, at 65–72.
29. Id.
Massachusetts, Ohio, Pennsylvania, Texas, Washington, and Wisconsin. Rather, the drafters designed and intended the clause to prevent a policyholder from obtaining a double recovery in very narrow circumstances.

From 1960 until 1970, insurers in the London market used the non-cumulation clause in umbrella primary and excess liability policies issued to North American policyholders. In 1971, insurers in the London market modified the LRD 60 policy form for use in North America, and they designated the modified policy form as the “Umbrella Policy London 1971” form, or the “London ‘71 umbrella form.” The London ‘71 umbrella form was prepared by three underwriters in the London market: Peter Wilson, Cliff Richies, and John Byrd.

The London ‘71 umbrella form incorporated the first paragraph of the non-cumulation clause in the LRD 60 form. The London ‘71 umbrella form omitted the second paragraph of the non-cumulation clause from the LRD 60 form because the drafters believed the second paragraph to be redundant of other language in the policy. Since 1971, London market insurers have issued countless policies using the London ‘71 umbrella form for North American excess liability policies.

As admitted by one of the drafters of the London ‘71 umbrella form, the “all sums” allocation scheme—under which the policyholder gets to select the policy year or years that will provide coverage among multiple consecutive policy years that are all liable for a loss—still had not been adopted in 1971 when the non-cumulation clause was modified for the London ‘71 umbrella form. Thus, as was the case with the LRD 60 version of the non-cumulation clause, the drafters of the 1971 version

40. See Wilson Deposition I, supra note 21, at 78 (stating that the LRD 60 form was introduced for umbrella business in May of 1960).
41. See id. at 64, 85, 87–88.
42. Id. at 64.
43. Id. at 84–85.
44. Id. at 85–86.
45. See id. at 98–100.
also did not intend for the non-cumulation clause to apply in “all sums” allocation jurisdictions.

The non-cumulation clause, as originally drafted in 1960 by insurers in the London market for the LRD 60 form and then modified in the London ‘71 umbrella form, was used for many years in London umbrella liability policies that were sold to U.S. companies. Many U.S. insurers also issued liability policies in excess of London umbrella policies that “followed-form”—that is, incorporated by reference the policy language of London umbrella liability policies—or issued policies with their own versions of a non-cumulation clause.

III. THE COURTS’ INCONSISTENT INTERPRETATIONS AND APPLICATIONS OF NON-CUMULATION CLAUSES

In jurisdictions where the courts have interpreted non-cumulation clauses, numerous courts have rejected interpretations of such clauses that would reduce or eliminate the policyholder’s recovery. Yet, the

46. Id. at 87–88.

courts’ reasoning and rationales for doing so have varied widely in these jurisdictions.

A. Courts in Pro Rata Jurisdictions

In pro rata jurisdictions, some courts have held that the application of non-cumulation clauses, as requested by certain insurers, would conflict with pro rata allocation.\(^48\) In short, these courts have reasoned that the insurer’s liability already has been reduced because the insurer is only being required to pay a portion of the policyholder’s loss.\(^49\) Thus, it would be inconsistent with such an allocation scheme to further reduce the insurer’s liability by giving the insurer an additional “credit” for amounts paid by other insurers.\(^50\)

B. Courts in “All Sums” Jurisdictions

Similarly, numerous courts in “all sums” jurisdictions have held that a non-cumulation clause should not be construed in a way that eliminates or reduces the policyholder’s recovery, but, as discussed below, their reasons for doing so have varied.\(^51\)

\(^48\). See Emp’rs Ins. Wausau, 1995 WL 870851, at *21–22 (adopting pro rata allocation and finding that competing other insurance and prior insurance clauses must be resolved in accordance with the terms of the policies); Outboard Marine, 670 N.E.2d at 750 (finding that application of non-cumulation clause “would be inequitable because no excess insurer is concurrently liable with any other”); Spaulding Composites Co. v. Aetna Cas. & Sur. Co., 819 A.2d 410, 422 (N.J. 2003) (“Once the court turns to pro rata allocation, it makes sense that the non-cumulation clause, which would allow the insurer to avoid its fair share of responsibility, drops out of the policy.”); Westinghouse Elec. Corp. v. Am. Home Assurance Co., No. A-6706-01T5, A-6720-03T5, 2004 WL 1878764, at *21 (N.J. Super. Ct. Law Div. July 8, 2004) (per curiam) (holding non-cumulation clauses to be inapplicable because the amounts do not become due until the insured selects the policy year to indemnify it).

\(^49\). See cases cited supra note 48.

\(^50\). See cases cited supra note 48.

1. There Are No Amounts “Due” Under Prior Policies if the Policyholder Does Not Pursue Coverage Under the Prior Policies

Some insurers premise their arguments regarding the application of non-cumulation clauses on the notion that if a policyholder’s liabilities span multiple policy periods, then there must be an “amount due” under prior insurance.\(^{52}\) This premise is fundamentally incorrect in an “all sums” jurisdiction where the policyholder has selected a single policy year to provide coverage for the liability. Under an ordinary dictionary definition, the word “due” means the amount “owed or owing as a debt.”\(^{53}\) There is no amount “owed” to the policyholder by prior insurance when the policyholder does not present a claim to the prior insurers. Indeed, in “all sums” jurisdictions, the policyholder may choose the policy year for which the insurer is obligated to pay—and thus “owe”—to the policyholder the full amount of the loss subject to policy limits in the chosen policy year. The policyholder has this right even if the policyholder also could have sought to recover the same amount from insurers in other policy years.

The decision in *Westinghouse Electric Corp. v. American Home Assurance Co.* is particularly instructive on this issue. In *Westinghouse*, in applying Pennsylvania’s “all sums” allocation rule, the court held that a non-cumulation clause was inapplicable to bodily injury claims that spanned multiple policy periods because the policyholder elected to recover for its losses under only one policy year.\(^{54}\) Therefore, the court concluded, “there are no ‘amounts due’ under any prior issued excess policies.”\(^{55}\) Critical to the court’s holding were the facts that (1) under “all sums” allocation, the policyholder’s coverage is “spiked” in a single year and (2) although other “policies are theoretically liable, the amounts do not become due until the insured selects the policy year to indemnify it.”\(^{56}\) Thus, because the policyholder in *Westinghouse* selected a single policy year to provide coverage, the non-cumulation clause did not apply.

\(^{52}\) See *Westinghouse*, 2004 WL 1878764, at *11.


\(^{54}\) *Westinghouse*, 2004 WL 1878764, at *21.

\(^{55}\) *Id.*

\(^{56}\) *Id.*
2. Application of the Non-Cumulation Clause as Requested by Insurers Would Allow the Insurers to “Escape” Liability

Some courts have found non-cumulation clauses to be unenforceable because, as interpreted by the insurers, they were similar to “other insurance” clauses that allowed the insurers to “escape” liability for a loss to the detriment of the policyholders. Some courts have found non-cumulation clauses to be unenforceable because, as interpreted by the insurers, they were similar to “other insurance” clauses that allowed the insurers to “escape” liability for a loss to the detriment of the policyholders. Where all triggered policies in all triggered years have provisions which purport to deflect coverage responsibility to another year, courts have concluded that these provisions cancel out each other. Thus, such courts have not allowed the clauses to defeat recovery by the policyholder.

As recognized by courts in “all sums” jurisdictions, the ability of the policyholder to select which policy year initially will respond to the loss would be illusory if clauses in those policies that purport to shift liability to another insurer were permitted to operate to the detriment of the policyholder.

57. See cases cited supra note 48.


59. See cases cited supra note 58.

60. See, e.g., Koppers Co. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3d Cir. 1996) (finding that under “all sums” allocation, an “other insurance” clause does not prohibit the policyholder from selecting the policy to respond, but rather permits an insurer to seek contribution from other insurers); Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1050 (D.C. Cir. 1981) (holding that “other insurance” does not diminish the primary duty of the insurer whose coverage is triggered to indemnify the policyholder in full); Aerojet-Gen. Corp. v. Transport Indemn. Co., 948 P.2d 900, 927–33 (Cal. 1997) (holding that “other insurance” clauses were without effect under “all sums” scheme); Owens-Corning Fiberglas Corp. v. Am. Centennial Ins. Co., 660 N.E.2d 770, 794–95 (Ohio Ct. of Common Pleas, Cuyahoga County 1995).
C. Some Courts Have Applied Non-Cumulation Clauses to Reduce, but Not Eliminate, the Insurer’s Payment Obligations

Some courts have applied non-cumulation clauses to reduce policy limits where the long-tail liabilities were covered under multiple policy years.\footnote{61} Such courts typically have done so where a single insurer issues policies in multiple years, and the court determines that the insurer should not have to pay for the same loss multiple times.\footnote{62} For example, in *Treesdale*, the non-cumulation clause at issue read as follows:

If the same occurrence gives rise to personal injury, property damage or advertising injury or damage which occurs partly before and partly within any annual period of this policy, each occurrence limit and the applicable aggregate limit or limits of the policy shall be reduced by the amount of each payment made by the company with respect to each occurrence, either under a previous policy or policies of which this policy is a replacement, or under this policy with respect to previous

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annual periods thereof.\footnote{Treesdale, 418 F.3d at 339 (emphasis added); see also Greene, Tweed & Co. v. Hartford Accident & Indem. Co., Civil Action No. 03-3637, 2006 WL 1050110, at *17 (E.D. Pa. Apr. 21, 2006) (distinguishing Treesdale because it dealt with a clause “that appear[ed] in multiple policies issued by the same insurer that cover[ed] the same loss”).}

The policyholder did not contend the clause was ambiguous.\footnote{Treesdale, 418 F.3d at 344.} Consequently, in applying the clause, the court decided that the insurer should only be required to pay for the loss under one of the policies it issued.\footnote{Id. at 345.}

Courts have shown a greater willingness to interpret the version of the non-cumulation clause at issue in the \textit{Treesdale} case to the detriment of the policyholder because, in several ways, the language at issue in that case was narrowly tailored and had a much smaller scope than the typical non-cumulation clause language. Moreover, the non-cumulation clause language in \textit{Treesdale} was clearly triggered by prior payment rather than by the amorphous phrase “any amounts due to the Assured” found in the London market version of the non-cumulation clause language.\footnote{Compare id. at 339 (“[T]he limits of the policy shall be reduced by the amount of each payment . . . .” (emphasis added)), with Stonewall Ins. Co. v. E.I. du Pont de Nemours & Co., 996 A.2d 1254, 1259 (Del. 2010) (“[The policy limits] shall be reduced by any amounts due to the Assured on account of such loss under such prior insurance.” (emphasis added)); see supra Part II.C.2.}

Further, rather than purporting to effectuate an automatic reduction in policy limits whenever any prior excess policy of any other insurer may owe obligations to the policyholder—as some insurers contend the clause should operate\footnote{See E.I. du Pont de Nemours, 996 A.2d at 1259 (describing insurer’s contention that the non-cumulation clause unambiguously operated to reduce insurer’s liability).}—the language found in such cases only reduced a policy’s limits when the “company,” that is, the same insurer, made payments under one of its own prior policies.\footnote{See, e.g., Treesdale, 418 F.3d at 339 (“[T]he limits of the policy shall be reduced by the amount of each payment made by the company . . . either under a previous policy or policies of which this policy is a replacement . . . .” (emphasis added)).} Thus, the non-cumulation clause at issue in cases such as \textit{Treesdale} does not purport to change the insurer’s coverage obligations by virtue of another insurer’s liability.

Tellingly, nearly all of the judicial decisions relied upon by insurers to support their coverage-reducing or coverage-eliminating interpretation of non-cumulation clauses contain policy language similar to, if not
exactly the same as, that at issue in the *Treesdale* case. Further, all of these cases involved one insurer that had issued successive policies that contained the same non-cumulation clause.

Essentially, these courts have held that the non-cumulation clauses were “valid so long as the insurer invoking the provision will be required to indemnify the insured pursuant to either the policy containing the provision or under other policies it issued to the insured.” Indeed, in such decisions, the insurer in whose favor a non-cumulation clause was interpreted had paid the policyholder the full limits of at least one of its policies.

IV. THE PRINCIPLES OF INSURANCE POLICY INTERPRETATION RELEVANT TO THE INTERPRETATION OF NON-CUMULATION CLAUSES

When courts interpret and apply policy language such as non-cumulation clauses, three well-established rules of policy interpretation emerge as particularly relevant to the analysis: (1) the doctrine of *contra proferentem*, (2) the doctrine of “reasonable expectations,” and (3) the construction of the policy as a whole.

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70. See cases cited supra note 69.


72. See, e.g., id. at *1.
A. The Doctrine of Contra Proferentem

It is hornbook insurance law that because insurers are the drafters of policy language such as non-cumulation clauses, the doctrine of *contra proferentem* applies, which means any ambiguities in the policy language should be construed against the insurers and in favor of coverage. The test under many states’ laws for determining whether

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policy language is ambiguous is whether the provisions at issue are reasonably or fairly susceptible to different interpretations or meanings.\(^{75}\)

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\(^{75}\) 13 \textit{APPLEMAN \& APPLEMAN, supra} note 74, § 7403 (noting that the insurer has the burden of establishing that insurer’s interpretation is the only fair interpretation of the contract); 4 \textit{LONG, supra} note 74, § 16.06. Ample case law supports this rule. \textit{See, e.g., New Castle, 243 F.3d at 750} ("The settled test for ambiguity is whether the provisions in controversy are reasonably or fairly susceptible of different interpretations or may have two or more different meanings."); \textit{New Castle Cnty. v. Nat’l Union Fire Ins. Co., 174 F.3d 338, 342–44 (3d Cir. 1999)}; \textit{W. Heritage Ins. Co. v. Magic Years Learning Ctrs. & Child Care, Inc., 432 A.2d 596, 599 (Pa. Super. Ct. 1981)} ("The very existence of two contrary schools of thought evidenced by the conflicting holdings in cases cited by both the Appellee and the Appellant is convincing in the conclusion that the clause in issue is ambiguous as to whether coverage is to be afforded under the fact situation presented. Such ambiguity, by itself, requires that we resolve the issue in favor of the Appellee, the insured driver."); Nat’l Union Fire Ins. Co. of Pittsburgh, Pa. v. Hudson Energy Co., 811 S.W.2d 552, 555 (Tex. 1991) ("If a contract of insurance is susceptible of more than one reasonable interpretation, we must resolve the uncertainty by adopting the construction that most favors the insured."); Garneau v. Curtis & Bedell, Inc., 610 A.2d 132, 134 (Vt. 1992) ("In determining whether the insurer has a duty to indemnify, any ambiguity in the insurance contract will be resolved in favor of the insured."); Murray v. W. Pac. Ins. Co., 472 P.2d 611, 615 (Wash. Ct. App. 1970) ("Exclusionary clauses in insurance policies are construed most strongly against the insurer.").
Where the controversy involves a phrase that insurance companies have failed to define and has generated many lawsuits with varying results, common sense dictates that the policy language must be ambiguous.\textsuperscript{76}

As discussed above, an ambiguous insurance policy provision is one that has more than one reasonable meaning. When one attempts to apply non-cumulation clauses to long-tail liability claims, it becomes apparent that the language in many non-cumulation clauses is riddled with ambiguities and unanswered questions regarding how it should apply.

To focus the discussion, consider again the language of the London version of the non-cumulation clause:

\begin{quote}
It is agreed that if any loss covered hereunder is also covered in whole or in part under any other excess policy issued to the Assured prior to the inception date hereof the limit of liability hereon . . . shall be reduced by any amounts due to the Assured on account of such loss under such prior insurance.\textsuperscript{77}
\end{quote}

\textsuperscript{76} See, e.g., \textit{New Castle Cnty.}, 243 F.3d at 755–56 (finding ambiguity where the contested phrase was not defined and had been interpreted differently by various courts); Sec. Ins. Co. of Hartford v. Investors Diversified Ltd., 407 So. 2d 314, 316 (Fla. Dist. Ct. App. 1981) (“The insurance company contends that the language is not ambiguous, but we cannot agree and offer as proof of that pudding the fact that the Supreme Court of California and the Fifth Circuit in New Orleans have arrived at opposite conclusions from a study of essentially the same language.”); \textit{Crawford}, 783 P.2d at 908 (“[T]he reported cases are in conflict, the trial judge and the Court of Appeals reached different conclusions and the justices of this court do not agree on the proper interpretation. Under such circumstances, the clause is, by definition, ambiguous and must be interpreted in favor of the insured.”); Allstate Ins. Co. v. Hartford Accident & Indem. Co., 311 S.W.2d 41, 47 (Mo. Ct. App. 1958) (“Since we assume that all courts adopt a reasonable construction, the conflict is of itself indicative that the word as so used is susceptible of at least two reasonable interpretations, one of which extends the coverage to the situation at hand.”); George H. Olmsted & Co. v. Metro. Life Ins. Co., 161 N.E. 276, 277–78 (Ohio 1928) (“[T]he fact that other jurisdictions have reached conflicting interpretations], coupled with the fact that the lower courts in the instant case are in disagreement . . . , presents [a] persuasive argument of the ambiguity of the clause . . . .”); Cohen, 432 A.2d at 599 (“The mere fact that [courts differ on the construction of the provision] itself creates the inescapable conclusion that the provision in issue is susceptible to more than one interpretation.”). See also 1 \textsc{Brook} \textit{et al.}, supra note 74, §§ 2.02[1], 5.8; 4 \textsc{Long}, supra note 74, § 16.06; Charles C. Marvel, Annotation, \textit{Division of Opinion Among Judges on Same Court or Among Other Courts or Jurisdictions Considering Same Question, as Evidence that Particular Clause of Insurance Policy is Ambiguous}, 4 A.L.R.4th 1253 (1981).

\textsuperscript{77} See \textit{Stonewall Ins. Co. v. E.I. du Pont de Nemours & Co.}, 996 A.2d 1254, 1259 (Del. 2010).
Even the basic part of the clause—“if any loss covered hereunder is also covered in whole or in part under any other excess policy issued to the Assured prior to the inception date hereof”—is unclear. How does one determine if a loss is “covered” under a prior-incepting policy? Must there be a court judgment stating as such? Though it is unlikely to happen, must there be an admission of coverage by the prior insurers? Need there be only an assertion of the prior insurer’s coverage responsibility by the subsequent insurer? In long-tail liability cases in “all sums” jurisdictions, the liabilities are covered by the policies in whatever year the policyholder has selected to cover them. Necessarily, therefore, these same liabilities are not “covered” by policies in prior years because the policyholder has not selected those prior policy years for coverage. Thus, the liabilities are not covered by both the policies in the selected year and the policies in the prior years.

Moreover, the clause states that “the limit of liability hereon . . . shall be reduced by any amounts due to the Assured on account of such loss under such prior insurance.” What constitutes an amount “due” under prior insurance? Is it an amount that a court adjudged was due? Is it an amount that the subsequent insurer alleges is due from the prior-year insurer? Is it an amount that the prior insurer acknowledges is due? Is it an amount actually paid by a prior insurer on the same loss? Again, given that the policyholder can choose the policy year that should cover its liabilities in an “all sums” jurisdiction, an insurer’s contention that the same amounts are “due” under prior policies makes no sense.

What about due process? If one were to accept the insurer’s argument, it very well could be determined that amounts are due from prior-incepting policies even though the insurers that issued the policies are not even parties to the case. Such a result arguably would not even be enforceable against the insurers that issued prior-incepting policies.

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78. Id. (emphasis added).
79. See supra Part III.B.
80. E.I. du Pont de Nemours, 996 A.2d at 1259 (emphasis added).
81. See supra Part III.B.
under the well-established rule of law that a judgment cannot be entered against a party that was not a party in the case.82

What happens if the policyholder has settled with prior insurers even though the settling insurers denied any obligation to pay for the liabilities and continued to deny such liability in the settlement agreements themselves? Surely, the payments made by such insurers cannot be viewed as having been due when the settling insurers continue to contend they owed nothing but settled for business reasons.

Additionally, what does it mean that the limits are “reduced”? For example, are the limits of the policy reduced for just the loss at issue but then reinstated for the next loss? Or are the limits reduced for all future losses as well?

In *E.I. du Pont de Nemours*,83 for example, one of the insurer’s experts contended the limits of the policy were reduced for just the liability at issue, but another expert of the insurer contended the limits were forever reduced for all future liabilities and for all types of claims.84 Thus, in the second expert’s opinion, because amounts were due under prior policies issued by other insurers, the insurer’s policy at issue was relieved of all coverage obligations for all types of claims even though the insurer had never paid a dime under the policy for any type of claim.85 Such an outcome would be incredible and completely inconsistent with insurance law. Moreover, if an insurer’s own “experts” do not agree on how the policy should work, how can the insurer credibly argue the policy language is unambiguous?

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82. See, e.g., Taylor v. Sturgell, 553 U.S. 880, 884 (2008) (“[O]ne is not bound by a judgment in personam in a litigation in which he is not designated as a party or to which he has not been made a party by service of process.” (quoting Hansberry v. Lee, 311 U.S. 32, 40 (1940))); Martin v. Wilks, 490 U.S. 755, 762 (1989) (“A judgment or decree among parties to a lawsuit resolves issues as among them, but it does not conclude the rights of strangers to those proceedings.”), superseded by statute, Civil Rights Act of 1991, Pub. L. No. 102-106, § 108, 105 Stat. 1071, 1076–77, as recognized in Landsgraf v. USI Film Prods. 511 U.S. 244 (1994); EEOC v. Pemco Aeroplex, Inc., 383 F.3d 1280, 1286 (11th Cir. 2004) (“This Circuit’s preclusion standards reflect the longstanding and deep-rooted principle of American law that a party cannot be bound by a judgment in a prior suit in which it was neither a party nor in privity with a party.”); Madison Square Garden Boxing, Inc. v. Shavers, 562 F.2d 141, 143–44 (2d Cir. 1977) (“[I]t is the general rule that no one can be bound by a judgment in litigation in which he or his privy was not a party.”).

83. 996 A.2d at 1259.

84. See Wilson Deposition I, supra note 21, at 27–28.

85. See id. at 28.
Another unanswered question is how does the “reduction of limits” language apply when multiple policies in the same policy year all contain the same non-cumulation clause? Which policies in that year receive the benefit of the reduction of limits, and which ones do not? For example, in the *E.I. du Pont de Nemours* case, the insurer argued that the lowest four layers of coverage in its policy year should have their limits reduced down to zero, but the two highest layers of coverage in that year must cover the policyholder’s claim.86 Where is it written in the clause, or elsewhere, that the lowest layers of coverage should have their limits reduced, but the higher layers should not? Indeed, such a result would be in conflict with language typically found in excess policies that requires exhaustion of the lower-layer policies before triggering the higher-layer policies.87

The foregoing are just a few of the many questions regarding the ambiguities and the possible different meanings of the words used in non-cumulation clauses, such as the London version, and the alternative applications in long-tail liability cases to which the clauses were never intended to apply. Indeed, the ambiguity in non-cumulation clauses as applied to long-tail liability claims is highlighted by the fact that the insurers themselves proffer different meanings, applications, and interpretations of such clauses and cannot agree on what the language in the clauses means or how the clauses apply.88 For example, in *In re*
Asbestos Insurance Coverage Cases, the San Francisco Superior Court held that the non-cumulation clause at issue was ambiguous “at best” and noted that, although the “insurers argue that the non-cumulation clauses are clear and unambiguous, they interpret the clauses differently.”

B. The “Reasonable Expectations” Doctrine

Another staple of insurance policy interpretation law is that the policy should be interpreted to allow the coverage to fulfill the “reasonable expectations” of the policyholder. More than forty years ago, then-Professor Robert Keeton wrote a seminal article regarding the “reasonable expectations” doctrine. In his subsequent treatise, then-Judge Keeton summarized the doctrine as follows:

In general, courts will protect the reasonable expectations of applicants, insureds, and intended beneficiaries regarding the coverage afforded by insurance contracts even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intention of the insurer.


89. No. 1072 at 31–32.

90. See, e.g., 1 BROOK ET AL., supra note 74, § 2.02[1]; ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES § 6.3(a)(3) (Student ed. 1988); 4 LONG, supra note 74, § 16.07; 1 OSTRAGER & NEWMAN, supra note 74, § 1.03[b][2][B] (identifying courts in forty-two states that have expressed support for, or applied a form of, the reasonable expectations doctrine); 2 RUSS & SEGALLA, supra note 74, § 22-11; STEMPEL, supra note 74, §§ 11.1–2. Courts recognize the doctrine. See, e.g., AIU Ins. Co. v. Superior Court, 799 P.2d 1253, 1264 (Cal. 1990) (en banc) (noting that ambiguous coverage clauses of insurance policies are to be interpreted broadly to “protect[] the objectively reasonable expectations of the insured”); Roland v. Ga. Farm Bureau Mut. Ins. Co., 462 S.E.2d 623, 625 (Ga. 1995) (“A contract of insurance should be strictly construed against the insurer and read in favor of coverage in accordance with the reasonable expectations of the insured.”); A.B.C. Builders, Inc. v. Am. Mut. Ins. Co., 661 A.2d 1187, 1190 (N.H. 1995) (“[T]he policy language must be so clear as to create no ambiguity which might affect the insured’s reasonable expectations.” (quoting Cacavas v. Me. Bonding & Cas. Co., 512 A.2d 423, 425 (N.H. 1986))); Fed. Ins. Co. v. Century Fed. Sav. & Loan Ass’n, 824 P.2d 302, 308 (N.M. 1992) (noting that the court will give effect to policyholder’s reasonable expectations in construing policy language); Mills v. Agrichemical Aviation, Inc., 250 N.W.2d 663, 671–73 (N.D. 1977) (invoking doctrine of reasonable expectations to discern intentions of parties and impose liability on insurer).


92. KEETON & WIDISS, supra note 90, at 633. For commentary regarding the reasonable
As Professor Mootz more recently commented, “[i]n other words, even when the policy language unambiguously precludes coverage, under certain circumstances, courts will hold that coverage exists.”

Stated differently, the policyholder should receive coverage that matches its objectively reasonable expectations even if the policy language does not expressly support such coverage. Thus, for example, a policyholder that is in the business of selling products can reasonably expect that it will receive coverage for product liability claims related to those products when it buys commercial general liability insurance for purposes of insuring itself against product liability claims. So, in oversimplified terms, if an insurer sells and accepts premiums for insurance that covers product liability claims, then courts generally should interpret the policy to cover product liability claims regardless of the insurer’s interpretation of the policy or which exclusions the insurer argues should apply.


So, how does this doctrine apply to non-cumulation clauses? Well, in general, a policyholder can reasonably expect to receive payment of the full amount of the loss up to the policy limits despite the presence of a non-cumulation clause if the policyholder both paid a premium for the policy\(^{94}\) and won determination that a covered loss triggered the policy.

**C. The Construction of the Policy as a Whole**

The third policy interpretation principle applicable to non-cumulation clauses provides that, if possible, courts should interpret the policy in a way that attempts to reconcile the various provisions of the policy and attempts to give effect to all of the policy’s provisions.\(^{95}\)

\(^{94}\) Although automobile insurance is a much more heavily regulated area of insurance law that largely is governed by statutes and public policy rather than policy wording, numerous courts throughout the country have held that, despite policy language which purportedly limits a policyholder’s recovery to a single policy limit, policyholders can recover multiple policy limits—or “stack” limits—in automobile insurance policies where the policyholder paid a separate premium for each policy limit and, therefore, is entitled to receive the benefit of the bargain. See, e.g., N. River Ins. Co. v. Tabor, 934 F.2d 461, 466 (3d Cir. 1991) (“The other main reason cited by the Pennsylvania courts in striking down anti-stacking provisions is protection of the reasonable expectations of the insured. This reflects the concept that the insured, having paid multiple premiums, is entitled reasonably to believe that he has multiple coverage . . . .”); Sturdy v. Allied Mut. Ins. Co., 457 P.2d 34, 42 (Kan. 1969) (“When [one] pay[s] a double premium [one] expect[s] double coverage.”), superseded by statute, Act of Apr. 24, 1981, ch. 192, § 1(d), 1981 Kan. Sess. Laws 836 (1981) (codified at Kan. Stat. Ann. § 40-284(d)), as recognized in Farmers Ins. Co. v. Gilbert, 802 P.2d 327, 329 (Ky. 1993) (rejecting an anti-stacking provision because “when separate items of ‘personal’ insurance are bought and paid for, there is a reasonable expectation that the coverage will be provided”); Chaffin v. Ky. Farm Bureau Ins. Cos., 789 S.W.2d 754, 756 (Ky. 1990) (stating that public policy requires that a policyholder has a reasonable expectation that payment of separate premiums results in separate coverages); Jimenez v. Found. Reserve Ins. Co., 757 P.2d 792, 794 (N.M. 1988) (finding stacking appropriate based upon the reasonable expectations of the insured who purchased multiple coverages); Wilson v. Allstate Ins. Co., 912 P.2d 345, 347 (Okla. 1996) (holding that insured could stack underinsured benefits under two policies where insurance company collected higher premium for two cars which was almost double the premium charged for single-car coverage); Schult v. Rural Mut. Ins. Co., 536 N.W.2d 135, 138 (Wis. Ct. App. 1995) (holding that where insured paid separate premiums he was entitled to stack coverage regardless of anti-stacking clauses).

essence, this principle requires that courts, if possible, give effect to all of the policy’s provisions in a way that is consistent with the purpose of the policy as a whole.

So how does this doctrine apply to a clause that is hopelessly ambiguous and is interpreted by some insurers in a way that is contrary to the reasonable expectations of the policyholder? As is further discussed below in Part V, non-cumulation clauses should be treated in the same way that “other insurance” clauses have been applied, because “other insurance” clauses purportedly serve a similar function as non-cumulation clauses—i.e., they attempt to shift liability from one insurer to another insurer. Of course, “other insurance” clauses should not impact the recovery of the policyholder, but, instead, only should come into play when insurers fight among themselves to apportion the liability.96 Indeed, to the extent the clause would allow an insurer to “escape” liability for a loss to the detriment of the policyholder, numerous courts have held such a result is impermissible.97

One version of an “other insurance” clause is known as an “excess”

96. See, e.g., Koppers Co. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3d Cir. 1996) (finding that under “all sums” allocation, an “other insurance” clause does not prohibit the policyholder from selecting the policy to respond, but rather permits an insurer to seek contribution from other insurers); Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1049–50 (D.C. Cir. 1981) (noting that “other insurance” provisions of each policy provide a scheme by which the insurer’s liability is to be apportioned, rather than saddle a single insurer with full liability); Aerojet-Gen. Corp. v. Transp. Indem. Co., 948 P.2d 909, 942 (Cal. 1997) (Chin, J., concurring in part and dissenting in part) (disapproving of the majority’s holding that other insurance clauses were without effect under “all sums” scheme); Owens-Corning Fiberglas Corp. v. Am. Centennial Ins. Co., 660 N.E.2d 770, 794–95 (Ohio Ct. Com. Pl. 1995) (holding that it is within insured’s discretion to select which triggered policy will be obligated to pay in full on a particular claim); J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502, 508–09 (Pa. 1993) (finding “that each insurer [that] was on the risk . . . is a primary insurer” and that the insured “should be free to select the policy or policies under which it is to be indemnified”).

97. See, e.g., Greene, Tweed & Co. v. Hartford Accident & Indem. Co., Civil Action No. 03-3637, 2006 WL 1050110, at *13–16 (E.D. Pa. Apr. 21, 2006) (holding a non-cumulation clause invalid as an unenforceable escape clause because its operation under the circumstances of the case would have totally abrogated coverage for the policyholder); UTI Corp. v. Fireman’s Fund Ins. Co., 896 F. Supp. 362, 378–79 (D.N.J. 1995) (invalidating non-cumulation clause as an unenforceable escape clause, stating that it is “‘unacceptable for an insurance company to provide no coverage under a policy for which it received premiums’” (internal quotation marks omitted) (quoting Contrans, Inc. v. Ryder Truck Rental, Inc., 836 F.2d 163, 166 (3d Cir. 1987))); Varian Assocs., Inc. v. Aetna Cas. & Sur. Co., No. 944196, at 30–31 (Cal. Super. Ct. 1997), in 11-11 MEALEY’S LITIG. REP.: INS. (Jan. 21, 1997) (refusing to enforce non-cumulation clause that purports “to reduce or eliminate the limits of liability of a policy because of the existence of other insurance covering the same loss” as a disfavored “escape clause”); In re Asbestos Insurance Coverage Cases, Judicial Council Coordination Proceeding No. 1072, at 30–32 (Cal. Super. Ct. Aug. 29, 1988), in 2-21 MEALEY’S LITIG. REP.: INS. (Sept. 14, 1988) (declining to apply a non-cumulation provision because it was (1) ambiguous; (2) merely another form of “other insurance” clause; and (3) difficult if not impossible to apply in the context of thousands of asbestos-related bodily injury claims).
“other insurance” clause, which typically provides that coverage is not available under the policy until the loss at issue exceeds the amount of insurance provided by other policies. 98 “Excess” “other insurance” clauses commonly are worded as follows: “If there is other insurance against a loss covered under this policy the insurance provided under this policy shall be excess insurance over any other valid and collectible insurance.” 99

Another type of “other insurance” clause is known as an “escape” clause, which sometimes is worded as follows: “Provided that where the Assured is, irrespective of this insurance, covered or protected against any loss or claim which would otherwise have been paid by the Assurer, under this policy, there shall be no contribution by the Assurer on the basis of double insurance or otherwise.” 100

When two or more policies cover a policyholder’s loss or liability


99. Kahn, supra note 87, at 595 (citing Cosmopolitan Mut. Ins. Co. v. Cont’l Cas. Co., 147 A.2d 529 (N.J. 1959)). Another variation provides “[t]he insurance under this policy shall be excess insurance over any other valid and collectible insurance available to the insured, either as an insured under another policy or otherwise.” Cosmopolitan Mut. Ins. Co., 147 A.2d at 531 (internal quotation marks omitted).

and contain an “other insurance” clause similar to the examples above—which, along with non-cumulation clauses, purport to avoid or shift coverage obligations to other insurers—then courts generally consider the clauses to be mutually repugnant and, thus, unenforceable. In such circumstances, after the policyholder has been paid in full, the courts then prorate the loss or liability between the triggered policy years.

According to some commentators, “other insurance” clauses are also really intended only to “prevent double recoveries by insureds.” Consequently, “[g]iven the purpose of the ‘other insurance’ clauses, these provisions do not provide any contractual basis for allocating a

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102. See, e.g., Car & Truck Leasing, 494 So. 2d at 489 (finding that conflicting excess insurance policies “cancel each other out” and result in pro rata apportionment); Ill. Nat’l Ins. Co. v. Farm Bureau Mut. Ins. Co., 578 N.W.2d 670, 672 (Iowa 1998) (“[W]hen confronted with mutually repugnant excess or escape clauses, the loss must be prorated between the insurers in accordance with the policy limits.”); Great N. Ins. Co. v. Mount Vernon Fire Ins. Co., 708 N.E.2d 167, 170 (N.Y. 1999) (“[I]f . . . two policies are excess to one another, the two ‘other insurance’ clauses cancel each other out and the companies must apportion the costs . . . on a pro rata basis.”); Iodice v. Jones, 514 S.E.2d 291, 293 (N.C. Ct. App. 1999) (“Where it is impossible to determine which policy provides primary coverage due to identical ‘excess’ clauses, ‘the clauses are deemed mutually repugnant and neither . . . will be given effect.’”) (quoting N.C. Farm Bureau Mut. Ins. Co. v. Hilliard, 369 S.E.2d 386, 388 (1988))); Buekeye Union Ins. Co. v. State Auto. Mut. Ins. Co., 316 N.E.2d 1052, 1053–54 (Ohio 1977) (“Since there can be no primary insurance of the risk where there are conflicting excess clauses, the excess clauses a fortiori cannot be a valid means of establishing only ‘secondary’ liability.”); see also 8A JOHN ALAN APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 4909 (1981); James R. Adams, Other Insurance in 4 THE LAW OF LIABILITY INSURANCE § 22.04[11] n.3 (Sally A. Swiss ed., 1999). Many courts recognize pro rata allocation of the loss. Ind. Ins. Co., 874 F.2d at 634 (“[I]f there are two policies of excess insurance and a literal construction of each policy would mean that neither would have to pay, the policies are mutually repugnant and a court will construe the contracts to require each insurer to pay its appropriate share.”).

103. See supra notes 101–02 and accompanying text.

portion of the insured’s loss to [the insured].”\textsuperscript{105} Thus, “other insurance” clauses are really intended to allow “equitable contribution” between and among insurers after one or more of the insurers has paid the policyholder’s claim in full.\textsuperscript{106}

The reasoning of these commentators and the decisions discussed and cited in this Part regarding “other insurance” clauses apply equally to non-cumulation clauses. Non-cumulation clauses similarly purport to shift the liability for a loss from the policy at issue to other policies issued in prior years, so the same principles apply. Consequently, such clauses should be understood to be intended only to prevent “double recoveries” by policyholders, and thus, the clauses only allow for “equitable contribution” between and among insurers after the policyholder’s claim has been paid in full by one or more of the insurers.

V. \textbf{HOW COURTS SHOULD INTERPRET AND APPLY NON-CUMULATION CLAUSES TO LONG-TAIL CLAIMS}

With this factual and legal background in mind, one can ascertain a framework for the courts’ interpretation and application of non-cumulation clauses in the context of long-tail claims. The framework has two primary components.

\textbf{A. Courts Should Construe Non-Cumulation Clauses in Favor of Policyholders}

The first part of the framework provides that, because many versions of the clause are hopelessly ambiguous when applied to long-tail claims for all of the reasons discussed above, courts should interpret them in favor of the policyholder. Indeed, because the courts that have interpreted and applied a non-cumulation clause have reached different conclusions as to its meaning and application, such clauses generally must be ambiguous.\textsuperscript{107} Further, such a result is consistent with the

\textsuperscript{105} Id.
\textsuperscript{106} Id. at 21.
\textsuperscript{107} See, e.g., Sec. Ins. Co. of Hartford v. Investors Diversified Ltd., 407 So. 2d 314, 316 (Fla. Dist. Ct. App. 1981) (“The insurance company contends that the language is not ambiguous, but we cannot agree and offer as proof of that pudding the fact that the Supreme Court of California and the Fifth Circuit in New Orleans have arrived at opposite conclusions from a study of essentially the same language.”); Crawford v. Prudential Ins. Co. of Am., 783 P.2d 900, 908 (Kan. 1989) (“[T]he reported cases are in conflict, the trial judge and the Court of Appeals reached different conclusions and the justices of this court [disagree]. Under such circumstances, the clause is, by definition,
reasonable expectations of the policyholder, who can and should expect its insurers to pay for covered losses instead of attempting to shift their coverage obligations to other insurers. Consequently, under well-established insurance law regarding policy interpretation, courts should construe non-cumulation clauses in favor of coverage for the policyholder.

Such a result should come as no surprise to insurers. Even one of the London underwriters responsible for the London version of the clause that is still found in many policies today has acknowledged that long-tail claims had not yet been recognized when the clause was drafted and allocation rules, such as “all sums” allocation, did not exist. Thus, the clause could not have been intended to apply to long-tail claims—such as asbestos bodily injury and environmental property damage—under current allocation rules. To the contrary, the drafters originally intended only to prevent a policyholder from receiving a double recovery by accessing coverage under differently worded policy forms as the insurance industry transitioned from one policy form to another in the early 1960s.

This conclusion also comports with the various states’ allocation laws. In jurisdictions that have adopted “all sums” allocation, if non-cumulation clauses were applied as requested by certain insurers, then the policyholder would be stripped of its right to select the policy year that will provide coverage because the insurers could effectively veto the policyholder’s selection. Similarly, in pro rata allocation jurisdictions, the insurers already have been given a discount on their obligations to the policyholder because they are only being held responsible for a portion of the policyholder’s liabilities.

Moreover, applying non-cumulation clauses as requested by the
insurers would be inconsistent with public policy, which encourages settlements. If a policyholder were required to “credit” either the amounts it has received in settlements or the entire policy limits of the settled policies toward the policy limits of non-settling insurers’ policies in later policy years, then the policyholder would have little or no incentive to settle. Conversely, if holdout insurers could reduce their policies’ limits by amounts paid by settling insurers in earlier policy years or the entire policy limits of prior-incepting policies that are settled, then insurers would have an incentive to hold out instead of settling.

In short, so long as the policyholder does not receive a double recovery, then the policyholder should receive the benefit of its bargain with its insurers, which did, after all, receive a premium for the policy.

B. Courts Should Treat Non-Cumulation Clauses Like “Other Insurance” Clauses

The second part of the framework provides that, because they purport to shift liability for a loss from one policy to other policies, non-cumulation clauses are just another variation of “other insurance” clauses that commonly are found in commercial general liability policies. Consequently, they should be given the same effect as “other insurance” clauses. As an initial matter, as discussed above in Part IV.C., “other insurance” clauses should not impact the policyholder’s recovery. As

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111. See, e.g., Koppers Co. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3d Cir. 1996) (finding that under “all sums” allocation, an “other insurance” clause does not prohibit the policyholder from selecting the policy to respond, but rather permits an insurer to seek contribution from other insurers); Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034, 1050 (D.C. Cir. 1981) (finding that the insured can collect from any triggered insurer and liability is apportioned among all); Greene, Tweed & Co. v. Hartford Accident & Indemn. Co., Civil Action No. 03-3637, 2006 WL 1050110, at *13–16
a result, such clauses only impact the allocation of the loss among insurers after the policyholder has been paid in full.

Further, in contribution actions between insurers, the doctrines of contra proferentem and “reasonable expectations” do not necessarily apply because the dispute is between insurers, not an insurer and a policyholder. Thus, many of the arguments set forth in this Article regarding the interpretation of non-cumulation clauses with respect to the policyholder do not apply in actions between insurers.

With that said, in contribution actions between insurers, a court should allocate the loss in accordance with the jurisdiction’s law relating to allocation and “other insurance” clauses. If, for example, all of the policies at issue contain non-cumulation clauses, then courts in “all sums” and pro rata jurisdictions should allocate the loss on a pro rata basis between the insurers because the non-cumulation clauses are mutually repugnant. If the policies do not all contain non-cumulation clauses, then courts in an “all sums” jurisdiction should apply the clause in favor of the later-issued policies to the extent that there are no competing policy provisions that would change the result. In pro rata jurisdictions, the insurers already have received a discount from their full


112. See, e.g., Parks Real Estate Purchasing Grp. v. St. Paul Fire & Marine Ins. Co., 472 F.3d 33, 43 (2d Cir. 2006) (implying that contra proferentem only applies to ambiguity questions about policy between insurer and policyholder); James v. Zurich-Am. Ins. Co. of Ill., 203 F.3d 250, 258 (3d Cir. 2000) (noting that contra proferentem construction applies when contract dispute is between the insurer and its insured); U.S. Fid. & Guar. Co. v. W. Cas. & Sur. Co., 408 P.2d 596, 598 (Kan. 1965) (finding that in a dispute between two insurance companies, the court does not apply the rule of liberal interpretation that is necessary to protect a policyholder); Boston Ins. Co. v. Fawcett, 258 N.E.2d 771, 776 (Mass. 1970) (noting that contra proferentem does not apply where “all the parties to the litigation are large insurance companies long engaged in far-flung activities in that field of economic activity”). But see Commercial Standard Ins. Co. v. Gen. Trucking Co., 423 So. 2d 168, 171 (Ala. 1982) (justifying a construction against an insurer even where both parties are equally informed insurers).

113. See, e.g., supra note 101.
policy obligations, so the clause would not apply.\textsuperscript{114} In jurisdictions such as New Jersey, which apply pro rata time on the risk allocation,\textsuperscript{115} the court should allocate the loss among the various triggered policies based upon the percentage of total insurance provided by each insurer.

VI. CONCLUSION

The manner in which courts allocate long-tail claim liabilities raises critical questions in complex, multi-party litigation and has a significant impact on the financial obligations of the parties involved. Certain insurers’ attempts to use non-cumulation clauses to reduce or eliminate their financial obligations for long-tail claims—such as asbestos bodily injury claims and environmental property damage claims—should be rejected with respect to the amount ultimately paid to the policyholder. Many versions of the clause are hopelessly ambiguous when applied to such claims under current insurance concepts such as continuous trigger and “all sums” allocation, which did not exist when the clauses were drafted. Nor was the existence of long-tail claims even recognized as such at the time the clauses were drafted. Consequently, non-cumulation clauses, such as the London version, were only intended to prevent the policyholder from obtaining a double recovery where two different types of policies covered the same loss. If such clauses have any relevance today, it is only for purposes of allocating losses among insurers after the policyholder has been made whole. Indeed, because non-cumulation clauses essentially are a variation on “other insurance” clauses, they should be treated like “other insurance” clauses and should not be applied to reduce the coverage that a policy otherwise affords.

\textsuperscript{114} See, e.g., Spaulding Composites Co. v. Aetna Cas. & Sur. Co., 819 A.2d 410, 422 (N.J. 2003) (“Once the court turns to pro rata allocation, it makes sense that the non-cumulation clause, which would allow the insurer to avoid its fair share of responsibility, drops out of the policy.”).

\textsuperscript{115} See Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d 1116, 1124 (N.J. 1998) (allocating coverage among multiple liability insurers in proportion to the degree of the risks transferred or retained during the years of exposure).