

**ALLOCATION OF COVERAGE AND LIABILITIES
IN LONG TAIL CLAIMS**

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Introduction

In its recent decision in *Jesuit Fathers of Upper Canada v. Guardian Insurance Company of Canada*, [2006] 1 S.C.R. 744, 2006 S.C.C. 21, the Supreme Court of Canada describes the two main approaches to establishing temporal limits to insurance coverage:

The first and more traditional approach, the occurrence-based approach, focuses on the occurrence of the negligent act. If the negligent act giving rise to the damages occurred during the policy period, the insurer is required to indemnify the insured for any damages arising from it regardless of when the actual claim was made. The second approach, the claims-made approach, focuses on the claim made by the third party. If the claim is made by a third party during the policy period, the insurer is required to indemnify, regardless of when the negligent act giving rise to the claim occurred. Naturally, a particular policy may use the first or the second approach, or a hybrid of both. The issue is always what a particular policy dictates. See generally, *Reid Crowther & Partners Ltd. v. Simcoe and Erie General Insurance Company*, [1993] 1 S.C.R.¹

It should be added that there are wrinkles and qualifications to the policies described in this passage by the Supreme Court of Canada. Claims-made policies are now frequently issued in the form of claims made-and-reported policies, which require not only that a claim be made by a third party during the policy period, but that the claim be reported to the insurer either during the policy period or during a somewhat longer, but defined, reporting period. The claims-made policy has also been modified in its most commonly used form to include only claims that occur subsequent to a specific retroactive date.²

The claims-made policy was developed by the industry in response to the numerous and difficult problems posed by the “long tail” under an occurrence-based policy. A claims-made form was introduced by the Insurance Bureau of Canada in 1996 with the IBC model Commercial General Liability (CGL) policy. The nature of the problem that led to the development of the claims-made policies was summarised by the Supreme Court of Canada in the *Jesuit Fathers* case at paragraph 24 in the following terms:

The development and growing use of claims-made or hybrid policies was, in large part, a response to serious problems encountered by insurers in relation to occurrence-based policies. An occurrence-based policy works well where the damage resulting from a particular negligent act is immediately apparent (or becomes apparent shortly thereafter). It is less well suited in cases of professional services such as medical, engineering or manufacturing services, where the damage from the negligent act may not be apparent for many years. First, the “long tail” nature of the liability in the examples above, makes it likely that many claims will be made well after the policy has expired. Second, the ongoing developments in law and science, make it difficult for the insurer to estimate the potential liability arising from claims made many years in the future. Finally, where an insured repeatedly changes insurance companies, a claim made in the future could result in legal battles between insurance companies where the exact timing of the negligence is unknown, or where the negligence was of an ongoing nature. These problems increase

¹ At para. 23.

² There is a useful discussion of claims made-and-reported policies in *Stuart v. Hutchins* (1998), 164 D.L.R. (4th) 67 (Ont. C.A.).

the difficulty of assessing actuarial risks. As a result, premiums may rise sharply. Coverage may even become unavailable on the market. (see *Reid Crowther* at pp. 262-63)

It is the difficulty that arises in apportioning losses between insurers, all of whom have long tail occurrence-based policies, which is the subject of this paper.

Even in a world where all insurance policies are written on a claims-made or claims-made-and-reported basis, there will be issues arising out of the temporal limits of coverage.³

The adoption of claims-made policies will, however, do away with much litigation with respect to when losses will be found or deemed to have occurred. Further, the Insurance Bureau of Canada in 2005, released a new form of commercial general liability insurance, IBC Form 2100, which incorporates changes intended to reduce disputes by providing some guidance with respect to when losses should be deemed to have occurred. The insuring agreement now provides:

1. Insuring Agreement

- (a) We will pay those sums that the insured becomes legally obligated to pay as “compensatory damages” because of “bodily injury” or “property damage” to which this insurance applies. We will have the right and duty to defend the insured against any “action” seeking those “compensatory damages”. However, we will have no duty to defend the insured against any “action” seeking “compensatory damages” for “bodily injury” or “property damage” to which this insurance does not apply....
- (b) This insurance applies to “bodily injury” and “property damage” only if:
 - (i) the “bodily injury” or “property damage” is caused by an “occurrence” that takes place in the “coverage territory”;
 - (ii) the “bodily injury or “property damage” occurs during the policy period; and
 - (iii) prior to the policy period, no insured listed under paragraph 1 of Section II - Who Is An Insured - and no “employee” authorised by you to give or receive notice of an “occurrence” or claim, knew that the “bodily injury” or “property damage” had occurred, in whole or in part. If such a listed insured or authorised “employee” knew, prior to the policy period, that the “bodily injury” or “property damage” occurred, then any continuation, change or resumption of such “bodily injury” or “property damage” during or after the policy period will be deemed to have been known prior to the policy period.
- (c) “Bodily injury” or “property damage” that occurs during the policy period and was not, prior to the policy period, known to have occurred by any insured listed under paragraph

³ Such as, for example, the issues addressed in *Jesuit Fathers of Upper Canada v. Guardian Insurance Company* (supra), *Aggresso Corporation v. Temple Insurance* 2007 B.C.S.C. 19 and *MWH International Inc. v. Lumbermen’s Mutual Casualty Company* 2007 B.C.C.A. 164, all of which involve the question of whether or not a claim has been made and reported in the period described by the coverage.

1 of Section II - Who Is An Insured - or any “employee” authorised by you to give or receive notice of an “occurrence” or claim, includes any continuation, change or resumption of that “bodily injury” or “property damage” after the end of the policy period.

- (d) “Bodily injury” or “property damage” will be deemed to have been known to have occurred at the earliest time when any insured listed under paragraph 1 of Section II - Who Is An Insured - or any “employee” authorised by you to give or receive notice of an “occurrence” or claim:
- (i) reports all, or any part, of the “bodily injury” or “property damage” to us or any other insurer;
 - (ii) receives a written or verbal demand or claim or “compensatory damages” because of the “bodily injury” or “property damage”; or
 - (iii) becomes aware by any other means that “bodily injury” or “property damage” has occurred or has begun to occur.

Most of the wording of the insurance agreement is unchanged and maintains traditional concepts of coverage afforded under an occurrence-based policy. The new language in the form, however, is an attempt to avoid expansive temporal coverage. The insured, in order to establish an entitlement to coverage under the policy, must now establish that it did not know, before the policy inception, that the bodily injury or property damage had occurred. There is no coverage for losses arising out of damage that had occurred in whole or in part before the inception of the policy. There will no coverage afforded by the policy in respect of damage that occurs in part before the policy period and then continues, changes or resumes in such a manner as to cause additional property damage or bodily injury. While the changes to the standard CGL will significantly limit the exposure of insurers to claims falling within a long tail, past experience suggests that it may be decades before insurers who wrote coverage under the old form of CGL will be able to close their books on long tail claims. For that reason the issues discussed below will continue to require consideration.

Summary Description of Trigger Theories

In order to appreciate the obligation of insurers to contribute to defence, settlement and payment of claims potentially falling under several policies, it is necessary to have an appreciation of the commonly applied trigger theories.

There is a helpful discussion of trigger theories in the 1988 case *Allstate Insurance Company of Canada v. Axa Pacific Insurance Company*, [1998] I.L.R. 1-3608 (B.C.S.C.). Mr. Justice Pitfield described that case as one in which the parties sought judgment on a test case inviting general consideration of the “trigger theory” in relation to comprehensive general insurance policies. The Court noted, at p. 5322:

The trigger is the point in time which the potential for liability under a policy of insurance arises such that there is a duty to defend. The identification of the time at which the trigger is pulled, fixes the insurer, whose policy is then in effect with the duty to defend and absolves any other insurer of such duty.

The Court noted that the trigger theory had been extensively considered in American cases, but very little in Canada. After citing at length from Gordon Hilliker's text *Liability Insurance Law in Canada*,⁴ the Court noted:

Four alternatives have been identified: the **time of first exposure** to that which does the harm; **continuous exposure** over the period from the date of first exposure to the date of manifestation of the harm; the **time of the first manifestation** of the harm; and the **time of injury-in-fact** which is the date that bodily injury or property damage actually occurs. (emphasis added)

In the case before the Court, Mr. Justice Pitfield held that the trigger could be identified as injury-in-fact by reference to the wording of the policy itself.

The Axa policy is not ambiguous on its face. In the context of this case, the risk insured is bodily injury, personal injury and injury to or destruction of property 'during the period of coverage'. The criteria selected by the insurer and agreed to by the insured is injury-in-fact during the term of the policy. (at. p. 5323)

The Court held that the policy afforded coverage in respect of bodily injury, personal injury and injury to or destruction of property during the period of coverage, regardless of when the accident or occurrence giving rise to that damage occurred. The Court held that both insurers, Axa and Allstate, were required to afford some coverage to the insured and that the extent of Axa's coverage was determined by the extent of the damage that occurred during its policy period. There had been agreement before trial between the insurers with respect to the extent of the obligation of each to contribute in the event that the Court found Axa was obliged to defend or indemnify the insured at all. The Court, therefore, did not engage in an examination of the question of the principles that should be applied in apportioning the liability to contribute.

The trigger theories are also described in useful general terms in *International Comfort Products Corporation (Canada) v. Royal Insurance Company of Canada*, [2000] 1-3828 (Ont. Superior Court) and *Hay Bay Genetics v. McGregor Concrete* (2003), 6 C.C.L.I. (4th) (Ont. S.C.). In these cases, the four alternatives are described as follows:

1. The **exposure theory** requires the policy in force at the time the injured person was first exposed to the harm to provide coverage.
2. The **injury-in-fact theory** requires the policy in force at the time the claimant suffers actual injury to respond.
3. The **triple trigger or continuous trigger theory**, which requires that the policies in force at the time of initial exposure, during continuing exposure, and at the time of manifestation, must all respond.
4. The **manifestation theory** requires the policy in force at the time the harm was first "manifest" to respond.

⁴ Now *Liability Insurance Law in Canada, Fourth Edition* (LexisNexis Canada Inc. 2006)

When the Superior Court of Ontario considered the competing theories in *International Comfort Products Corporation v. Royal Insurance*, it chose the continuous trigger theory in determining which insurance policies were applicable to a loss that occurred as a result of continuing damage over a ten-year period. The choice in that case appears in part to have been motivated by a desire to maximise the available insurance coverage. Additionally, the Court appears to have been influenced by the fact that there was no cogent evidence of when the damage occurred throughout the policy term.

In considering choice of theories the Court held that the manifestation theory had been rejected in dealing with injuries that occurred over an extended period of time in *University of Saskatchewan v. Firemen's Fund Insurance Company* (1997), 50 C.C.L.I. (2d) 272 (Sask. C.A.) and *Irving Oil v. London Hull and Maritime Insurance Company* (1998), 9 C.C.L.I. (3d) 69 (N.B.Q.B.).

In *Hay Bay Genetics v. McGregor Concrete*, the Ontario Superior Court of Justice applied the “continuous trigger theory” to conclude that two insurers were liable to partially indemnify an insured in respect of losses that occurred from 1994 to 1998 as a result of continuous leakage from a septic tank. The insurers whose policies were in force at the time of the leakage were held to be responsible for indemnification during their precise and respective periods of policy coverage. There was a period during the course of the leakage and damage when the insured had no coverage and the Court expressly held that damages during any period not covered by the insurance policy would be borne entirely by the insured.

The “continuous trigger theory” was also applied in *Alie v. Bertrand and Frère Construction Company* (2000), 30 C.C.L.I. (3d) 166 (Ont. S.C.). That case, the “infamous cement case”, was a claim brought by 137 plaintiffs who had purchased houses built on foundations of defective concrete. The foundations were poured during 1986-87. Within a year or two, the houses began to suffer from problems and the problems continued for years. The Court found against certain defendants in contract and against others in negligence. When it turned to the question of insurance, the Court noted that the defendant that was principally liable had had five different insurers who provided primary and umbrella insurance over the relevant period of time. The Court was called upon to address the question in the following terms (at page 255):

Having made a determination that the plaintiffs' property damage was caused by an occurrence and covered by the insurers' policies, I now have to ascertain which policy or policies provide coverage to the insured, Bertrand. ... Generally speaking, if a finding is made that property damage occurred within the period of a particular policy, that policy will have been “triggered” and the insurer will be required to indemnify the insured in accordance with the coverage afforded by the policy.

The Court rejected the application of the “exposure theory”, at page 258:

In conclusion, given the evidence from experts and the homeowners that the damage was ongoing and progressive, I find that the application of the exposure theory to trigger coverage would be inconsistent with the wording of the policies and inequitable to the insurers who had policies in effect for the years 1986, 1987 ad 1988.

At p. 159, the Court held the “manifestation theory” to be “inappropriate”:

The cumulative evidence before me demonstrates that the damage to these foundations took place between the years 1986 and 1992. The damage was progressive and cumulative. To apply the manifestation theory would be inconsistent with the wording of

these CGL policies and the intentions of the parties to the contract. The CGL policy requires that the injury or damage take place during the policy period. If I apply the manifestation theory on our facts, it would mean that the policies in existence in 1992 would be triggered and they would be responsible for the damage, which was in fact occurring during earlier policy periods. That would not only be unreasonable, but also inequitable. A number of learned authors on this issue have questioned whether it is fair that the last carrier on risk should have to carry the burden of defence and indemnity.

In addressing the injury-in-fact theory, the Court held that although it is the theory most consistent with the actual wording of CGL policies:

The problem in applying only the injury-in-fact theory to this case, is determining when the damage actually occurred. My findings as to causation, the expert evidence and the observations of the plaintiffs ... would support a finding that the damage actually started the same year the foundations were poured, that is in 1986, 1987 and 1988. The evidence would also support a finding that the damage continued, was progressive and cumulative resulting in a finding by the experts in 1992 that all of the plaintiffs' foundations would have to be replaced.

Obviously, the injury-in-fact is taking place over a number of years covering different policy periods. Attempting to apportion liability to various policy periods would be impossible. ... Given that the application of the injury-in-fact theory alone cannot respond to our facts, I have to look at the continuous or triple trigger theory.

In support of the application of the continuous or triple trigger theory, the Court referred, among other cases, to the decision of the Supreme Court of British Columbia in *Surrey v. General Accident Assurance Company* (1994), 92 B.C.L.R. (2d) 115 (S.C.); (1996), 19 B.C.L.R. (3d) 186 (C.A.).

The Court found the logic of a number of American cases helpful and attractive. In particular, the Court seems to have been impressed by the view that in cases where actual apportionment of the injury to specific periods is impossible, the continuous trigger theory may be employed to equitably apportion liability among insurers.

The Court ultimately applied what it believed to be a combination of the injury-in-fact and continuous trigger theories.

Apportionment of Liability to Indemnify and Pay Defence Costs

The trigger theories discussed above have been enunciated in addressing the question of whether or not a policy responds to a claim; in other words, whether coverage has been triggered by an occurrence within the policy period. If coverage under a number of policies is triggered, it is then necessary to engage in another exercise: Apportioning liability to the respective insurers to pay defence costs or indemnify the insured in relation to the damage.

As noted in the *American Handbook on Insurance Coverage Disputes* (10th ed.):

There is a growing trend for Courts to consider the issue of allocation of liability among triggered policies as distinct from what constitutes the trigger of coverage.⁵

So it should be. Having engaged in the process of assessing time-on-risk for the purpose of determining what coverage is triggered, there is a strong tendency to apply the same method in apportioning liability amongst insurers but there is no reason in principle why that should be the case. There are alternate methods of allocating liability amongst insurers at risk. Among these are:

1. Apportioning liability jointly and severally to all insurers for the entire loss.
2. Allocating the loss to triggered policies on a pro rata basis in proportion to time-on-risk;
3. Allocating the loss to triggered policies on a pro rata basis in proportion to injury-in-fact during the policy period;
4. Allocating the loss to triggered policies on a pro rata basis in the same proportion to the ratio of policy limits to total insurance implicated; and
5. Allocating the loss to triggered policies on a pro rata basis in the same proportion as the ratio of premiums paid to each insurer to the total premiums paid to all.

These approaches are more frequently and fully addressed in American litigation. There are few Canadian cases in which the Courts have adopted any approach to apportioning of liability to insurers other than a pro rata apportionment by time on risk.

The question whether coverage is triggered is usually asked in relation to an application for an order requiring an insurer to provide a defence. At that stage the courts are wrestling with different issues than those that will ultimately be faced after a judgement on the merits of the underlying claim in litigation. The duty to defend in most cases will be addressed with reference to the pleadings. There will often be no other factual matrix. The injury-in-fact analysis is particularly difficult to undertake at that stage. Despite the fact that the insuring intent may have been to cover only losses proven to have been caused by covered risks, litigants are forced to address the duty to defend before the factual matrix is drawn. Having said that, the Courts have on occasion directed insurers to pay defence costs on an apportionment that may be varied after trial. For example, in *Continental Insurance Company et. al v. Dia Met Minerals* (1996), 20 B.C.L.R. (3d) 331 (C.A.) the trial judge ordered that a percentage of defence costs attributable to covered claims be paid by the insurer, without prejudice to proceedings at the end of the tort action to reapportion those percentages. The Court of Appeal sent the matter back to the trial court, after settlement, for apportionment after production of relevant documents with respect to the conduct and expense of the defence.

The same is not true of the obligation to indemnify an insured against liability. It is only after sufficient facts are known to permit judgment or settlement to be arrived at that the duty to indemnify must be finally resolved.

⁵ Ostranger and Newman (Aspen Law and Business, 2000) at p. 505.

Our courts have occasionally addressed the relative obligation of multiple insurers to defend claims but rarely considered their respective obligations to indemnify. The approach taken to defence costs is exemplified by the decision in *Alie v. Bertrand* (supra), at pp. 292-293. In that case Roy J. noted that the apportionment of the costs incurred in defending the action is done “on a basis of equitable consideration”. The principles to be applied in doing so, according to the Court, were described in *Canadian Indemnity Company v. Simcoe and Erie* (1979), 103 D.L.R. (3d) 485 by the Nova Scotia Supreme Court Appeal Division:

As a general rule, it appears reasonable that when two or more insurance companies are at risk on a claim and the amount of that claim is unascertained at the time of commencement of the action, then the companies should be equally liable for the costs of defending the action. This approach, albeit arbitrary, avoids the possibility of becoming involved in complicated calculation based upon criteria that may change radically in each case.⁶

In *Canadian Indemnity Company v. Simcoe and Erie*, the Court rejected the argument that apportionment should be based upon the risk represented by the limits of each insurer. Similarly, in *Broadhurst and Ball v. American Assurance Home Company* (1990), 76 D.L.R. (4th) 80 (Ont. C.A.), the Court held, at page 96:

... I do not think it appropriate to allocate costs simply by reference to the respective policy limits, although I would add, in other situations, this may well be a fitting basis for allocation. The costs of providing the defence here are clearly not necessarily related to the monetary limits of the policies.

This principle had also been adopted in *Schmieder v. Singh* (1998), 165 D.L.R. (4th) 503.

The Court in *Alie v. Bertrand* divided the loss into equal annual segments representing the policy periods and required the insurers to contribute to costs in accordance with the time on risk. Within each period costs were apportioned equally between primary and excess insurers. This time-on-risk analysis appears to have become the norm in Canadian cases. That is particularly so in cases where only defence costs are being apportioned before any finding of liability.

In one of the few reported Canadian cases dealing with the issue after the conclusion of the underlying claim, *Surrey v. General Accident* (supra), the Court of Appeal considered Surrey’s claim to indemnity for damages for unjust enrichment payable to a plaintiff that had suffered losses both before and during the term of a policy⁷. The General Accident policy in question required the insurer to pay “all sums” that Surrey became obligated to pay by reason of liability imposed by law. Surrey urged the Court to apply the principles employed in *California Union Insurance v. Landmark Insurance* 193 Cal Rptr. 461 (Cal App.2 Dist. 1983) to arrive at joint and several liability for “all sums”. The Chief Justice, for the Court rejected that approach, noting that it had not been universally accepted in the United States and “had not been authoritatively accepted in Canada”(at para 38).

The Court noted that the policy covered “injury to or destruction of property...during the policy period” and held that the trial judge had not been wrong in allocating the loss to periods, during some of which Surrey was uninsured, and apportioning liability accordingly.

⁶ *Canadian Indemnity v. Simcoe and Erie*, at p. 488 cited in *Alie v. Bertrand*, at p. 293.

⁷ Another case occasionally referred to as authority for apportionment after trial on the merits of the tort claim is *St. Andrews Service Co. Ltd. v. McCubbin* (1987) 22 B.C.L.R. (2d) 38 (B.C.S.C.)

Support for a time-on-risk or injury-in-fact analysis may also be found in our courts' reluctance to accept any approach to insurance disputes which sees the insured obtain a benefit for which no consideration has been paid, such as the "benefit of a free defence" sought by the Plaintiffs, and refused by the Court, in *Continental Insurance Company et. al v. Dia Met Minerals (supra)*.

American cases may yet provide some useful guidance on the allocation of the obligation to indemnify. *Keene Corporation v. Insurance Company of North America* 667 F. (2d) 1034 (D.C. Circuit 1981) and *California Union Insurance v. Landmark Insurance* 145 Cal. App. 3d 462 (2nd Dist. 1980) are both often cited as authority for the adoption of the joint and several approach to apportioning liability between responding insurers and as authority for the proposition that once an insurer is liable to indemnify an insured in respect of continuing injury, that liability continues to the limits of the policy without regard to other insurance coverage or even periods during which the insured was uninsured. They are also said to stand for the proposition that the insured is entitled to select the policy under which it desires to be indemnified and leave it to the insurer to seek contribution or indemnity from other insurers. The principal justification for the joint and several liability approach appears to be the standard wording of a liability policy itself, which is to pay "all sums that the insured becomes legally obligated to pay as 'compensatory damages'". For this reason the joint-and-several approach is sometimes referred to in the American literature as the "all sums" approach.

It may have been in reaction to this line of authority that the standard IBC form of CGL now refers not to payment of "all sums" but to the payment of "those sums that the insured becomes legally obligated to pay as compensatory damages".

It should be borne in mind that even in California, the joint and several approach has fallen into disfavour in cases where its application is likely to be "patently arbitrary and inequitable". (See, for example, *Centennial Insurance Company v. United States Fire Insurance Company* (2001, Cal. C.A.) 01 CDOS 2596)

The American case regarded as persuasive authority for pro rata allocation is *Insurance Company of North America v. Forty-Eight Installations Inc.* 633 F. (2d) 1212. That case was an asbestos case. Both indemnity and defence costs were allocated to insurers by years on risk, on the theory that the offending asbestos was inhaled and caused damage on an ongoing, cumulative basis. This approach has been approved in other American cases as the "logically consequent rule of proration of liability"⁸.

In the cumulative injury cases there is little distinction between the years-on-risk and the injury-in-fact approaches to allocation of the obligation to indemnify, because of the inference that the damage in fact occurs cumulatively over the years on risk. For that reason the basis for allocation is sometimes blurred. Years on risk is simply used as a proxy for injury-in-fact.

In summarising the American case law on pro rata apportionment, Ostranger and Newman note, at p. 515:

Courts across the country have not settled on a universal system for allocating losses on a pro rata basis.

⁸ Porter v. American Optical Corp., 641 F.2d 1128 (Fifth Circuit) cited in Ostranger and Newman (supra) at pp. 510-511.

In Canada the prevailing approach to apportionment appears to be the time-on-risk approach but that may be as much due to the paucity of authority on the issue of apportionment after a finding in the underlying litigation as to the acceptance of one approach as persuasive in law.