Personal lines liability insurance carriers enjoy, at least, the certainty of a date of loss. Although a large number of fires and traffic accidents appear to occur overnight, it must be the rare case where the accident occurs at between 12:00 and 12:01 a.m. between two policy terms. Insurers writing Commercial General Liability insurance, however, frequently receive claims straddling two or more coverage terms. The famous examples include environmental, tobacco and asbestos claims, in which properties or victims can suffer effects from years, even decades, of exposure to toxins or product defects. In Canada, we have encountered the multi-term occurrence in construction defect claims, such as concrete structures, corrosion-affected mechanical equipment, and leaking underground tanks. This paper deals with two frequently misunderstood or overlooked questions: Do the policy limits merge into a single limit equivalent to the per-occurrence limit of one policy, thereby projecting the claim upwards to excess insurers or to the insured? Or do multiple policies accumulate limits over time? The analogy of filling water glasses is quite helpful. If you have a multi-year single occurrence, do the damages fill up like water evenly over several glasses, one for each term, so as to multiply the overall volume? Or do you fill only the amount in each glass which, collectively, would fill one glass? An August 9, 2012, decision of the Supreme Court of California, has entrenched the position in that state as favouring the multiplication of the total volume. Which way should Canadian courts adopt?

Example
Perhaps there is no subject more abstract in insurance than the competing concepts about the “stacking” of CGL insurance limits. In order to facilitate the exploration of this nebulous topic, I am going to draw an example of a construction defect claim triggering two separate sets of insurance policies. In each of Year 1 and Year 2, imagine a
primary CGL policy with typical (but not standard) wording, each issued by different insurers and each insuring up to $1 million above a $1 million self-insured retention. In each year, there is also an excess insurer with a large tower of coverage above the primary. We may also consider a year in which there is no excess coverage, meaning the insured self-insures above the primary limits.

“Per Occurrence” Limits

Most common CGL policies insure commercial and industrial insureds with limits that apply in the general aggregate per term (usually a year), per occurrence ("occurrence" being defined as a single cause or a continuous exposure to substantially the same cause), and for specific causes (most notably products liability and “completed operations”). In our typical example, this would mean that the primary policies would insure up to $1 million for construction defects resulting in property damage or bodily injury, whether it be a single occurrence resulting in damages of $1 million or more, or many smaller occurrences leading to liability for damages of less than $1 million but in total exceeding that figure. Products and “completed operations” (eg. buildings) are usually subject to a separate aggregate limit, to control the overall insurer exposure to multiple claims arising from the products or buildings sold or built for different consumers.

The multiplication of occurrences can, however, increase the number of self-insured retentions (SIR) if the policies or endorsements describe those SIR’s on a per-occurrence basis. Most large companies and public entities carry $500,000 or more in SIR’s so as to control their own risks. This means that an insured can incur claims arising from numerous occurrences and never receive the benefit of insurance, until and unless a claim exceeds the SIR. This is the policy rationale for the courts’ tendency to group losses caused by a common cause. In our example, claims arising from four separate building projects could result in $4 million in uninsured liabilities, before recourse to insurance. It is for this reason that insureds and their coverage lawyers favour methods of characterizing multiple losses as having a common cause, the so-called single-occurrence theory. A steel company might want to construe an entire production run of brittle concrete reinforcement products as a single occurrence, even if they give rise to several separate building collapses.

Most of the North-American case law, including the Ontario Court of Appeal’s decision in Alie v. Bertrand, appears to support the single-occurrence approach. A 2009 divided decision of the Supreme Court of Wisconsin, however, treated each sufferer of asbestos claims to constitute a single occurrence: Plastics Engineering v. ABC Mutual Insurance Company, 2009 WI 13. This ruling is not consistent with the general trend of decisions made in the courts, however. The courts have mostly embraced the single-occurrence theory where the facts allow, avoiding the accumulation of SIR’s.

The significance of the number of occurrences to the insurer, beyond the size of the SIR’s, is that two or more occurrences spread out across a similar multiple of insurance policy calendar terms can result in accumulation of limits,
according to the number of occurrences. By illustration, two occurrences over two years can result in $2 million in limits, according to our example. The question for this paper is: Will a single occurrence over the same two years also result in $2 million in limits, or $1 million?

Most CGL policies are “occurrence-based” policies, in that the trigger for the insurer’s obligation to indemnify the insured under the insuring agreement is liability for damages caused by an accident or source of harm during a particular calendar term. Claims-based policies are triggered by claims during the term, and therefore a completely different analysis comes into play.

In our example, each of the CGL policies contain an “each occurrence” limit of $1,000,000 and a $1,000,000 aggregate limit for products liability. Policy No. 1, covering the first period might contain the following provisions pertaining to the limits of insurance (simplified for illustration purposes):

LIMIT OF LIABILITY

(a) The Limits of Liability stated in the declarations are the most the Insurer will pay under the policy regardless of the number of insureds, claims made or actions.

(b) The Each Occurrence limit is the most the Insurer will pay for the sum of damage under [enumerated categories of coverage] because of all Bodily Injury, Personal Injury, Advertising Injury, Property Damage arising out of any single occurrence.

(c) The Products Hazard limit is the most the Insurer will pay for damages because of Bodily Injury and Property Damage occasioned by Products Hazard.

(d) The limits of the policy apply separately to each consecutive annual period and to any remaining period of less than twelve months, starting with the beginning of the policy period shown in the declarations.

Policy No. 2, covering the next annual period, might contain the following provisions pertaining to the limits of insurance:

LIMITS OF LIABILITY

(a) The Limits of Liability stated in Item No. [##] of the declarations determine the maximum amount the Insurer will pay regardless of the number of:

- “Insureds”;
- claims made or “suits” brought;
- coverages provided under this policy; or
- persons or organizations making claims or bringing “suits”.

(b) The Each Occurrence Limit of Liability stated in Item [###] of the Declarations is the maximum amount the Insurer will pay for damages arising out of any one “occurrence”.

(c) The Products and Completed Operations Aggregate Limit stated in Item [####] of the Declarations is the maximum amount the Insurer will pay for damages arising out of the “products and completed operations hazard” in anyone “policy period”.
(d) The Limit of Liability stated in Item [###] of the Declarations applies separately to each consecutive annual period and to any remaining period of less than twelve (12) months.

Each of these provisions contained provisions which would prevent the result in the aforementioned Wisconsin case, so that the limits apply despite the number of individual claimants. The two policy provisions differ most significantly in that the limit of liability provision in Policy No. 1 appears to apply all policy limits separately to each consecutive annual period, but the analogue in Policy No. 2 restricts this to the product hazard limit only. (If you missed this, go back and compare the two clause “d” provisions, above.) While this difference does not have a bearing on our discussion, it may have a bearing on particular types of claims.

Apart from this difference, the interaction of clauses “b” and “d” of both policy wordings appears to limit both insurers’ total liability to a combined limit equivalent to a single limit. Whether this is or is not fair can depend on the facts, and how one characterizes them. Compared to the asbestos and pollution litigation out of which much of the U.S. case law on the issue of limits arises, the typical defective building or building materials case took place in a relatively short period of time. Concrete, for instance, can be proven to be damaged within hours of mixing, if the defect is a contaminant in the mixture or too much water. But a single batch or production run of concrete or one of its ingredients can be mixed and poured into two separate buildings during two calendar periods on each side of an insurance policy expiry date. Courts will strive to find a common cause, and therefore a common occurrence.

Does the single occurrence straddling the anniversary date between policies give rise to $1 million in available primary insurance, or $2 million? There is no direct case law on the issue in Canada. The trial decision in *Alie v. Bertrand* [2000] O.J. No. 1360, as approved on appeal, [2002] O.J. No. 4697, 62 O.R. (3d) 345 (C.A.), a case involving defective concrete, apportioned an ingredient manufacturer’s liability among its insurers on a pro rata basis, based on time on risk for defence and pour dates for indemnity. In the case of indemnity, the trial judge’s comments were:

> [386] The evidence before me would dictate that the most equitable allocation of responsibility would be on a pro-rata basis on the time coverage provided by the insurers. Between the years 1986 and 1992, there are seven different policy periods (see Ex. 564A). Approximately 45 houses and one condominium had their foundations poured in 1986. In 1987, approximately 70 homeowners had their foundations poured. Finally, the last three homeowners had their foundations poured in 1988. This would mean that of the seven policy periods the first period would have only the units built in 1986; the next period all the units built in 1986 1987; and the next five periods all the units built in 1986, 1987, and 1988. During that time, Canadian General Insurance was the primary insurer for four of those years and Royal for three. The umbrella insurers during Canadian General’s four years were Guardian, General Accident, and Chubb for two years. Royal provided the umbrella...
Limits generally eliminate deductibles.

Therefore, Canadian General Insurance and their respective umbrella insurers would be responsible for the first four periods. Royal would be responsible for three of the periods for all of the foundations poured in 1986, 1987 and 1988. Obviously, if Canadian General’s and Royal’s limits were exceeded for any given year, the umbrella insurer for that year would be responsible for the balance.

There is no part of the decision, either at trial or on appeal, which discloses how the pro rata allocation was actually allocated among the insurers in terms of dollars and cents, in relation to their limits. We have to find reference to the allocation in a related subsequent decision of the Superior Court of Justice in Boreal Insurance Inc. v. Lafarge (2004), 70 O.R. (3d) 502, at paragraphs 11-12 where the court stated that Boreal paid one set of limits in 1987-88, and implied that Cigna paid five sets of limits of $1,000,000 each, for 1988-93:

[11] In the policy year April 1, 1987 to April 1, 1988, damages of $2,728,057.20 were found to have occurred. Subject to the deductible\(^1\) payable by Lafarge under the Boreal policy, that liability was settled by Boreal’s payment of the policy’s per occurrence limit of $1 million plus interest, and by Scottish & York’s payment of $1,728,057.20 plus interest, to Lafarge, by way of indemnification for payments made to satisfy the judgment. In this policy year, the portion of defence costs allocated to each of Boreal and Scottish & York was 4.76 per cent.

[12] For the Cigna Policy Years, damages in excess of $5 million were found to have occurred. Cigna’s liability was settled by Lafarge’s payment of the Cigna policy’s per occurrence limit of $1 million through its captive insurer. The remainder of the damages, $7,057,785 (exclusive of interest) was paid by National Union. In these policy years, the portion of defence costs allocated to Cigna was 35.72 per cent (being 7.14 per cent for each of the five years) and to National Union was 28.58 per cent (being 7.14 per cent for four of the five policy years).

The judgment stated that these contributions were settled, however, and so the decision does not stand for a proposition that these were in fact what Cigna had to pay as a matter of law. The stacking of limits was not an issue on the radar screen of any of the counsel involved, in the Boreal case or in the Alie case. Despite a diversity of opinion in the U.S. case law, arguably Cigna ought to have raised the point before the Alie court, and Cigna may have overpaid by $4 million and spared the excess layer of that payment. (There was no point in doing so before the Boreal court, because its argument was that it owed no defence in a subsequent class proceeding, having paid out limits in the Alie litigation.)

The American case law appears divided into state courts that adopt the “all-sums” approach (sometimes described as the “joint and several” theory), and others who adopt the “pro-rata” approach. The significance of these approaches is that:

\(^1\) The courts often refer to deductibles when they should be referring to self-insured retentions. Limits generally eliminate deductibles.
- The “all sums” courts tend to favour the availability of stacking of limits (although not universally so).

- The “pro-rata” courts deny the availability of stacking but nevertheless sometimes appear to have allowed stacking in some instances.

In both instances, unity and certainty of causation (i.e. when the damage occurred) always leads to only one policy being triggered. It is either the uncertainty of when the damage occurred, or different times when damage occurred, that leads to these judicial approaches.

**All-Sums Approach**

The “all-sums” approach comes from the language in some widely used CGL policies. The insuring agreement typically provides that the insurer will pay for “all sums” for which the insured is liable to a third party for property damage or bodily injury, etc. (Some policies refer to “all damages,” instead of “all sums,” but they amount to the same idea.) Thus, in California, for example, “all-sums” means that when there is a continuous loss over multiple policy periods, any insurer is liable for the entire loss, up to its limits. The insured can look to any insurer, and the insurer must seek contribution from other insurers who are also on risk.

In taking the “all-sums” approach further, the California courts have also held that the insured can look to one insurer up to the limits, and then proceed to the next one, etc., so the number of limits is cumulative or serial, not parallel. This is the purest form of “stacking of limits.” Critical of the argument that this affords more insurance than has been bargained for, the Court of Appeals for California recently stated: “a continuous loss spanning two or more policy periods is fundamentally different from an instantaneous loss, such that it is appropriate to place a greater contractual obligation on the insurers”: California v. Continental Jan. 5/09, E041425, at p. 35.

In 2012, the Supreme Court of California affirmed this decision, in Court File No. S170560, August 9, 2012, and stated:

> [I]f an occurrence is continuous across two or more policy periods, the insured has paid two or more premiums and can recover up to the combined total of the policy limits. There is nothing unfair or unexpected in allowing stacking in a continuous long-tail loss.

This argument is not always convincing, because in most instances the insured has paid for a certain level of insurance over a longer period of risk exposure. The additional period is paid for time insured, not for more limits. The Supreme Court then went on to say that insurers can always draft anti-stacking clauses. The counter to that is that the insured can always buy more insurance, if its activities may lead to such losses. Indeed, that is the very purpose of excess or catastrophic umbrella policies beyond primary coverage. While the stacking argument may be politically attractive in dealing with pollution or asbestos claims, in our case the anniversary date is unrelated to the risk and imports an element of arbitrariness. Why should the insured be afforded twice the insurance
because the risk occurred over months or years? What if the insured self-insured for a hiatus during the multi-year occurrence?

Pro Rata Approach
In contrast to the “all sums” approach, the “pro rata” approach does not permit stacking because it treats the limits horizontally across policy years as a single limit, and allocates portions of the limit by time on risk. The insurers, by the same principle, share a common set of limits equivalent to the limits of each. If one policy has higher limits, then the overage occupies a separate level above the common limit. The “pro-rata” approach, also called “time-on-risk,” allocates damages arising from a continuous occurrence because it is considered unfair to pin any one insurer where it cannot be said for certain that it occurred while it was on risk. It is a sharing of liability similar to the approach used in tort law where the identity of the perpetrator is unknown, or where the fault of the defendant has thwarted the means to prove causation: Resurface Corp. v. Hanke, [2007] 1 S.C.R. 333, 2007 SCC 7, at paras. 27-28. The essential rationale for pro-rating a loss is that an insurance policy is purchased to indemnify against damages occurring within a policy period, not outside the period, from a causal perspective: Prudential Lines Inc., 158 F.3d 65 (2nd Cir. 1998), at para. 103. Despite the liberal reliance on some California law in the Alie decision, Ontario is a “pro rata” jurisdiction: E.M. Reed, [2001] O.J. No. 3515; also the decisions in Alie apply a pro rata approach. (Para. 386 of the Alie trial decision). British Columbia is also said to be a pro rata jurisdiction: Lloyd’s v. Cominco, [2006] B.C.J. No. 1917.

In Con-Edison v. Allstate, 2002 NY Int. 51, the New York Court of Appeals held: “Proration of liability among insurers acknowledges the fact that there is uncertainty as to what actually transpired during any particular policy period.” Even in the case of the pro rata approach, there is some variation in which it is applied. Some U.S. courts have taken the view that multiple policies responding to a single occurrence fill up like water glasses, up to their limits in equal proportion. This is actually a method of stacking policy limits: Mayor and City Council of Baltimore v. Utica Mutual Ins. Co., 145 Md. App. 256 (Md. C.A., 2002), at 38 of 40. Other courts maintain that the pro rata approach is antithetical to the stacking rule: Sybron Transition Corp. v. Security Insurance of Hartford 258 F3d 595 (2001). In Sybron, the U.S. Court of Appeals for the 7th Circuit stated: “A time-on-risk approach spreads responsibility among insurers to reflect uncertainties about causation, but is does not justify treating one loss as more than one occurrence and requiring insurers individually (or in the aggregate) to pay more than the occurrence limit of their policies.” The court also stated that “Stacking is incompatible with confidence about causation. Security insured Sybron to a limit of $500,000 per occurrence, not $500,000 per year.”

Similarly, in Great Lakes Dredge & Dock v. Commercial Union, 260 F.3d 789 (7th Cir. 2001), the 7th Circuit Court of Appeals stated: “This means that the whole loss from the tunnel collapse is ‘one Occurrence’ even if parts of the
injury were felt in two policy periods. Thus it remains only to determine which period is the right one.” In the instances where stacking seems to have crept in via the back door, counsel did not raise the “each occurrence” limit because the primary carriers were different. The “each occurrence” limit tends to be drafted so as to protect any one insurer from multiple limits. Where the carrier is the same over the multiple periods, pro-rata courts have employed an “all sums” approach up one vertical tower, in order to avoid the duplication of SIR’s: Olin Corporation v. Ins. Co. of North America, 221 F.3d 307 (2nd Cir. 2000), at para. 64. This is seen as preferable to horizontal “stacking.” Similarly, in Re Prudential Lines Inc., 158 F.35 65 (2nd Cir, 1998), at paras 106-08, the Second Circuit stated:

[106] Fortunately, a number of factors that often complicate the inquiry are absent here. Prudential had insurance coverage in each policy period implicated by the claims, and had no periods of self-insurance. In any event, no issue has been raised that a self-insured period existed, or arose by exhaustion of limits. And for virtually the entire span of years, American Club was Prudential’s only insurer. In 1971-74, Prudential was insured by another club that is not a party to this litigation, though apparently there exists an understanding among the insured shipowners and P & I insurers providing for allocation of loss among themselves. American Club argues that its membership varies year by year, and that allocation among the policy years is important to determine each member’s liability. However, American Club may develop (and seems already to have developed) an internal allocation mechanism for claims.

[107] The financial significance of the allocation issue in this proceeding lies in its impact on the number of deductibles that will be applied to each claim. Under American Club’s pro rata allocation approach, one deductible would apply per claim as well as per triggered policy, whereas under the Claimants’ approach, all losses from any single claim would be recovered under a single policy and therefore a single deductible would apply to each claim. Given: (i) the policy’s broad language covering “any loss [or] damage” which Prudential becomes liable to pay resulting--presumably even in part--from injuries occurring during the policy period; (ii) the absence of a contractual intent to require allocation of liability among policies in the first instance; and (iii) the lack of any compelling policy or equitable considerations favoring allocation, we decline to read the policies in a way that would have the (probably unintended) effect of multiplying the deductibles applicable to each claim.

[108] We hold that, in the circumstances presented, Prudential has the right to demand that a policy pay full coverage for each insurance claim in which the underlying Claimant suffered asbestos exposure and therefore asbestos injury during the policy period.

Ontario appears to lean toward the pro rata approach, but has not arrived there on the stacking issue. However one treats the “each occurrence” limit, the approach must be applied to the facts. According to the Alie approach to apportionment, it would be inappropriate to assign damage occurring in the first term pour to the second term. The Alie trial judge’s pro rata apportionment at para. 387, upheld on appeal (at paras 143
and 144 of the appeal decision), stated as follows:

[387] Therefore, Canadian General Insurance and their respective umbrella insurers would be responsible for the first four periods. Royal would be responsible for three of the periods for all of the foundations poured in 1986, 1987 and 1988. Obviously, if Canadian General’s and Royal’s limits were exceeded for any given year, the umbrella insurer for that year would be responsible for the balance. [italics added]

Perhaps the judge did not intend to make the call, but the potential for an asymmetrical insurance coverage distribution points to an approach against the stacking of CGL limits. Nevertheless, the court undeniably stacked the limits, probably because no counsel raised the issue.

A major challenge to the pro rata / non-stacking argument comes from the appearance that an occurrence that takes time to cause damages is more likely to cause a larger amount of damages. This is the argument mentioned above used by the California court. A convincing practical counter-argument against this is that the commercial or industrial insured looks after its interests by purchasing a large tower of excess insurance. Furthermore, the purchase of such an insurance package is clearly geared toward catastrophic losses, such as the undermining and destruction of an office building worth tens of millions of dollars. The intent is clearly to maintain a layer of primary insurance no matter how many terms there are. Companies purchase excess and umbrella coverage to cover less frequent, large losses.

Perhaps the most compelling argument is that when there are a large number of claims brought under the rubric of one “occurrence,” for the purpose of limiting the number of SIR’s, it would not be fair to turn primary insurance into de facto unlimited insurance by stacking limits horizontally. We appreciate that the California courts, and others who have followed the “all sums” and “stacking” method have essentially made that leap. However, the New York courts and others who have rejected this approach seem to be impressed by the fact that an insured purchases insurance for a particular amount of limits per occurrence, not more. A layer is purchased and extended over time. Time is not intended to increase the thickness of the layer, and the U.S. Federal Courts applying New York law appear to appreciate this point.

The insurers in our hypothetical have a reasonable argument that the total occurrence limit for both policies was $1 million. This is entering uncharted territory for Canadian insurance lawyers. However, one can gauge from the recent case law encroaching on the isolation previously enjoyed by excess carriers (eg. Alie, supra; Broadhurst & Ball v. American Home Assurance Co., [1990] O.J. No. 2317, 1 O.R. (3d) 225 (C.A.); and St. Mary’s Cement Company Inc. v. Ace Ina Insurance, 2008 CanLII 32307 (ON SC)), that the courts are leaning toward the position of primary carriers, especially if they have honoured their underlying obligations. Because each case must be considered on its factual merits, there is a
good argument that, where an insured has purchased adequate excess insurance, there is a clear intent to purchase a vertical tower of insurance in the event of a large loss, not to spread loss horizontally over multiple periods of coverage. The horizontal purchase of insurance is less intentional, more automatic, in terms of insurance planning against the risk of a large loss.

**Canadian Law: Which Direction to Follow?**

A potential vulnerability of the pro rata argument, in comparison with the “all sums” approach, is that insureds might plan their insurance on the basis that claims come in sporadically. For example, a home heating appliance with a common design flaw corrected within a few years of production may cause one or two fires a year over the course of the next decade of use. If the manufacturer faces liability for $1 million per year worth of house fire losses over its SIR, a per-occurrence limit based on the common occurrence theory can leave the insured without insurance for all but the first year. It could be argued that an insured, provided with a prior claims history, would be accepting a premium in bad faith, if its policy was not intended to provide coverage for further claims arising from the same defect. Thus, a judicial treatment of “occurrences” intended to protect against multiple SIR’s would have the effect of depriving coverage before the subsequent policies take effect. This does not mean, however, that the “all sums” approach is better. Rather, there is a flaw in the judicial treatment of separate events as being common occurrences for the purpose of reducing the number of SIR’s.

Instead of choosing between the “all sums” and “pro rata” American jurisdictions, and their respective “stacking” and “non-stacking” theories, the advantages and disadvantages of each approach should lead to a case-by-case analysis. On the whole, the pro rata approach does appear to be truer to the insuring intent in most instances. Take two identical losses, one caused by an occurrence taking place during a single insurance policy period, and another straddling the expiry date of the first policy and the inception date of the next. There should not be more insurance available to cover the second loss than the first. The threshold between two policies, the common expiry and inception date, determines which of two policies respond, one or the other, or both. The threshold does not determine how much insurance the insured has bought in consideration for the premium.

Nevertheless, this logic breaks down the less contiguous the losses are in relation to the occurrences causing them. Some common-cause damages do spread out, as the California courts have said, in a manner that implies more insurance coverage because of the long-term nature of the risk. Certainly if the cause of the liability is an occurrence which lasts longer than a single insurance term, such as a two-year long period of manufacture of a product with the same defective design, the case for stacking of limits appears compelling. In the instance of latent and sporadic loss arising from a product defect, one would foresee more losses from a longer period of distributing defective products in the marketplace.
When viewed in this light, both interpretations of the insurance agreement could be valid, depending on the losses. Any arbitrary choice in favour of one or the other is not based on the agreement and therefore contrary to justice. This would certainly apply to commercial general insurance, which arises between equal contracting parties in an open market. Beyond any issue of fairness, the solution appears to be in choosing the interpretation of the insurance contracts which best suits the facts. Is the occurrence an isolated incident which happens to take place in a time straddling two policies, either because it does or because the evidence has obscured the precise date of occurrence? That would support a pro rata approach, and a resort to excess (or underinsured) levels of exposure beyond the primary insurance layer. Or is the occurrence one which, by its nature, takes place over a long period of time? That would support a spreading of the loss first among a series of primary insurers, until the claims exhaust each of their limits. Seen in these terms, the exercise becomes that much less arbitrary. You determine the size of the water glasses to fill, by determining what kind of water you are pouring. Will that be flat, or sparkling?