

A Fact of Life

By Eric Hermanson
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The industry has not adopted standard policy language, and the general principles affecting transfer of risk depend on a complex, shifting body of case law, which varies from jurisdiction to jurisdiction.

Retained Limits, Deductibles, and Self-Insurance

The last few years have been challenging for insurers and policyholders alike. As the economy has faltered and competitive pressures have increased, many companies have tried to restructure their insurance programs to reduce

premium outlays. Insurers, meantime, have looked for ways to manage their limits more conservatively. In this cost-conscious environment, it has become increasingly common for policyholders, in exchange for reduced premiums, to agree to forego first-dollar coverage and to self-insure or otherwise to assume some part of the risks that they might otherwise transfer to insurers.

A retention, or self-insured retention (SIR), sometimes known as a “retained limit,” is a feature of an insurance policy under which an initial portion of covered risk is borne by the policyholder, not the insurer. A deductible is a feature of an insurance policy under which the insurer, after defending a lawsuit and paying a covered loss, may charge part or all of that loss to the policyholder to reclaim it. Although the two provisions operate differently and have different coverage implications, they are often confused with one another. This confusion, combined with a poor understanding of how the two features operate in practice, has led at times to complicated coverage disputes.

This article outlines the basic features of self-insured retentions, describes how they differ from deductibles, and discusses some common issues that have arisen in interpreting them, such as how the duty to defend is allocated in policies to which these provisions apply, how retentions are exhausted, who may exhaust them, and how a policyholder satisfies retentions when a single claim triggers multiple policies with retention provisions.

Retentions and Deductibles: What's the Difference?

Many courts, and some commentators, mistakenly believe that a retained limit is just a kind of large deductible. While retentions and deductibles both require a policyholder to contribute financially to a covered loss, they serve fundamentally different functions and operate very differently in practice.

The International Risk Management Institute (IRMI) definitions of the two terms provide guidance as to the differences. IRMI defines “deductible” as



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[a]portion of covered loss that is not paid by the insurer. Most property [and some liability] insurance policies contain a per-occurrence deductible provision that stipulates that the deductible amount specified in the policy declarations will be subtracted from each covered loss in determining the amount of the insured's loss recovery.

In contrast, IRMI defines "self-insured retention" as

[a] dollar amount specified in an insurance policy (usually a liability insurance policy) that must be paid before the insurance policy will respond to a loss. SIRs [self-insured retentions] typically apply to both the amount of the loss and related costs, e.g., defense costs, but some apply only to amounts payable in damages, e.g., settlements, awards, and judgments.

In sum, a deductible represents a portion of a covered loss lying within the terms of the policy for which the policyholder may eventually be obligated to reimburse the insurer. In contrast, a retention is an initial portion of a loss that lies outside the policy. It is a risk that the policyholder has agreed contractually to retain for itself.

Acknowledging this distinction, most courts treat retained limit policies as a species of excess insurance, meaning that they treat it as secondary coverage in which the insurer's coverage obligation takes effect only after the policyholder has first satisfied its own obligations with respect to the alleged loss. See, e.g., *Spaulding Composites Co. v. Aetna Cas. & Sur. Co.*, 819 A.2d 410, 36 n.4 (N.J. 2003). Under this construction, a policy with a retained limit is analogous to "traditional" excess policies in which coverage begins only after a predetermined amount of underlying primary insurance has exhausted.

Why Does the Distinction Between Retentions and Deductibles Matter?

The distinction between deductibles and retentions has a number of ramifications, but one of the largest relates to the timing and receipt of payment. When a deductible is involved, an insurer generally defends and settles the claim, up to the limits of its policy, then seeks reimbursement from the policyholder for any amount that falls within the deductible. The portion of loss comprising the deductible is covered within the pol-

icy limits. It is "deducted" from the policy limits through reimbursement.

In contrast, when a retention is involved, a policyholder must pay its portion of the loss up front because that amount is not covered by the policy at all. An insurer's coverage obligation begins and its limits come into play only *after* the policyholder satisfies this initial "retained" portion of the covered loss. Once the policyholder satisfies the retention, triggering the policy coverage, however, the insurer is liable up to its full limits. The retention is not "deducted" from those limits and does not reduce the amount of the insurer's potential financial obligation. See *In re September 11th Liability Insurance Coverage Cases*, 333 F. Supp. 2d 111, 124 n.7 (S.D.N.Y. 2004).

A simple example will illustrate. Suppose that a large company is exposed to frequent small losses of a type generally covered by commercial general liability policies. These small losses are relatively consistent and always total at least \$500,000 per year. The company also has occasional larger losses, which are less frequent and less predictable.

The company in these circumstances has several choices. First, it could purchase traditional first-dollar insurance, in which an insurer agrees to defend and indemnify the company against covered claims up to a specified aggregate limit of, say, \$5 million. This arrangement would cover the company's expected initial \$500,000 of covered loss, plus up to \$4.5 million in additional covered claims. The insurer, not the company, would defend and settle all of these claims, until the aggregate limits were exceeded.

This insurance, however, would likely be quite expensive. The annual premiums would include, at a minimum, the \$500,000 in initial expected loss each year, plus the costs of handling and adjusting that loss, plus the additional costs that the insurer expected to accrue in adjusting, defending, and settling larger claims that exceeded the \$500,000 amount.

If the company liked the idea of having an insurer defend and settle its claims but did not want to pay such high premiums, it might choose to purchase a \$5 million policy with a \$500,000 aggregate deductible, operating indemnity only. A few policies also apply deductibles to defense

expenses, but this is relatively rare. Under this arrangement, the insurer would agree to defend the policyholder against any claims that fell within the scope of the policy. It would have the right to attempt to settle these claims within policy limits. It would pay for any losses that the policyholder incurred up to the \$5 million aggregate. As indemnity payments were made,

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however, the policyholder would have to reimburse the insurer until the \$500,000 aggregate deductible was reached. Moreover, the insurer's payment of deductibles would reduce the limits available to pay other claims: if the company's covered loss in a particular year exceeded the \$5 million policy limits, but the policyholder reimbursed the insurer for \$500,000 of that amount under the policy's "deductible" provisions, the policyholder would ultimately receive \$4.5 million in indemnity.

Alternatively, the company might choose to purchase a \$5 million policy with a \$500,000 aggregate retention. In that case, the company would have the obligation to pay, and would have the obligation, under most policies, to defend itself against, the first \$500,000 of covered loss. The insurer's obligations would be triggered only after the company's losses exceeded \$500,000 in the aggregate. At that point the insurer would take over the company's defense and would pay the next \$5 million toward covered claims. Notably, however, the retention, unlike a deductible, would *not* be deducted from the policy limits, so the policyholder, after satisfying the retention, would be eligible to receive the full \$5 million limits of the policy.

In another variation on this approach, the company might choose to purchase

a \$5 million policy with a \$500,000 *per occurrence* retention or deductible. Under this approach, the company would be responsible either to defend and to pay, in a retention arrangement, or to reimburse the insurer for paying, in a deductible arrangement, all of the small-dollar claims that were asserted against it. Its obligation would apply to every occurrence that gave

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rise to claims not exceeding the \$500,000 threshold. The insurer's obligations would be limited to large or catastrophic events, meaning occurrences that led to claims exceeding the \$500,000 amount.

One final variation on this theme consists of "matching deductibles," or fronting policies. These policies have deductibles equal to the policy's limits. Thus, in our hypothetical, the company would purchase a \$5 million policy with a \$5 million deductible. The effect, in most cases, would be that the insurer would defend and handle claims but would not be required to pay any indemnity at all. Fronting policies have their own specialized body of case law and lie outside the scope of this article. In general, they may be useful devices for sophisticated policyholders that have the financial capacity to cover their own losses but that need to satisfy state financial responsibility laws "guaranteeing... third persons who are injured that their claims against [the policyholder] will be paid." *Columbia Cas. Co. v. Northwestern Nat. Ins. Co.*, 231 Cal. App. 3d 457 (Cal. Ct. App. 1991).

Are We Dealing with One or the Other?

When a company wishes to buy insurance and wishes to retain some risk in exchange for lower premiums, it may plausibly choose to employ either a retention or a deductible. Neither approach is inher-

ently more favorable than the other. The choice is one of preference based on the company's risk profile, its liquidity, its desire to control its own defense, its tax accounting, and other factors. To the extent that one approach or the other offers financial advantages, those advantages generally will be factored into the policy's premiums.

When a claim arises under a policy, however, an insurer and a policyholder sometimes dispute whether the policyholder purchased a deductible or a retention and how the insurer should apply relevant policy provisions to the claim. For example, when a loss exceeds the amount of the policy limits, the policyholder may wish to characterize the policy as containing a retention. This characterization would allow the policyholder, after satisfying the retention, to access the full stated limits of the policy. The insurer, in contrast, may prefer to construe the provision as a deductible because a deductible would oblige the insurer to pay less than it would with a retention.

On the other hand, in some circumstances an insurer may prefer to construe a policy as containing a retention rather than a deductible. This is because policies with retentions typically require the policyholder to pay the entire retention up front as a precondition to receiving coverage under the policy. Under a strict application of this language, if a policyholder does not or cannot satisfy the retention, the insurer may not have any coverage obligations whatsoever. See *Pak-Mor Manuf. Co. v. Royal Surplus Lines Ins. Co.*, 2005 WL 3487723 (W.D. Tex. 2005); *Insurance Co. of the State of Pa. v. Acceptance Ins. Co.*, 2002 WL 32515066, at *3 (C.D. Cal. Apr. 29, 2002).

Finally, the retention versus deductible issue may arise when excess coverage is at play. The case of *Tokio Marine and Fire Ins. Co.*, 693 N.Y.S.2d 520 (N.Y. App. Div. 1999), is illustrative. There, a primary insurer issued a \$1 million policy with a \$250,000 "deductible," which was defined a bit vaguely as "the amount of damages under this policy which the insured has a duty to pay." The policyholder contributed \$250,000 and the primary insurer contributed \$750,000 toward a settlement. The excess insurer argued, however, that the \$250,000 amount was not a true deductible but a form of self-insured retention. It argued that its excess policy was not triggered until after the pol-

icyholder paid its \$250,000 and the primary insurer then contributed the entire \$1 million limits of its policy.

The court rejected this argument and held that the primary policy contained "a true deductible, properly subtracted from the policy limits." The court in part relied on the policy's use of the term "deductible," but it also went further, noting that the policy gave the insurer the right to pay damages within the deductible if the policyholder failed to do so and stating that if the insurer did choose to pay this portion of loss, it was entitled to obtain reimbursement from the policyholder. This is, of course, exactly how a true deductible is meant to operate.

Who Defends and How?

One key distinction between retentions and deductibles relates to the defense and handling of claims under each of the two types of policies, which can lead to difficult conflicts between policyholders and insurers. As a general rule, while the terms of a policy always control, insurers have immediate obligations to defend claims that are subject to deductibles. Moreover, in most jurisdictions, the insurer controls the settlement of these claims, subject only to its limited obligation of good faith toward the policyholder. Unless the policy language provides otherwise, the insurer does not need to obtain the policyholder's consent, and it can settle a claim for an amount within the deductible if it believes that a settlement is appropriate even if the insurer knows that in the end the policyholder will need to pay the settlement amount due to the policy's deductible provisions. See, e.g., *American Protection Ins. Co. v. Airborne, Inc.*, 476 F. Supp. 2d 985 (N.D. Ill. 2007); *Hartford Accid. & Indemn. Co. v. U.S. Natural Resources*, 897 F. Supp. 466 (D. Or. 1995).

In contrast, under an excess policy that sits above a retained limit, the insurer generally has no obligation to defend the policyholder until the policyholder has exhausted the retention by paying covered claims. In these types of policies, the policyholder is permitted to handle its own defense and to make its own settlement decisions—a feature that some policyholders find desirable. See, e.g., *National Union Fire Ins. Co. of Pittsburgh, PA v. Lawyers' Mutual Ins. Co.*, 885 F. Supp. 2d 202 (S.D. Cal. 1995) ("unlike a deductible, 'the excess

insurer's [defense] obligations do not arise until after the amount of the self-insured retention has been paid.”).

Sometimes policyholders, accustomed to the proposition that the duty to defend is broader than the duty to indemnify, will argue that an insurer that issued a policy with a retained limit has an immediate duty to defend any claim that *could* exceed the amount of the retention. Most courts have rejected this argument, although a few courts have accepted it. *E.g., Cooper Laboratories, Inc. v. International Surplus Lines Ins. Co.*, 802 F.2d 667 (3d Cir. 1986). The rejecting courts observe, correctly, that a policy with a retention provision is a type of excess policy. Similar to an excess policy, such policies generally require exhaustion of an underlying amount—the retained limit—as a *precondition* to generating any obligation. So, regardless of the severity of the underlying claim, the policyholder must satisfy that condition to trigger the insurer's defense obligations. *See Hormel Foods Corp. v. Northbrook Property and Cas. Ins. Co.*, 938 F. Supp. 555 (D. Minn. 1996); *United States Fire Ins. Co. v. Scottsdale Ins. Co.*, 264 S.W.3d 160 (Tex. App. 2008); *Allianz Ins. Co. v. Guidant Corp.*, 884 N.E. 2d 405 (Ind. App. 2008); *City of Oxnard v. Twin City Fire Ins. Co.*, 37 Cal. App. 4th 1072 (1995). In general, when courts have departed from this principle, they have done so only after finding the retention provisions of a policy to be ambiguously or vaguely worded. *See, e.g., Legacy Vulcan Corp. v. Superior Court*, 185 Cal. App. 4th 677 (Cal. Ct. App. 2010).

In some high-deductible policies, tensions may arise when a defending insurer has the chance to settle a claim for less than the amount of the deductible but fails to do so. In that case, if a larger judgment is entered, and the policyholder ultimately has to pay the entire amount of its deductible, it may second-guess the insurer's decision not to settle earlier for a lower amount. *Roehl Transport, Inc. v. Liberty Mut. Ins. Co.*, 325 Wis. 2d 56, 115, 784 N.W.2d 542, 571 (Wis. 2010).

Alternatively, in some high-deductible policies, tensions may arise when an insurer has an opportunity to settle a claim for an amount close to or just above the deductible amount. In that case, the policyholder might prefer to pass up the settlement and to try the case to a verdict,

using the insurer's money for a defense, in the hope of avoiding liability altogether. The insurer, in contrast, may be tempted to reach a settlement, cutting off its own ongoing expenditures for a defense with the knowledge that the policyholder will largely or entirely need to pay the settlement. *See, e.g., American Protection Ins. Co. v. Airborne, Inc.*, 476 F. Supp. 2d 985 (N.D. Ill. 2007). To help mitigate these tensions, some policies now contain provisions that give a policyholder the right to participate in the settlement decision when claims fall within the deductible amount.

In policies with retained limits, the opposite tensions may exist. The policyholder is responsible for defending the claim, but it knows that its liability will be capped at the amount of the retained limit, and the insurer will pay for any judgment or settlement beyond that amount. Thus, if a claimant offers to settle with the policyholder for the amount of or an amount near the retention, the policyholder may have an incentive to roll the dice and will decide to try the case, knowing that its own exposure will not increase further with an adverse judgment and that its exposure may decrease, perhaps to zero, if it can avoid liability altogether. These tensions are exacerbated by the fact that a policyholder, in contrast to an insurer, has no generally recognized good-faith obligation to consider an excess insurer's interests in engaging in settlement discussions. *See Commercial Union Assurance Co. v. Safeway Stores, Inc.*, 610 P.2d 1038, 1042 (Cal. 1980) (“a policy providing for excess insurance coverage imposes no implied duty upon the policyholder to accept a settlement offer which would avoid exposing the insurer to liability”).

To remedy these tensions, many policies now require a policyholder to report to the insurer claims that meet a specified threshold deemed likely to exceed the retention, and they give the insurer “the right, but not the duty” to associate in the defense and settlement of these claims. Once an insurer invokes that right, the policyholder has a duty to cooperate. For example, the policyholder may not refuse to convey the insurer's proposed settlement terms to the plaintiff, *New York City Housing Auth. v. Housing Auth. Risk Retention Group, Inc.*, 203 F.3d 145 (2d Cir. 2000), and it may not refuse to contrib-

ute its retained limit to allow the insurer to enter an otherwise reasonable settlement. *Harbor Ins. Co. v. City of Ontario*, 282 Cal. Rptr. 701 (Cal. Ct. App. 1991).

Can't Get No Satisfaction

As noted, in policies that are written excess of a retained limit, the satisfaction of the retained limit is generally viewed as a

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precondition to coverage. This raises two issues: *who* can satisfy the retention, and *how* the retention must be satisfied.

These issues can arise in various contexts. However, they most commonly occur when a policyholder becomes insolvent and is unable to satisfy the retention with its own assets. In those circumstances, can a third party, an additional insured, or perhaps another insurer, step forward to satisfy the retention on the policyholder's behalf? Conversely, can the insurer avoid any of its coverage obligation if the policyholder, for whatever reason, has not properly satisfied the retention?

Who Must Satisfy the Retention?

There is no standard language for retained limit policies. Each policy is different, and each contains slightly different requirements for satisfying the specified retention. While some policies allow the retained limit to be satisfied by third parties or other insurance, other policies have retentions that are explicitly “self-insured.” In an effort to ensure that the policyholder keeps its own “skin in the game,” these policies

require that *the policyholder itself*, or the named insured specifically, “actually pay” the retention amount.

In general, the rule is that “the insured may purchase other insurance to cover an SIR unless the policy clearly requires the insured itself, not other insurers, to pay this amount.” *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal. App. 4th 1466,

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1474 (Cal. Ct. App. 2010); *National Fire Ins. Co. v. Federal Ins. Co.*, 843 F. Supp. 2d 1011, 1017 (N.D. Cal. 2012). When the policy does require this, courts will generally enforce that language. For example, in *Forecast Homes*, the policy stated that “you,” a term that the policy defined narrowly to mean only the Named Insured, had to satisfy a self-insured retention as a precondition to coverage. 181 Cal. App. 4th at 1466. Applying the policy’s definition of “you,” the court held that payments made by additional insureds under the policy did *not* satisfy the retention and did not trigger the excess insurer’s coverage obligation. In other words, the payments made by the additional insureds did not exhaust the retention, and the insurer’s coverage obligations were not triggered until the *named insured* had made payments exceeding the retention amount. See also *Virginia Sur. Co. v. Lexington Ins. Co.*, 2011 WL 2653374, at *4 (N.D. Cal. July 6, 2011) (enforcing policy language that precluded “another insured or an insurance company [from] attempting to ‘pay’ or satisfy the SIR on [the Named Insured’s] behalf”) (emphasis added).

How Must the Retention Be Satisfied?

A related issue is *how* a retention must be satisfied. Is it sufficient for a policy-

holder to show that its liability on a particular claim exceeds or might exceed the retention amount? Or must the policyholder show some actual judgment or settlement in excess of the retained limit has occurred? Assuming that satisfying the retention requires some judgment or settlement, must the policyholder, or some other party if permitted, actually pay the liability before the insurer’s obligations are triggered? What if the party responsible for paying the retention is insolvent and cannot make the payment? Can an insurer be required to “drop down” to cover the policyholder’s retention obligations?

The last of these questions is the easiest, particularly when the amount of the settlement or judgment does not exceed the amount of the retention. Analogizing to traditional excess policies, most courts hold that an insurer that sits excess to a retained limit is not required to “drop down,” or to pay amounts falling within the retention even when the policyholder becomes insolvent. As one court has stated, the “self-insured retention is... not an amount that is owed by the [policyholder] to [the insurer] but, rather, represents the threshold of [the insurer’s] liability to the [policyholder].” *Home Ins. Co. of Illinois v. Hooper*, 691 N.E.2d 65 (Ill. App. Ct. 1998).

The question becomes more difficult, however, when a policyholder faces liabilities exceeding the retention but has not yet incurred any direct financial obligation. In these circumstances, while the policy language will ultimately control, most policies require that the liabilities be reduced to actual obligations in the form of “judgments or settlements” before the retention can be satisfied. Moreover, many insurers argue that the policyholder, or another party authorized by the policy, must *actually pay* the amount owing, as a precondition to coverage. See *Pak-Mor*, 2005 WL at 3487723. Construing these provisions strictly, most courts hold that when a policyholder has not satisfied and cannot satisfy the retention, the policyholder does not have coverage even though the policyholder’s liability would exceed the SIR amount.

For example, in *Insurance Company of the State of Pennsylvania v. Acceptance Insurance Company*, 2002 WL 32515066, at *3 (C.D. Cal. Apr. 29, 2002), the court dealt with a policy that clearly required

the *policyholder* to pay the full amount of a self-insured retention before coverage under the policy was triggered. The policyholder, however, was bankrupt and was unable to satisfy this obligation. Thus, the insurer argued, the policyholder did not have coverage under the policy. An indemnitee argued that this interpretation rendered coverage illusory: since the retention could never be satisfied, as a result of the policyholder’s insolvency, coverage never could exist. The indemnitee asserted, further, that this interpretation was contrary to the “bankruptcy or insolvency” clause of the policy, which said that the policyholder’s bankruptcy or inability to pay would not relieve the insurer of its obligations.

The court rejected the indemnitee’s argument. Since the retention had not been satisfied, it held that the insurer did not have an *obligation* that was being “relieved” by the policyholder’s bankruptcy. The court explained: “[The insurer] is not attempting to avoid its obligations because of [the policyholder’s] inability to pay. Rather, it argues that it does not have any obligations because [the policyholder] has not satisfied the SIR.” The court also rejected the indemnitee’s argument about the “illusory” nature of the coverage. The court pointed out that companies in Chapter 11 bankruptcy are limited but not entirely precluded from paying funds, and it noted that the policyholder had benefited from the contract before it became insolvent. See also *Rosciti v. Liberty Mut. Ins. Co.*, 659 F.3d 92 (1st Cir. 2011) (concluding that a policy required actual payment of the retention before the insurer’s obligations were triggered but holding the policy language unenforceable as a matter of state public policy).

How Does Allocation Work?

Questions may also arise when multiple policies are triggered by the same claim and some of the policies contain deductibles or retentions. Under these circumstances, does a retention qualify as “other insurance” within the meaning of the policies’ “other insurance” clauses? When more than one policy applies to the same, long-tail loss, how many retentions or deductibles should the policyholder have to pay? These kinds of questions are often extremely complicated, and disputes may take place not only between the policy-

holder and its various insurers, but also between the various insurers themselves.

Is “Self-Insurance” Considered “Other Insurance”?

In many cases, when a policyholder has purchased several insurance policies that provide concurrent coverage for a particular loss, some or all of the policies will contain “other insurance” clauses that specify that the policy provides excess insurance over “other insurance,” or “all underlying insurance,” that may be available to respond to the loss. Insurers intend these provisions to make clear that the policy containing the “other insurance” clause will only respond to the loss after the policyholder’s other applicable coverage is exhausted. In such cases, is the policy with the “other insurance” clause also excess over an unsatisfied, self-insured retention that appears in a different but otherwise applicable policy? Courts have split on the answer to this question. Some courts hold that a self-insured retention does not constitute “other insurance” and that an insurer’s policy, written to be excess over “other insurance,” must respond on a primary basis: paying the loss even though the SIR in another policy has not been satisfied. See *Wake County Hospital System, Inc. v. National Cas. Co.*, 996 F.2d 1213 (4th Cir. 1993); *American Nurses Ass’n v. Pas-saic General Hospital, et al.*, 484 A.2d 670 (N.J. 1984). Other courts, however, hold that “self-insurance,” falling within the terms of a self-insured retention, should be treated as “other insurance” because a contrary holding would “allow[] the insured to ‘manipulate the source of its recovery and avoid the consequences of its decision to become self-insured.’” *Atchison, Topeka & Santa Fe Railway Co. v. Stonewall Ins. Co.*, 71 P.3d 1097, 1131 (Kan. 2003) (quoting *Missouri Pac. R. Co. v. Int’l Ins. Co.*, 679 N.E.2d 801, 810 (Ill. App. Ct. 1997)).

A related question can arise concerning the duty to defend. If one policy contains a self-insured retention, and a second policy contains a duty to defend provision but that policy is excess to “other insurance,” is the first policy’s retention considered “other insurance,” which essentially would obligate the policyholder to defend the claim as long as the retention remains unsatisfied? Or is the policyholder considered to

be uninsured under the first policy, which would require the second carrier to defend?

When the second policy is a primary policy, excess only to “other insurance,” many courts hold that the retention is not “other insurance” and that the second insurer has a first-dollar duty to defend. *Commonwealth Edison Co. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 752 N.E.2d 555 (Ill. App. Ct. 2001). The rule has exceptions, however, and a different outcome will result when the “other insurance” clause has been drafted to address this situation. Thus, in *Nabisco, Inc. v. Transport Indemnity Company*, 192 Cal. Rptr. 207 (Cal. Ct. App. 1983), the policyholder had one primary policy with a \$50,000 retention and was an additional insured under a second primary policy, which contained an “other insurance” clause, rendering the second primary policy excess over “other insurance or self insurance.” *Id.* at 208 (emphasis added). The plaintiff argued that its \$50,000 retention made it “uninsured” for that amount. Thus, it argued, the “other insurance” clause did not apply. The court rejected this argument, finding that the policyholder “made a risk management decision not to buy coverage for the first \$50,000” of exposure and that it could not have had any reasonable expectation of coverage for that amount.

How Many Retained Limits Must Be Exhausted?

A final issue related to deductibles and retentions arises in “long-tail” cases, which involve a single occurrence that produces bodily injury or property damage in multiple, successive policy periods. In a minority of states, known as “all sums” jurisdictions, coverage for these claims is allocated on a joint and several basis. The policyholder is allowed to select a particular policy year and allocate all of its loss to that year. The insurer in the selected year must pay the loss, up to the limits of its policy, and then seek contribution from the other insurers of the other years when injury or damage took place. See, e.g., *State of California v. Continental Ins. Co.*, 55 Cal.4th 186 (Cal. 2012). As a rule, however, in these “all sums” states, if the policyholder elects to allocate losses to a year in which it is subject to substantial deductibles or retentions, the deductibles and retentions must

be satisfied before the policyholder can recover. Thus, all else being equal, the policyholder will generally choose to trigger policies in years with low or no deductibles or retentions and with the fewest other limitations on recovery.

If the insurer from the triggered year in an “all sums” jurisdiction then seeks equitable contribution from policies in other

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years in which injury or damage occurred, can those insurers avoid paying by relying on the fact that the retentions underlying their policies remain unsatisfied? In general, they cannot. In the context of equitable contribution claims among successively triggered insurers, courts generally hold that policies that have retentions must contribute to liabilities exceeding the unsatisfied SIR, along with policies that do not contain any SIR whatsoever. See *Aerojet-General Corp. v. Transport Indem. Co.*, 948 P.2d 909 (Cal. 1997). The reason for this is that an equitable contribution claim is not derivative of the policyholder’s rights. *Id.*; *Fireman’s Fund Ins. Co. v. Maryland Cas. Co.*, 65 Cal. App. 4th 1279 (Cal. Ct. App. 1998). It is, instead, a matter “between insurers” that are co-obligors on the risk. *Aerojet*, 948 P.2d at 929. Even if an insurer might be able to deny coverage to its policyholder on the grounds that a retention remained unsatisfied, the insurer cannot necessarily use that argument to defeat an equitable contribution claim brought by another insurer.

In sharp contrast to these “all sums” jurisdictions, a majority of states, known as **Limits**, continued on page 90

Environmental, from page 36
entrenchment in protecting that investment. The best time to mediate a dispute is as soon as possible after things have settled down a bit, the lawyers have a basic understanding of the underlying facts and evidence, the parties have a clear understanding of what lies ahead both in terms of cost and commitment, if they take their case further, but well before the incurred costs have escalated beyond the point of no return.

Conclusion

As noted at the outset, well-managed mediations can be extremely effective at settling environmental disputes, in whole or in part. Summarizing the highlights of this article, legal counsel will ask the following questions in organizing, preparing for, and participating in a successful mediation effort:

- Is this the right time for a mediation?
- Have we selected a skilled mediator with requisite industry knowledge of environmental issues?

Limits

from page 69
as “pro rata” jurisdictions, allocate coverage for long-tail claims across all years in which bodily injury or property damage has occurred. In these jurisdictions, the policyholder’s liability for a single triggering occurrence is divided by the number of years triggered, and liability is apportioned among the various insurers, most often based on each insurer’s time on the risk, most often with the policyholder retaining liability for self-insured periods, deductibles, and the like. See *Boston Gas Co. v. Century Indemn. Co.*, 910 N.E.2d 290 (Mass. 2009).

In pro rata jurisdictions, when a single occurrence produces injury or damage over multiple policy periods, should the policyholder pay one retention or deductible? Or should it pay multiple retentions, specifically one for each policy year? Logic suggests one possible answer: since the *pro rata* approach divides the policyholder’s liability into distinct “chunks,” each assigned to a different policy year and insurer, the policyholder should be obligated to satisfy the applicable retention or deductible before accessing coverage in that year

- Have steps been taken to ensure that all of the necessary parties on *both* sides participate? Counsel should not leave it to chance that opposing counsel will ensure that all necessary participants are at the mediation.
- Have I prepared my own client to come to the mediation with the requisite readiness to compromise?
- Have I explained to my own client the nature of the process and how it is different from litigation?
- Have I ensured that my client has an accurate understanding of the mediator’s role?
- Have I explained the confidentiality of the process to my client so he or she feels free to participate openly?
- Have the parties exchanged all of the necessary documents and materials to ensure that there is no knowledge deficit that will impede a successful outcome?
- What efforts have been made to narrow the gap before the mediation?
- Is my mediation brief more than a simple restatement of my pleading? Have

for the particular “chunk.” Indeed, some courts have reached exactly that conclusion and required the policyholder to exhaust the retention in each triggered year. See, e.g., *Benjamin Moore & Co. v. Aetna Cas. & Sur. Co.*, 843 A.2d 1094, 1105 (N.J. 2004) (“[O]nce the amount of loss allocable to the policy period is determined, it is to be treated exactly as any actual loss during that period would be treated in accordance with the policy provisions, including limits and exclusions.”); *Liberty Mut. Fire Ins. Co. v. J.T. Walker Indus., Inc.*, 817 F. Supp. 2d 784, 790 (D. S.C. 2011) (“The majority of courts to adopt a pro rata allocation method for liability based on progressive damage have agreed that an insurer is entitled to a full deductible for each triggered policy.”).

In *Boston Gas*, however, the Supreme Judicial Court of Massachusetts, perhaps sensitive to the potential harshness of the *pro rata* rule, opted to split the baby. It held that “unless the policy language unambiguously provides otherwise, a policyholder’s self-insured retention should be pro-rated on the same basis as an insurer’s liability[.]” See *Boston Gas*, 910 N.E.2d at 316. The court did not offer concrete guidance on how to

I used it as an effective tool to educate the mediator and to show the opposing party that I have an understanding of its point of view and a willingness to compromise?

Despite everyone’s best efforts, mediations do not always succeed on the day of the mediation session. It is sometimes necessary for one or more of the parties to have some time to reflect on and absorb the day’s efforts. Some mediators make it a practice to follow-up with the parties’ counsel following a failed mediation, after a few days have passed, in an attempt to move the settlement process forward. In other instances, while the mediation does not result in a complete resolution of the issues, it can sometimes resolve the matter between two or more parties in a multi-party dispute. And, finally, even when none of the issues can be settled, a mediator may be able to assist the parties in designing a more cost efficient and time effective dispute resolution process than protracted litigation. 

carry out this proration, but one possibility might be to allocate to the policyholder, for each policy year, a fraction of the retention or deductible that would otherwise apply to that year, corresponding to the ratio that that policy year bears to the total number of years of potential coverage.

Conclusion

Over the last several years, retentions and deductibles have become a fact of life in many insurance markets. But these provisions, which require policyholders to bear or to reimburse an initial portion of covered risk, can pose significant interpretive challenges. The industry has not adopted standard policy language, and the general principles affecting transfer of risk depend on a complex, shifting body of case law, which varies from jurisdiction to jurisdiction. Policyholders, insurers, and attorneys need to examine the policy language carefully. If the policy language is unclear, it may be necessary to hire specialized coverage counsel or other experts to navigate the legal pitfalls and to guide the parties, or the courts, toward a satisfactory result. 