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Apportioning Coverage Responsibility of Consecutive Insurers When the Actual Occurrence of Injury Cannot be Ascertained: Who Has to Contribute in a Settlement?

I. INTRODUCTION

Injuries cannot always be traced to a specific point of causation. Sometimes injuries are discovered after years of exposure to conditions precipitating the actual damage. In those circumstances the term "continuous injury" is used.1 If a lawsuit is brought, it is common for the liable party to discover that insurance policies covering the years of exposure were provided by more than one insurance company.2 In some


2. For the purposes of this comment, the primary type of insurance policy to be discussed is the Comprehensive General Liability ("CGL") policy.
cases, it is impossible to determine when the injury occurred or when the injury-causing conditions existed. This leads to questions regarding the responsibility for coverage among the liability insurers. \(^5\) Often a settlement is entered into and paid with the knowledge that the decisions regarding apportionment of liability and indemnification from other responsible insurers will be left to a court.

An initial review of the case law in this area may lead to the false perception of inconsistency among the courts. However, it is important to note that minor variations in the facts lead to entirely different apportionment standards. Let us not forget that determining the appropriate method of apportionment is ultimately a matter of contract interpretation. \(^4\) The courts are required to apply the wording of the policy language to the facts surrounding each injury. \(^5\) Also, the courts usually decide these cases in a manner that will provide the maximum coverage for the insured. \(^6\)

The settlement of a continuous injury claim presents even more problems in this complex area of litigation. Usually, as a result of the settlement, the court is left to make an apportionment decision without the benefit of a trial court's fact finding. This leaves the parties with an imprecise determination of the actual occurrence of the injury. Most of the court decisions that address a settlement situation may not deal with all of the issues that are actually present when an attorney is confronted with indemnification among the liable insurers. \(^7\) Consequently, when involved in these matters, the parties should look to case law from other states and circuits to construct a complete argument to the court. This comment addresses the diverse issues involved in determining the appropriate apportionment of and indemnification for the settlement amount among contributing insurers, including: triggers of coverage,

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3. It is a common practice for businesses to change insurance carriers over time. Many factors may influence a change including better rates or more coverage.


5. For the purposes of this comment, the discussion of apportionment will center around a factual scenario in which the exact moment of injury causation cannot be determined. Furthermore, this scenario will rely on an assumption that the plaintiff cannot apportion the damage during each policy period through any direct link to an actual moment of causation.

6. Though not always mentioned in the opinions, courts tend to favor the insured based upon the assumption that because premiums were paid to cover such losses in the preceding years, the litigation should concern indemnification among the insurers thereby avoiding additional costs to the insured.

7. Every "continuous injury" claim involves a unique injury causation factor. The ability or lack thereof to determine when the causation occurred plays a crucial role in determining the liability of the insurers.
how to apportion liability for the settlement amount, contribution, and subrogation. This comment also analyzes the cases in which a court focused on the determination of amounts owed by consecutive insurers to an insured in the settlement of a case involving injuries that span several policy periods.

II. WHICH INSURANCE POLICIES ARE "TRIGGERED"

Prior to 1966, a standard Comprehensive General Liability ("CGL") policy covered liability for bodily injury and property damage that was "caused by accident."8 The courts interpreting the provision considered this language to be ambiguous.9 As a result, insurers redrafted their policies changing the language to cover liability for injuries resulting from an "occurrence."10 The theory behind this change of policy terms arose because of three ambiguities that the courts found in the term "accident."11 First, there were contradicting opinions regarding the proper perspective to be chosen in deciding whether an act was accidental or intended.12 The insurers believed the victim's perspective should be the pivotal point while some courts ruled otherwise.13 Second, there were ambiguities about the understood definition of accident.14 Insurers concluded that the historical meaning of accident was "a sudden and unexpected event that is identifiable in time and place," but some courts had already ruled that an injury resulting from a gradual exposure to conditions was also an accident.15 Third, there was an ambiguity about when an accident actually happened.16 The majority opinion shared by courts and insurers alike was that an


9. Id.

10. Id.

11. Id. (citing Wendorff, supra note 8).

12. Id. at 208.

13. Id. at 208-09 (citing Knight v. L.H. Bossier, Inc., 118 So. 2d 700 (La. Ct. App. 1960)). To remedy this problem and clarify the policy, the insurers added language stating that an occurrence had to be "neither expected nor intended from the standpoint of the insured." Id. (citing Wendorff, supra note 8). This addition resulted in the inclusion of continuous injuries under the coverage of the standard CGL policy.

14. Id. at 209.

15. Id. (citing Beryllium Corp. v. American Mut. Liab. Ins. Co., 223 F.2d 71 (3d Cir. 1955)). The insurers again extinguished this ambiguity by adding language to explicitly cover injurious exposure to conditions in the definition of "occurrence." Id. (citing Wendorff, supra note 8).

16. Id. at 209.
accident occurred when an injury took place; however, some courts held that an accident occurred when the negligent act was taken.\textsuperscript{17} The language of CGL policies written after this change use the key word “occurrence” that was defined as “an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended.”\textsuperscript{18} As history has shown, this change did little more than shift the ambiguity to the new words. In reality the only significant difference is that the policies now include a term that requires expertise to discern.\textsuperscript{19} These policies do not, and probably for a specific reason, include a precise definition of what triggers the coverage liability.\textsuperscript{20} As a result, courts have been forced to decide on an appropriate method to determine exactly what constitutes an occurrence. As expected, the decisions are varied and conflicting. Four main theories have emerged: (1) the exposure trigger; (2) the manifestation trigger, (3) the injury in fact trigger, and (4) the continuous trigger.\textsuperscript{21} Note that the use of the word “trigger” is a judicially created term meant to incorporate the event or events that instigate coverage responsibility under a particular policy.

The exposure trigger defines an “occurrence” at the earliest possible time, usually when the exposure to injury causing conditions first occurs.\textsuperscript{22} This theory arose from asbestos litigation.\textsuperscript{23} Recently it has gained support in the areas of toxic torts and environmental litigation.\textsuperscript{24} These types of cases often trigger concurrent insurance policies that are liable for one continuous or progressive injury.\textsuperscript{25} Under this theory, if there are multiple exposures to the injury-causing conditions then the CGL coverage liability is triggered every time the exposure

\textsuperscript{17} Id. at 257 (citing Kendrick v. Mason, 99 So. 2d 108 (La. 1958)). The insurer included language in the new policy to specifically indicate that the bodily injury or damage must result during the policy period. Id. (citing Wendorff, supra note 8).

\textsuperscript{18} Id. at 257 (citing SPENCER L. KIMBALL, CASES AND MATERIALS ON INSURANCE LAW 335 (1992)).

\textsuperscript{19} Rappaport, supra note 8, at 208. “Thus, to eliminate the ambiguities, insurers lengthened the contract and changed its focus from a concept that ordinary people comprehend (accident) to a technical term that requires expertise to understand (occurrence).” Id.

\textsuperscript{20} Apparently, vagueness in the insurance policy language allows room for argumentative interpretation when the possibility of coverage is speculative.

\textsuperscript{21} Gelman Sciences, 572 N.W.2d at 821.

\textsuperscript{22} Id.


\textsuperscript{24} Richmond, supra note 23, at 1439.

\textsuperscript{25} The reason being that responsibility and liability emanate from the victim's exposure to the conditions precipitating the injury.
occurs no matter how many policy periods are included.\textsuperscript{26} This trigger disregards the actual moment of injury because many times that moment cannot be discovered or proven precisely.

The manifestation trigger defines an "occurrence" at the latest possible time, according to when the injury is discovered. The event giving rise to liability is considered to occur when the injury manifests itself in an ascertainable form no matter how or why it occurred. Under this theory, if the injury has been discovered, or should have reasonably been discovered during a policy period, then that specific policy is triggered.\textsuperscript{27} This method of determining responsibility for the coverage results in the most narrow determination of liability because once the trigger is invoked no other policies are liable.\textsuperscript{28} The policy triggered bears the loss in its entirety.\textsuperscript{29}

The injury in fact trigger is also known as the actual injury trigger. This theory requires a finding of actual injury during the exposure to the conditions causing the injury. This is different from the manifestation trigger in that coverage liability can be found even if the injury is not discoverable during the policy period.\textsuperscript{30} If the injury can be traced to prior events, this theory limits the liability to the policy covering the coverage period or periods in which the events occurred.\textsuperscript{31} If the circumstances allow for identification of the injury causing event, this theory reflects an interpretation of the policy's plain language and supports the reasonable expectations of the parties.\textsuperscript{32}

The continuous trigger, also known as the triple trigger or multiple trigger, requires evaluation of the injury from exposure to manifestation. This theory affords the broadest coverage by deeming liable all policies that covered the periods from the initial event through discovery of the injury.\textsuperscript{33} The rationale is that the injury may have occurred at any number of points during the coverage periods.\textsuperscript{34} In cases of injuries where the causation cannot easily be pinpointed, this method offers the most common sense analysis. Also, the competing interests of the insured and insurer are accommodated best under this trigger.\textsuperscript{35}

\textsuperscript{26} This is the case in most continuous injuries.
\textsuperscript{27} Richmond, supra note 23.
\textsuperscript{28} Id. at 1431-32.
\textsuperscript{29} Id. at 1432. Obviously this theory is more applicable to situations with injuries that are readily apparent or obvious.
\textsuperscript{30} Id.
\textsuperscript{31} Id.
\textsuperscript{33} Richmond, supra note 23, at 1432.
\textsuperscript{34} Gelman Sciences, 572 N.W.2d at 621.
\textsuperscript{35} Richmond, supra note 23.
In evaluating the varied theories of when policies are triggered, it is important to remember that though needed to categorize the opinions of courts, the usefulness of trigger theories can be deceptive.\(^6\)

In reality, reference to trigger theories is more useful in describing what has been decided than in determining what the decision should be in a given case. The Court can discern no consistent pattern in the myriad trigger cases that prescribes the specific trigger theory to apply in a specific type of case. Furthermore, reference to trigger theories can be deceiving. Comparison of the manifestation theory with the injury in fact theory is absolutely meaningless unless there is some real possibility of a substantial time lag between the actual injury and the resulting manifestation. Similarly, comparison of the injury in fact theory with the exposure theory means nothing unless the advocate of the exposure theory presses for a ruling that coverage was triggered prior to the point when injury in fact occurred. Moreover, in all of these scenarios, "real" or "actual" injury must be defined in temporal relation to initial exposure or ultimate manifestation. Any effort to logically organize all of the trigger cases along these lines would be perforce ineffectual. Consequently, trigger rulings are most appropriately derived by reference to the operative policy language, as opposed to the judicial gloss placed upon similar language in ostensibly analogous cases.\(^7\)

To underscore the problems associated with reliance upon a particular trigger theory, it becomes apparent upon review of the case law that some courts categorically apply a theory without an in depth evaluation of the factual basis upon which each trigger turns.\(^8\) The rules of contract interpretation dictate that courts interpret insurance policies in favor of the nondrafting party to the extent that defense obligations of CGL policies are subject to more than one reasonable interpretation.\(^9\) A court must also apply the "reasonable expectations" doctrine, which provides that "a policyholder's reasonable expectations regarding the nature, scope and terms of his coverage should be honored by the courts even though a careful review of the policy language reveals a particular limitation or exclusion."\(^10\)

36. Gelman Sciences, 572 N.W.2d at 622.
38. Gelman Sciences, 572 N.W.2d at 622. Furthermore, the over emphasis of the trigger theory lends to a lack of consideration for the policy language involved.
For the purposes of this comment, it is assumed that the actual moment of injury cannot be pinpointed when settlement is reached. For that reason, the continuous injury trigger will apply and the main issue becomes how to apportion the liability for the settlement amount between all triggered CGL policy providers. This dilemma has been addressed by many courts under all triggers of coverage, yet no solid precedent has been formed upon which courts may rely upon today.

III. HOW LIABILITY IS APPORTIONED AFTER SETTLEMENT

If the proportionate liability among the insurers is not agreed upon when a continuous injury claim is settled, the insurance companies will seek a court order to determine the appropriate apportionment of the amount owed by each insurer. This may include claims for contribution through indemnification from any insurer whose policies were triggered but did not participate in the settlement. The court will first determine the triggered policies as discussed before. Thereafter, the court must choose a method to apportion the liability among the liable insurers. The method chosen by the court will determine the amount of the prorated portion owed by each insurer. This proration should ideally lead to an equitable distribution of the aggregate settlement payment. Any insurer who paid more than its share will be reimbursed and those insurers not paying originally will be ordered to contribute.

The primary factor in requiring the equitable distribution of the settlement payment stems from the doctrine of joint and several liability. Courts are split on whether the liable insurers should be allowed to sever their liability from that of the other insurer. The reason for this desired separation is obvious: if all triggered insurers are jointly and severally liable the court could require the insurers to pay any portion of the settlement not recoverable from another liable insurer thereby maximizing coverage for the insured.

In Keene Corp. v. Insurance Co. of North America, the court was confronted with determining the extent to which many different policies covered liability for asbestos related diseases. The court found that the terms of the policies did not lead to a resolution of the coverage issues. The court sought to interpret the contracts "in a manner that is equitable and administratively feasible and that is consistent with

42. 667 F.2d 1034 (D.C. Cir. 1981).
43. Id. at 1038. Keene Corporation was named as a codefendant in over six thousand lawsuits alleging injury from prolonged exposure to asbestos products. Id.
44. Id. at 1041. The insurers did not develop policy language that directly addressed the liability issue. Id.
insurance principles, insurance law, and the terms of the contracts themselves.\textsuperscript{45} The controlling principle for the court's holding was the reasonable expectation of the company when it purchased the insurance policies.\textsuperscript{46} The court interpreted injury to include any part of the process by which the injury developed and held that all the policies in place from exposure to manifestation were triggered.\textsuperscript{47}

Based upon its own definition of injury, the court in \textit{Keene} found that only part of the injury would have developed in any single policy, and the rest of the development could have occurred in any other policy period.\textsuperscript{48} This finding, as well as the court's continued reliance on the contract terms and expectations of the insured, led to the conclusion that the insurers were all fully liable for the claims.\textsuperscript{49}

The holding in \textit{Keene} is one of the earliest signs that courts will use a method of apportionment that delivers a favorable result to an insured. In that regard, the apportionment theories are reduced to mere labels for the desired need to maximize insurance coverage.\textsuperscript{50} Today, the jointly liable approach to apportionment has met much resistance.\textsuperscript{51} In another asbestos case, \textit{Insurance Co. of North America v. Forty Eight Insulations, Inc.},\textsuperscript{52} the court allowed severable liability. Though \textit{Forty Eight Insulations} has its critics as well,\textsuperscript{53} the most recent trend has been for courts to follow its lead, especially in the application of the method chosen by that court in apportioning liability.

The court in \textit{Forty Eight Insulations} upheld the district court's method of apportioning the costs between all triggered insurers and held that each insurer is liable for its prorata share.\textsuperscript{54} The court used the same contract interpretation principles as those used by the court in \textit{Keene}.\textsuperscript{55}

\begin{thebibliography}{99}
  \bibitem{1} Id.
  \bibitem{2} Id. at 1042 (citing Keeton, \textit{Insurance Law Rights at Variance with Policy Provisions}, 83 HARV. L. REV. 961, 967 (1970)). The court noted that Professor (now Judge) Keeton argued that insurance policies are contracts of adhesion. Id. at 1042 n.12.
  \bibitem{3} Id. at 1047.
  \bibitem{4} Id.
  \bibitem{5} Id. The court did note that each policy was subject to the "other insurance" clauses, a topic which is outside the scope of this comment.
  \bibitem{6} Some courts have disagreed with the decision in \textit{Keene}, primarily because the injuries were more readily ascertainable and the causation more readily attributable to specific time periods.
  \bibitem{7} See Northern States Power Co. v. Fidelity & Cas. Co. of New York, 523 N.W.2d 657 (Minn. 1994); Cole v. Celotex Corp., 599 So. 2d 1058 (La. 1992).
  \bibitem{8} 633 F.2d 1212 (1980).
  \bibitem{9} See Montrose Chem. Corp. of California v. Admiral Ins. Co., 897 F.2d 1 (Cal. 1995);
  \bibitem{10} Zurich Ins. Co. v. Raymark Indus., Inc., 118 Ill. 2d 23 (Ill. 1989).
  \bibitem{11} 633 F.2d at 1225.
  \bibitem{12} Id. at 1216-18.
\end{thebibliography}
The medical evidence presented to the court showed that each exposure to inhalation of asbestos fibers causes some damage. The negligent act was the failure by the company to warn its employees of the danger presented by breathing these fibers. The court noted that a reasonable means of apportionment was available and prorated liability among all the insurers based upon the time that they were "on the risk" while the injured employees were breathing asbestos fibers. The court also stated that the burden of disclaiming coverage would be on the insurer for any year in question that it believed no exposure occurred.

The apportionment method used by the court in Forty Eight Insulations is commonly referred to as the "time on the risk" method. In the settlement of continuous injury cases, where the causation of injuries cannot be placed in definite policy periods, the "time on the risk" method seems to be the tool of choice for apportioning responsibility for a settlement payment. This is evidenced by the case of Northern States Power Co. v. Fidelity & Casualty Co. In that case, the Supreme Court of Minnesota was confronted with the question of how to allocate damages between multiple insurance companies found liable for environmental clean-up costs. The insured had previously settled with all insurers except the defendant insurer. Because of the scientific complexity of the issues involved, the length of time over which damages may have occurred, and the number of parties involved, the court chose to use a "pro rata by time on the risk" method of apportion-

56. Id. at 1222.
57. Id. at 1218.
58. Id. at 1219.
59. Id. at 1224. For example, if insurer A provided three years of coverage, insurer B provided three years of coverage, and insurer C provided three years of coverage, and the total time of exposure was nine years, the apportionment would be one-third for each respective insurer. Id.
60. Id. at 1225. If an insurer could show that no exposure occurred or an employee used an effective respirator during a year of coverage, then that insurer would not be liable for coverage for that period. See id. at 1225 n.27.
62. 523 N.W.2d 657 (Minn. 1994).
63. Id. at 658.
64. Id. at 659.
ing the damages. This decision resulted in a finding of the proportionate amount owed by the one delinquent insurer, to the other insurers who had already paid.

The analysis used by the court in *Northern States* is logical and realistic. The court concluded that even though it would have been scientifically possible to prove the amount of harm occurring during each policy period, it was nonetheless far too expensive to warrant such proof in that case. With an eye towards future litigation, the court reasoned that to require such an investigation would reduce the likelihood of settlement and, as a public policy matter, the insured would be faced with extreme difficulty as a general matter if it had to prove the damages for each policy period. The court held that damages were to be evenly distributed among each insurer proportionate to the number of years it was on the risk relative to the total number of years of coverage triggered.

Missouri adopted the time on the risk method in *Continental Casualty Co. v. Medical Protective Co.*, where three successive dental malpractice insurers sought a declaratory judgment regarding the proper apportionment of a ninety-thousand dollar settlement for the repeated acts of negligence by the insured dentist over the course of twenty years. The suit alleged professional malpractice by way of the

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65. *Id.* at 663. The court noted that liability would normally be limited to the policy periods in which damages occurred or "as proven," however, here, that method would not be practical. *Id.*

66. *Id.*

67. *Id.* (citing William R. Hickman & Mary R. DeYoung, *Allocation of Environmental Cleanup Liability Between Successive Insurers*, 17 N. Ky. L. Rev. 291 (1990)).

68. *Id.* The court provided the following example:

If contamination occurred over a period of ten years, one-tenth the of the damage would be allocable to the period of time that a policy in force for one year was on the risk and [three-tenths] the of the damage would be allocable to the period of time three-year policy was in force. The amount so determined does not, however, necessarily represent the amount of the insurer’s liability with respect to that policy.

*Id.* at 664.

69. 859 S.W.2d 789 (Mo. App. 1993).

70. *Id.* at 790. All three insurers issued policies during the course of the dentist’s treatment of plaintiff. Their coverage never overlapped. Continental Casualty Company insured the dentist for two periods. Each policy had an annual liability limit of one million dollars for a two million dollar total. Federal Insurance Company insured the dentist for three periods. All three policies had annual liability limits of one million dollars for a three million dollar total. Medical Protective Company issued annual policies beginning in 1965 and ending in 1981. The liability limits of Medical Protective’s policies varied from a ten thousand dollars to two hundred thousand dollars per policy, aggregating to one million dollars. *Id.*
dentist’s failure to exercise ordinary skill and care throughout the course of plaintiff’s treatment. One insurer, Continental, defended the suit and eventually settled with plaintiff. Continental incurred defense costs of $11,237. The trial court, focusing on the “other insurance” clauses in the insurance policies, ordered a pro rata apportionment of the loss based on the total policy limit exposure of each insurer. The Missouri Court of Appeals reversed, holding that the coverage liability should be allocated among the three successive insurers based upon the proportionate exposure period of each insurer’s coverage.

The court in Continental began its analysis of the apportionment issue by looking to the wording of the policies involved. The court recognized a distinction in the provisions of liability insurance policies pertaining to “other insurance” coverage for the same loss. The court stated that these provisions contained “other insurance” clauses that related only to concurrent insurance coverage of a single occurrence. The court found that these provisions have no application to a loss that results from a series of occurrences with consecutive insurance policy coverage. The court also found that the wording of the documents obligated each insurance company to pay on behalf of the dentist all damages for which he would become liable as a result of professional services rendered during the term of each policy. The court reasoned that the policy did not purport to establish liability on the part of the insurers for damages that occurred before or after the designated coverage, as the lower court’s order had forced the companies to do.

In devising a proper allocation of liability for the settlement among the three insurers, the court noted that each of the policies provided coverage for specified periods of time and that these terms of coverage constitute the policy language that supports a per diem theory of

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71. Id. at 790-91. Plaintiff alleged that the dentist failed to properly diagnose and treat her condition. Id. at 791.
72. Id.
73. An “other insurance” clause limits the liability of the insuring policy in the event of other or additional liability insurance coverage of a loss.
74. Id. The court found Continental liable for two-sixths of the settlement, Federal liable for three-sixths of the settlement, and Medical Protective liable for one-sixth of the settlement. Id. at 790.
75. Id. at 792-93.
76. Id. at 791.
77. Id.
78. Id.
79. Id.
80. Id.
81. Id.
allocating liability between successive insurers. The court clarified this method from the method that would be used when a single loss results from conduct that is simultaneously insured by two or more companies. In that situation, the court stated that the application of the “other insurance” proration clauses is logical. However, the court held that where a single loss results from conduct successively insured by more than one insurer, the method of proration based upon policy limits becomes “illogical and patently artificial.” The reason for this is that both the risk taken by an insurer and the premium received are more accurately reflected by the amount of time of exposure to the risk than to the amount of coverage.

Acknowledging the fact that insurance premiums are primarily determined by the time period of minimum coverage, the court found that the proper basis of allocation is the length of exposure to liability by the insurer. Using this basis, the court calculated that the dentist was subject to liability for damages for a period of 7,169 days. With the periods of coverage stipulated, the court found that Medical Protective Company was exposed to liability as the insurer of Dr. Winter for 5,577 days, or seventy-eight percent of the total; Federal Insurance Company for 1,155 days, sixteen percent of the total, and plaintiff, Continental Casualty Company, for 437 days, six percent of the total. Because the premiums paid by the dentist for insurance coverage were based primarily upon these periods of time, the proration among the

82. Id.
83. Id. at 791-92.
84. Id. at 792. In that situation, each insurer received a premium to cover the same loss resulting from the same conduct, and each insurer is responsible for the loss up to its respective policy limits. Therefore, those policy limits may be properly used as a means of apportioning the loss fairly. Id.
85. Id.
86. Id. The court noted that the cost of purchasing insurance does not proportionately increase with the amount of the policy limit, but the time period of minimum coverage is the principal factor with additional amounts being relatively inexpensive by comparison. Id. (citing Reliance Ins. Co. v. St. Paul Surplus Lines Ins. Co., 753 F.2d 1288, 1291 (4th Cir.1985)).
87. Id. Analogizing the facts of the case with those of Insurance Co. of North Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980), the court decided that the fair method of apportioning a loss among consecutive insurers is an application of the “exposure theory” utilized in asbestos cases where a loss results from a series of cumulative acts or omissions. Id.
88. 859 S.W.2d at 792. The patient was under the care of the dentist from October 25, 1965 until June 11, 1985. Id.
89. Id.
three insurers on the basis of the proportionate period of each company’s exposure was “the fairest method of allocating the loss.”90

In a recent case, Roman Catholic Diocese of Joliet, Inc. v. Interstate Fire Insurance Co.,91 involving the disturbing act of pedophilia, the church reached a settlement in the civil action and thereafter sought reimbursement from its insurers.92 In determining the proper method of loss apportionment, the court found that the liability resulted from negligent supervision of the priest who abused the child and from the church’s failure to take remedial action.93 The court stated that damage can occur because of the continuous nature of the abuse and in such instances it becomes difficult to determine when the damage to the victim occurs.94 With this in mind, the court determined that there was no way to accurately measure the damage caused by the abuse during any given policy period; therefore, under its construction of the contract language, the loss should be apportioned based on the policy periods.95 The court noted that “if the number of molestations were known and . . . could be proved, [it] could allocate the loss(es) according to the actual injury suffered during each policy period.”96 However, because this determination was not an available option, the court apportioned the losses pro rata between all relevant policy periods.97 There were two policy periods triggered, thus the liability was divided in half and then subject to policy limitations.98

Some commentators believe that the “time on the risk” method of apportionment should be used in all continuous injury cases.99 This comment only speaks to settlement of cases where the injuries are not easily ascertainable. However, the author agrees with many of the reasons used in promoting this method for other cases as well. For instance, the time on the risk method furthers one of the main goals pursued by all parties-to arrive at an administratively manageable

90. Id.
92. Id. at 934.
93. Id. at 938.
94. Id. at 939 (citing Diocese of Winona v. Interstate Fire & Cas. Co., 841 F. Supp. 894, 898 (D. Minn. 1992)). The court reasoned that finding otherwise could potentially deny coverage liability. Id.
95. Id.
96. Id.
97. Id. The court stated that the losses were attributable according to the percentage of the time or period of each child’s molestation occurring during each policy period. Id. (citing Diocese of Lafayette v. Interstate Fire & Cas. Co., 26 F.3d 1359 (1990)).
98. Id. at 939-40.
interpretation of insurance policies that can be applied with a minimal need for expensive litigation.\textsuperscript{100} One commentator suggests:

The time-on-the-risk method should be adopted by courts because its inherent simplicity promotes predictability, reduces incentives to litigate, and ultimately reduces premium rates . . . . Courts can easily administer the time-on-the-risk method. Once a court determines the scope of the progressive injury, that is, the total damage and the period of time from exposure to manifestation, it can readily allocate the damages among the triggered policies. The court divides the total damages by the number of triggered years and simply allocates to each year the result.\textsuperscript{101}

In a perfect world it would be possible to hold each insurer liable only for that portion of liability that is allocable to the policy period in question. This is "theoretically satisfying, but will almost always be infeasible."\textsuperscript{102} For all practical purposes, once a settlement is reached and liability is found for all triggered insurers, the real issue becomes whether the injury or damage suffered during the different policy periods is indivisible. If so, the apportionment of the settlement costs should based on a pro rata by time on the risk method. This allocation scheme is attractive in many ways, yet it is always important to "recognize that damages are by their nature fact-dependent and that trial courts must be given the flexibility to apportion them in a manner befitting each case."\textsuperscript{103} Often that manner will reflect what is best for the insured.

Assuming that the settlement entered into is what is best for the insured, the remaining questions regard apportionment among the insurers liable for the settlement payment. Following equitable principles of unjust enrichment and basic division of liabilities, the courts must conclude that each contributing insurer has a right to reimbursement from any other insurer found responsible as a result of its policy or policies being triggered. Often because of the very nature of the injuries, this apportionment method will require an approximate calculation of the amounts owed. Because of the uncertainty involved, it appears most equitable to announce that in these specific situations the courts will conclude that all liable insurers must share in the

\textsuperscript{100} Forty Eight Insulations, 633 F.2d at 1218 (referring to its task of apportionment as a "Solomonian" possibility).

\textsuperscript{101} See Doherty, supra note 99, at 281 (defending the time on the risk method).

\textsuperscript{102} Northern States, 523 N.W.2d at 663 (quoting KENNETH S. ABRAHAM, ENVIRONMENTAL LIABILITY INSURANCE LAW: AN ANALYSIS OF TOXIC TORT AND HAZARDOUS WASTE INSURANCE COVERAGE ISSUES 120 (1991)).

\textsuperscript{103} Id.
payment of the settlement according to their respective policy periods triggered. Use of this method would result in less confusion during the litigation process. Furthermore, a forewarning that the insurers will eventually be liable could lead to more efficient resolution of the matters involved.

IV. CONTRIBUTION AND SUBROGATION

As mentioned earlier, often an insurer or possibly the insured will go forward with the defense of a continuous injury claim, settle the suit, and then seek apportionment through the court system. Under the doctrine of subrogation, the settling party may equitably allocate the loss over all triggered policies. The court will look to the triggers of coverage to determine the policy periods and thus the insurance companies responsible for payment of all costs associated with the litigation. The proper apportionment method will then be used to determine the amount of liability. The resulting claims will be for indemnification of any monies owed. If insurers paid more than their fair share they will seek to subrogate to recover payments from other liable insurers. When the insurer indemnifies the insured, it then becomes equitably entitled to recover any “over payment” from the other carriers. This action derives from the principle that an insurer who covers its insured's settlement is entitled to recover all or part of that settlement from another responsible party, based on the latter's proportion of fault. In such instances, the insurer is subrogated to the insured's rights of recovery.

Subrogation of an insured's rights is an equitable remedy which is derived from rights of and is limited to those rights. Most often the insured is a plaintiff against a tortfeasor or a nonpaying insurer. Essentially, the principle of subrogation permits one who is legally obligated to pay the debt of another to “stand in the shoes” of the person owed payment and enforce that person's right against the actual wrongdoer. The insurer will retain part interest in the insured's claim against the tortfeasor to the extent that the insurer has compensated the insured for his loss or, in our case, overpaid for more than its pro rata share. Any contributing insurer may have a cause of action

104. The doctrine of subrogation enables an insurer that has paid all or a portion of an insured's loss to recoup the payment from any other party responsible for the loss.
105. 44 AM. JUR. 2D Insurance § 1792 (1982).
107. 44 AM. JUR. 2D Insurance § 1794 (1982).
for equitable subrogation against any noncontributing insurers whose policies were also triggered. It is universally accepted that an insurer settling a claim that should have been covered by another insurance company can recover any amount overpaid in settlement under the equitable doctrine of subrogation. Courts have reasoned that equity allows an insurer that paid a debt owed by another to obtain reimbursement from those who ought to have paid it. This includes the right to an action to recover defense expenditures. However, courts differ on the issue of whether the doctrine of subrogation also applies to settlement and defense costs where two or more insurance companies were equally obligated to defend.

Whether an insurer can compel contribution from a coinsurer who is equally obligated to defend is a question that has resulted in a split of authority. Some jurisdictions have held that because the duty to defend is personal to each insurer, the obligation is several, and where many carriers are obligated to defend, each separate carrier is neither entitled to divide the duty nor to require contribution from another, absent a specific contractual right. The trend in other jurisdictions has been to allow an insurer, under the doctrines of contribution or equitable subrogation, to recover costs of defense from other insurers who were equally obligated to defend yet failed to do so. One court reasoned that an insurer should not be encouraged to avoid its responsibility to provide a defense for its insured, nor should that insurer be rewarded for breaching its duty under its insurance contract.

110. Id. at 985.
111. National Farmers Union Property & Cas. Co. v. Farmers Ins. Group, 377 P.2d 786, 787-88 (Utah 1963) (holding that insurer who had successfully defended an insured which should have been covered and thus defended by another insurance company could recover the costs and attorney fees under the doctrine of subrogation).
114. National Indem. Co. v. St. Paul Ins. Cos., 724 P.2d 544, 545 (Ariz. 1986). Under the principle of equitable subrogation, the insurer which has performed the duty to provide a defense to its insured should be able to compel contribution for a share of the cost of defense from another insurer who had a similar obligation to the same insured but failed to perform it.
115. Id. In agreement with this approach, one scholar comments:
These holdings are indefensible. The courts are ignoring realities and encouraging insurers who are not concerned with their obligations to their insureds in the hope that someone else will step into the breach . . . . Further, as a matter of public policy, courts should be demanding that insurers give prompt defense of claims to
This comment agrees with those jurisdictions that have allowed contribution where one insurer has paid more than its fair share of the defense costs. Where it can be shown that a co-insurer failed to defend or failed to pay its share of the defense expenses, that insurer should not be rewarded and payment excused when another co-insurer has taken upon itself the provision of that defense. Holding otherwise would not only lead to an inequitable result but may also conflict with the public policy of encouraging prompt payments to the insured, leaving disputes concerning coverage to be determined later. In addition, an insurer does not lose its right to equitable subrogation because it failed to take timely action to protect its rights. An insurer may wait until it has paid its insured in full before instigating an action to compel reimbursement.

It should be noted that the settlement of a nondefending and noncontributing insurer with the primary insured does not extinguish any rights owed by that insurer to the defending insurers. Admittedly, under the law of most states, "any defenses that are valid against the insured are also valid against the [subrogated] insurer." However, even though the insured settled and released all claims against a prior non-contributing insurer, that release does not act as a complete defense against a defending insurer's claims. This eliminates the ability of a noncontributing insurer to "lock in" its amount of liability or responsibility for a settlement.

Similarly, in third-party insurance contexts, courts have held that where the insured settles with a tortfeasor, and the tortfeasor and/or its insurer was on notice of the other insurer's subrogation right, then the settlement and release will not affect the insurer's right of subrogation.

The overwhelming majority of states allow a subsequent

policyholders rather than to tolerate the shifting of responsibility with such impunity.


116. State Farm, 912 P.2d at 987.
117. Id. at 985-87.
118. Fashion Place Inv., Ltd. v. Salt Lake County/Salt Lake County Mental Health, 776 P.2d 941, 945 (Utah Ct. App. 1989).
119. Sharon Steel, 931 P.2d at 138.
equitable subrogation action by an insurer if the insurer did not consent to the release and the tortfeasor knew of the insurer's interest prior to the release. These authorities reason that allowing a general release between the tortfeasor and the insured "constitutes a trap for the unwary insured plaintiff" and "encourages fraud or, at the very least, sharp practice on the part of the tortfeasor or his insurance carrier." Ultimately, these courts find that to require the unsophisticated insured to execute a release of all claims, even though the tortfeasor has knowledge of the insurer's interest and the probable existence of a standard insurance policy provision obligating the insured to protect the insurer's subrogation rights, is simply not consistent with fair dealing and ought not be encouraged. This rationale was affirmed when the Washington Supreme Court stated that although equities also favored encouraging settlements and avoiding litigation, "such a speculative result is not equitably purchased at the price of either abandoning the subrogation rights of the insurer or limiting recovery to reimbursement from the injured insured."

This same reasoning is equally applicable to consecutive insurers where one insurer is on notice that another has paid all or more than its share of the defense costs. "Indeed, there is probably even more of an incentive for an insurer to engage in 'sharp practices' to settle for a limited amount with the possibly unsophisticated insured to avoid the subrogation rights of another insurer who has paid substantial defense costs." "[I]t is more equitable to hold that an insurer who is on notice that another insurer has been paying significant defense costs should not be allowed to settle for a minimal sum to avoid having to contribute its fair share."
contribution from the other liable carriers. The liability, and therefore the responsible parties, is determined by applying the trigger of coverage theories to the policy periods in which exposure to injury-causing conditions existed. Courts have often applied pure equitable principles to assert that the right of contribution arises out of an equitable doctrine that one who pays money for the benefit of another is entitled to reimbursement. The case law supports the equitable distribution of the loss among the affected insurers. Normally, the insurer's indemnification will be dispersed to the paying insurance companies according to one of the proper apportionment methods.

When the injury is indivisible between all triggered policies, the best method of apportioning the triggered insurer's payments into the settlement of a continuous injury claim is the pro rata time on the risk method. This method is based on the equitable contribution arising out of what is in essence a subrogation to part of the insured's right to indemnification as well as prorata apportionment of the cost by way of the time on the risk for each policy period triggered. First, actual triggered policies must be determined by using the continuous trigger theory of defining an occurrence. All policies covering the insured from the exposure until manifestation of the injury are triggered. The number of policy periods to which each insurer provided coverage will be proportionally related to the aggregate number of policy periods triggered. Each insurer is then left with a corresponding percentage of the entire cost of defense and settlement. This amount is then compared individually by way of the deductibles and policy limits to determine the grand total of the insurer's liability payment. If any of the insurers whose policies were triggered failed to participate in the defense or settlement payments, then all contributing insurers have an equitable right to receive contribution payments from those delinquent insurers by way of subrogation to the rights of the insured.

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