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**LIABILITY INSURANCE IN  
INTERNATIONAL ARBITRATION**  
The Bermuda Form

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INTERNATIONAL ARBITRATION**

The Bermuda Form

Richard Jacobs QC • Lorelie S Masters • Paul Stanley



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LIABILITY INSURANCE  
IN INTERNATIONAL  
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*THE BERMUDA FORM*

RICHARD JACOBS QC

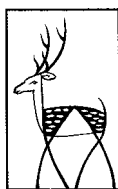
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## *The Legal and Economic Origins of the Bermuda Form*

### **POLICY FORMS AND LIABILITY PROBLEMS**

In the mid 1980s the excess casualty insurance market in the United States collapsed. This was due to a number of reasons including the impact of liability claims, the cyclical 'boom' and 'bust' nature of the insurance industry, and poor investment results in the early 1980s.<sup>1</sup> A number of insurance companies rose from the ashes, fuelled in part by capital from large United States manufacturing companies which, as policyholders, sought to help stabilise capacity in the excess casualty insurance market. The effort to create this 'alternative' excess liability insurance market was spearheaded by insurance brokerage Marsh & McLennan and bankers JP Morgan. These two companies created ACE Insurance Company Ltd ('ACE') in 1985 to provide excess catastrophe coverage at layers in excess of US \$100 million. Capital was provided by their clients. Due to ACE's success and the need for excess insurance at layers below ACE's US \$100 million attachment point, XL Insurance Ltd ('XL') was created and began underwriting in May 1986. Both were based in Bermuda and began to write insurance on a freshly-drafted and novel policy form which rapidly became known as the Bermuda Form. The drafting of that form was commissioned by Marsh & McLennan, with input from other insurance professionals.<sup>2</sup> **1.01**

The collapse of the existing market,<sup>3</sup> and many of the distinctive features of the Bermuda Form that followed, had their origins in actual or perceived problems for insurers that arose as a result of the interpretations given by **1.02**

<sup>1</sup> See, eg, Richard Stewart, *A Brief History of Underwriting Cycles* (1991) (available at [www.stewarteconomics.com/publicat.htm](http://www.stewarteconomics.com/publicat.htm)).

<sup>2</sup> A lawyer, Thorn Rosenthal of Cahill Gordon in New York City, is often credited as the primary drafter of the Bermuda Form policy. The broad concept of the Form was conceived by Bob Clements of Marsh. Thorn Rosenthal worked with a committee of brokers from Marsh. (Robert Redmond, Al Holzgruber, Tom Keating, Vince Stahl and Myra Tobin). Thorn Rosenthal worked on the later versions of the XL form and the ACE 5 form which was developed at the same time as XL 004.

<sup>3</sup> A detailed economic analysis of the cause of the 'liability insurance crisis' in the mid-1980s is beyond the scope of this book. Apart from the decisions of the United States courts, other factors contributed to severe economic problems for insurers; for example the inflation which followed the 1974 decision of Organization of Petroleum Exporting Countries ('OPEC') to raise oil prices substantially. See further: Richard E Stewart, 'The Eighth Cycle,' *Marsh & McLennan newsletter* (Dec. 1985) (reprinted at [www.stewarteconomics.com](http://www.stewarteconomics.com)).

courts in the United States to the existing Comprehensive General Liability or 'CGL' insurance policies, particularly in the context of asbestos but also other latent-injury claims.<sup>4</sup> CGL insurance policies, like the umbrella and excess liability insurance policies that often followed form to CGL or other underlying liability insurance policies, used standardised terms drafted by insurance industry organizations like the Insurance Services Offices Inc. in the United States and the Non-Marine Association for Lloyd's and the London market.<sup>5</sup>

- 1.03** Until shortly after the Second World War, general liability and product liability insurance policies (often called 'public' liability insurance in the United States) granted coverage for liability for bodily injury and property damage that were 'caused by accident.'<sup>6</sup> Coverage was normally afforded on a first-dollar basis or with a small deductible, and most of the United States market bought primary insurance only from United States insurance companies. Policy limits were specified for each accident, as well as on an aggregate basis for liability for 'bodily injury' or 'property damage.' After the War, two insurance brokers in Canada and the United States and one underwriting organisation at Lloyd's introduced the 'umbrella' policy, written at low excess levels on a broad form with attractive pricing. This policy form granted coverage on the basis of an 'occurrence.' Umbrella liability insurance was the first type of excess liability insurance widely marketed and purchased by United States policyholders as additional coverage above the primary or 'working' layer.<sup>7</sup>
- 1.04** Within a few years of the umbrella policy's introduction, major United States insurance companies copied it, and occurrence coverage began to drive 'accident' coverage out of the market. In 1966, the American rating bureau—the organisations that set premium rates and drafted policy forms for nearly all United States insurance companies—changed the standard primary general liability policy to an occurrence basis.<sup>8</sup> The occurrence policy responds to—or, in insurance parlance, is 'triggered

<sup>4</sup> In the revision of the primary CGL policy form completed in the United States in 1986 under the auspices of the insurance industry trade group, the Insurance Services Office, Inc. ('ISO'), the insurance industry changed the name of the CGL policy from the 'Comprehensive General Liability' policy to the 'Commercial General Liability' policy.

<sup>5</sup> For a history of CGL standardized form language in the United States and the London market, see *In re Insurance Antitrust Litigation*, 938 F2d 919 (9th Cir 1991), *aff'd in part, rev'd in part and modified sub nom. Hartford Fire Ins Co v California*, 509 US 764 (1993).

<sup>6</sup> For additional history on the CGL and umbrella insurance, see Eugene R Anderson, Jordan S Stanzler & Lorelie S Masters, *Insurance Coverage Litigation* (2nd ed. Aspen Law & Business 2000) Ch. 13 (*Insurance Coverage Litigation*).

<sup>7</sup> Legend has it that underwriters in the London market used the term 'umbrella' as shorthand in trans-Atlantic cabling. The term now generally refers to a broad form of excess catastrophe liability insurance that will, as its hallmark feature, 'drop down' in place of underlying primary insurance when the primary insurance does not apply to cover a loss. For additional background on CGL primary, umbrella, and excess insurance, see *Insurance Coverage Litigation* Ch. 13.

<sup>8</sup> The rating bureaus were the predecessors of ISO and included the Insurance Rating Board ('IRB'), Mutual Insurance Rating Board ('MIRB'), and National Bureau of Casualty Underwriters ('NBCU'). Eg, *Insurance Coverage Litigation* Chs. 1 and 4.

by'—liability from bodily injury or property damage that takes place during the policy period. The bodily injury or property damage must be caused by an 'occurrence,' defined as 'accident, including continuous or repeated exposure to conditions' that is neither expected nor intended from the standpoint of the insured.<sup>9</sup>

At the same time as the insurance industry was moving from 'accident' to 'occurrence'-based coverage, concepts of products and other liability widened. Liability that, at the turn of the twentieth century, had been based on privity of contract, expanded towards strict or virtually strict liability.<sup>10</sup> By the early 1980s, policyholders had been held liable, and they and their insurers had paid, for strict liability in tort, often in a mass-tort context. A number of problems existed at around that time. In malpractice, there had been a migration of the law, rather like that for products, from negligence to a concept more like strict liability, coupled with inflation in the cost of the service (medical care) that often measured damages. In asbestos bodily injury, the 'exclusive remedy' provisions of workers' compensation laws broke down.<sup>11</sup> In the environmental context, the United

<sup>9</sup> See, eg, Jack P Gibson & Maureen C McLendon, *Commercial General Liability* (2003) at IV.T.16 (1973 CGL Form). The occurrence, or cause of the bodily injury or property damage, need not take place during the policy period; instead, occurrence coverage is activated when bodily injury or property damage takes place during the policy period. Courts have found that the bodily injury or property damage needed to trigger a CGL policy may be 'microscopic' and need be 'discovered only in retrospect.' *American Home Prods Corp v Liberty Mut Ins Co*, 748 F2d 760, 765 (2d Cir 1984) (applying New York law).

<sup>10</sup> The expansion of tort liability throughout the twentieth century traces its roots to the landmark decision by the New York Court of Appeals, New York's highest court, in *MacPherson v Buick Motor Co*, 145 NYS 462 (App Div 1914), *aff'd*, 217 NY 382 (1916). The court there held a manufacturer liable for injuries resulting when it put an 'inherently dangerous' product into the stream of commerce:

If the nature of a thing is such that it is reasonably certain to place life and limb in peril when negligently made, it is then a thing of danger. Its nature gives warning of the consequences to be expected. If to the element of danger there is added knowledge that the thing will be used by persons other than the purchaser, and used without new tests, then, irrespective of contract, the manufacturer of this thing of danger is under a duty to make it carefully . . . . We are dealing now with the liability of the manufacturer of the finished product, who puts it on the market to be used without inspection by his customers. If he is negligent, where danger is to be foreseen, a liability will follow. We are not required at this time to say that it is legitimate to go back of the manufacturer of the finished product and hold the manufacturers of the component parts. To make their negligence a cause of imminent danger, an independent cause must often intervene; the manufacturer of the finished product must also fail in *his* duty of inspection.

217 N.Y. at 389–90.

<sup>11</sup> An important turning point in relation to asbestos bodily injury claims was the decision in *Borel v Fibreboard Products Corp*, 493 F2d 1076 (5th Cir 1973). The United States Court of Appeals for the Fifth Circuit applied the doctrine of strict liability in asbestos disease cases and subjected producers to joint and several liability, adopting a theory of enterprise liability. In order to state a viable claim, a claimant needed only to show exposure to the defendants' asbestos or asbestos-containing product, and an asbestos-related disease.

States Congress had enacted the Comprehensive Environmental Recovery, Compensation, & Liability Act ('CERCLA'), imposing retroactive liability without fault for environmental damage at a polluted site. In asbestos 'property damage' cases, claims against insurers arose from the cost of removal of asbestos-containing building materials ('ACBM') from buildings, despite the absence of scientific evidence that it was actually doing any harm if it was encapsulated and not disturbed or friable.<sup>12</sup> Other mass torts that had imposed liability at that time included Agent Orange, a defoliant that the United States armed forces had used in Vietnam,<sup>13</sup> and DES (diethylstilbestrol), a drug taken by pregnant women to prevent miscarriage.<sup>14</sup>

**1.06** These claims presented serious problems for insurers who had written 'long-tail' occurrence-based liability insurance policies. Because liability insurance policies insure the policyholder's liability, they generally pay under the law and economic circumstances as they exist at the time liability is decided. That may be years after the insurance policy was underwritten and priced. During the time interval between pricing and underwriting on the one hand, and paying claims on the other, general liability insurers are exposed to the risk of adverse legal and economic change. In the ten or fifteen years before the 'liability crisis' of the 1980s, the cumulative effect of the expansion of liability law during the post-war period, the decisions of the United States courts on insurance coverage, and the economic inflation after the oil embargo of 1973, worked its way through insurance company financial accounts. These events reduced insurers' capital and demonstrated that their premium rates were far too low. Insurers became unwilling to take on new risks, or even keep the risks they had, on anything like the old basis. In addition to the serious troubles of the day, there was no assurance that the problem was not going to continue or even get substantially worse. The refusal of insurers to renew or to take on new accounts, the raising of insurance rates, and the tightening of underwriting criteria, took place most forcefully in the parts of the liability insurance market with the greatest exposure to adverse change and the least reliable data, such as excess general liability insurance. It was these developments that led to the creation of new sources of capacity, including ACE and XL.

<sup>12</sup> See, eg, *Dayton Indep Sch Dist v WR Grace & Co*, 682 F Supp 1403 (ED Tex 1988), *rev'd on other grounds sub nom. WR Grace & Co v Continental Cas Co*, 896 F2d 865 (5th Cir. 1990). The Environmental Protection Agency in the U.S.A. eventually decided that building materials containing asbestos already in place, if undisturbed, should usually remain in place in schools and other public buildings.

<sup>13</sup> *Uniroyal v Home Ins Co*, 707 F Supp 1368 (EDNY 1988).

<sup>14</sup> See, eg, *ER Squibb & Sons, Inc v Accident & Cas Ins Co*, 241 F3d 154 (2d Cir 2001) (*per curiam*).

## UNITED STATES LEGAL DECISIONS ON INSURANCE COVERAGE ISSUES

In the late 1970s and early 1980s, courts in the United States decided a number of significant cases involving insurance policy interpretation in the context of asbestos bodily injury claims, resulting in several different trigger theories.<sup>15</sup> By that time, claims were being filed in increasing numbers,<sup>16</sup> albeit nothing compared with those seen later. Disputes arose between the asbestos producers, who were on the receiving end of claims from injured individuals, and their general liability insurers. The primary question, in the early claims involving delayed-manifestation of bodily injury, concerned trigger of coverage: ie the event that activates coverage. In those early cases and in the cases that followed, insurance companies on the risk early in a period of continuing injury over a number of years would argue that ‘occurrence’ policies are triggered only at time of ‘manifestation’ of injury. Insurance companies on the risk later in that period would argue that ‘occurrence’ policies were triggered only at time of first exposure. Relying on insurance industry documents, policyholders often argued that the policies were triggered at all times from first exposure to manifestation—the so-called continuous trigger.<sup>17</sup> For example, an asbestosis sufferer might have been exposed to harmful asbestos conditions for a period of 20 years prior to manifestation of the disease in year 21. The asbestos producer might have bought insurance coverage for that entire period, or some part of it. If the ‘exposure’ theory of insurance liability were adopted, then all the insurance policies in force during the period of exposure to asbestos would respond.<sup>18</sup> If the ‘manifestation’ theory were adopted, then the only insurance policy that would respond would be the policy issued in year 21. It was in the economic interests of the insurers who had underwritten in the exposure years to support the ‘manifestation’ theory, and vice-versa. Apart from these economic

<sup>15</sup> For a further discussion of trigger theories, see *Insurance Coverage Litigation* Ch. 4.

<sup>16</sup> In the late 1970s, claims against the principal asbestos producers were running at approximately 1,000 a year. At the time, these figures seemed very substantial, but by the late 1980s they were running at approximately 24,000 per year, and in the early 1990s 60,000 per year. For further details, see *Society of Lloyd's v Jaffray* 3 November 2000. New Law Online case 2001119805 (Cresswell J.), Chapter 16; [2002] EWCA Civ 1101 (CA).

<sup>17</sup> This theory arose in part as a result of insurance industry documents that policyholders received in discovery in early insurance coverage cases. See, eg, *Keene Corp v Insurance Co of N Am*, 667 F2d 1034, 1039–41 (DC Cir. 1981).

<sup>18</sup> Two ‘exposure only’ theories have developed. Under an exposure trigger, all policies in effect during exposure to injurious conditions are triggered. If the exposure continues over a period of years, multiple policy periods may be triggered. In contrast, a ‘first exposure’ trigger typically activates only one policy period, that during which the first exposure to the injurious agent takes place.

interests, many in the insurance market held strong views as to how occurrence policies were intended to respond.

- 1.08** If the exposure or continuous trigger theory were adopted, so that there were a number of insurance policies potentially on risk, further questions often would arise as to the extent to which each policy would respond. For example, would the insured producer be able to claim the full amount of a loss (subject of course to policy limits) from any insurer that had written during the exposure years, leaving that insurer to seek contribution from other insurers? Or would the policyholder be required to pro-rate the amount of its liability among all the insurers during those years, leaving each insurer with a one-twentieth share (assuming coverage had been bought during each of the exposure years)? What would happen if the policyholder had not bought coverage during each of the twenty years, but had only bought it only for (say) five of the years? Could the policyholder in these circumstances recover the full loss from any of the insurers who had written coverage during the five years? If pro-rata allocation were applied, would the full loss be divided among the five insurers and, if so, how? Or would the policyholder have to bear three-quarters of the loss, leaving only one-quarter to be prorated among the insurers?
- 1.09** These and related to questions came before the United States courts in the years leading up to the 1985 liability insurance crisis, and indeed they still arise in litigation to this very day. Despite successes, many of these decisions in coverage cases on trigger and allocation issues were adverse to the insurance industry, which came to view courts in the United States as giving effect to social engineering to ensure that injured parties, and the companies that they were suing, were not left without a financial remedy. The decisions during that period not only contributed to the liability crisis, but also shaped many aspects of the policy wording of the Bermuda Form; for example, the dispute resolution mechanism (London arbitration), the choice of law (New York, perceived as a more neutral or pro-insurer jurisdiction, and modified), the redefinition of an 'occurrence,' limited environmental coverage, and the specific exclusion of asbestos and other known problems.
- 1.10** In the United States, insurance is a matter for of state law and, therefore, can vary from state to state. The courts in the United States were not united in their approach to construing the standard-form CGL insurance policy provisions that came before them.<sup>19</sup> There were, however a number of themes, adverse to insurers, which ran through many of the

<sup>19</sup> See the Appendix for a description of the hierarchy of the United States court system.

decisions.<sup>20</sup> Generally speaking, courts rejected the ‘manifestation-only’ theory. Instead, courts adopted trigger-of-coverage theories that activated coverage in multiple policy years, calling the theory by a variety of names. A number of courts adopted the exposure theory, or some variant of it.

<sup>20</sup> The principal decisions on trigger and allocation in the late 1970s and early 1980s, prior to the first Bermuda Form, were as follows:

- (1) *Porter v American Optical Corp*, No. 75-2202, 1977 US Dist LEXIS 12735 (ED La 1977): Federal trial court applied a manifestation-only trigger of coverage for asbestos bodily injury claims.
- (2) *Insurance Co of N Am v Forty-Eight Insulations, Inc*, 451 F Supp 1230 (ED Mich 1978): Federal trial court applied exposure theory of coverage for asbestos bodily injury claims, and apportioned liability on a pro-rata basis on the basis of the relative lengths of their respective coverage.
- (3) *Insurance Co of N Am v Forty-Eight Insulations, Inc*, 633 F2d 1212 (6th Cir 1980), *clarified*, 657 F2d 814 (6th Cir 1981): United States Court of Appeals for the Sixth Circuit upheld application of exposure theory and concluded that insurers had a duty to defend asbestos bodily injury claims brought against the manufacturers of asbestos. The court pro-rated liability among all insurers on the risk during the exposure period, with the burden of any uninsured years falling on the policyholder.
- (4) *Keene Corp v Insurance Co of N Am*, 513 F Supp 47 (DDC 1981): Federal trial court applied exposure theory of coverage for asbestos bodily injury claims (ie, the same as the decision in *Forty-Eight*, not ‘continuous’ or triple trigger).
- (5) *Porter v American Optical Corp*, 641 F2d 1128 (5th Cir 1981): United States Court of Appeals for the Fifth Circuit reversed district court’s application of the manifestation-only trigger of coverage and applied the exposure trigger for asbestos bodily injury claims. The court expressly concurred with the Sixth Circuit’s decision in *Forty-Eight* and pro-rated liability among all insurers on the risk during the exposure period.
- (6) *Eagle-Picher Indus, Inc v Liberty Mut Ins Co*, 523 F Supp 110 (D Mass 1981): Federal trial court held that coverage for asbestos bodily injury is triggered when signs or symptoms become manifest, as determined by the date of actual diagnosis or, with respect to those cases in which no diagnosis was made prior to death, the date of death.
- (7) *Keene Corp v Insurance Co of N Am*, 513 F Supp 47 (DDC 1981), *rev’d*, 667 F2d 1034 (DC Cir 1981): On appeal, United States Court of Appeals for the District of Columbia Circuit applied a ‘triple’ or continuous trigger of coverage for asbestos bodily injury claims. In doing so, the appellate court reversed the decision of the federal trial court limiting coverage to the exposure period.
- (8) *Commercial Union Ins Co v Pittsburgh Corning Corp*, 553 F Supp 425 (ED Pa 1981): Federal trial court applied the exposure theory of coverage to asbestos bodily injury cases, holding in addition that the primary insurer owed an unlimited duty to defend despite exhaustion of liability limits. In 1988, in the case of *Pittsburgh Corning v Travelers*, No. 84-3985 (ED Pa 21 Jan 1985), the same court broadened its decision to incorporate the continuous trigger, following *Keene*.
- (9) *Eagle-Picher Indus, Inc v Liberty Mut Ins Co*, 682 F2d 12 (1st Cir 1982): United States Court of Appeals for the First Circuit affirmed the federal trial court’s application of the manifestation theory of coverage for asbestos bodily injury claims, rejecting *Keene*, but modified the appropriate definition of ‘manifestation date’ to be not when the disease was actually diagnosed but when it becomes reasonably capable of medical diagnosis. Remanded to the federal trial court for factual investigation as to when manifestation took place. In August 1984, on remand, the trial court determined that asbestos-related disease becomes reasonably capable of medical diagnosis ‘six years prior to the date of actual diagnosis.’

Footnote 20 (Cont.)

- (10) *American Home Prods Corp v Liberty Mut Ins Co*, 565 F Supp 1485 (SDNY 1983): Federal trial court refused to apply *Keene* to a DES case, criticizing *Keene* as 'result-oriented' and instead applied an 'injury-in-fact' trigger triggering coverage when disease was diagnosable and compensable.
- (11) *Crown, Cork & Seal Co, v Aetna Cas & Sur Co*, No. 1292, slip op. (Pa Ct CP 2 Aug 1983) (Mealey's, Asbestos Litigation Reporter at 7022 (12 Aug 1983)): Pennsylvania state trial court, in an unpublished decision, triggered all insurance policies in effect during exposure, exposure-in-residence, and manifestation to indemnify and defend the policyholder, following *Keene*.
- (12) *AC&S, Inc v Aetna Cas & Sur Co*, 576 F Supp 936 (ED Pa 1983): Federal trial court followed *Keene* and held that coverage was triggered by exposure, exposure-in-residence, and manifestation and that the duty of liability insurer to defend is separate from, and broader than, the duty to indemnify, and insurers must continue to defend their policyholders even after exhaustion of policy limits.
- (13) *American Home Prods Corp v Liberty Mut Ins Co*, 748 F2d 760 (2d Cir 1984): United States Court of Appeals for the Second Circuit affirmed the federal trial court's reading of the policy language as calling for a 'injury-in-fact' trigger but rejected the federal trial court's requirement that 'injury-in-fact' be 'diagnosable' or 'compensable' and remanded the case to the federal trial court for further proceedings to determine when 'injury-in-fact' took place.
- (14) *Owens Illinois, Inc v Aetna Cas & Sur Co*, 597 F Supp 1515 (DDC 1984): Federal trial court concluded that it was bound by the DC Circuit's decision in *Keene*; applied continuous or triple trigger theory of coverage for asbestos bodily injury claims.
- (15) *Vale Chem Co v Hartford Accident & Indem Co*, 490 A2d 806 (Pa Super Ct 1985), *rev'd on other grounds*, 516 A2d 684 (Pa 1986): Pennsylvania court found DES claims alleged continuous injury and triggered all insurance policies in effect from ingestion to discovery of cancer in offspring, following *Keene*. The Pennsylvania Supreme Court reversed on procedural grounds.
- (16) *AC&S, Inc v Aetna Cas & Sur Co*, 576 F Supp 936 (ED Pa 1983), *aff'd*, 764 F2d 968 (3d Cir 1985): United States Court of Appeals for the Third Circuit affirmed the federal trial court's decision that exposure, exposure-in-residence, and manifestation all trigger coverage, following *Keene*, but overturned the district court's decision that there was an unlimited duty to defend, holding that an insurer has no duty to defend if it is established at the outset of the action that the insurer cannot possibly be liable for indemnification because policy limits have been exhausted (explicitly refusing to determine whether or under what circumstances an insurer may terminate its defense of a claim in 'mid-course').
- (17) *Commercial Union Ins Co v Sepco Corp*, 765 F2d 1543 (11th Cir 1985): United States Court of Appeals for the Eleventh Circuit upheld exposure trigger of coverage, following *Porter*.
- (18) *Lac D'Amiante du Quebec, Ltee v American Home Assurance Co*, 613 F Supp 1549 (DNJ 1985), *vacated as to one defendant on other grounds*, 864 F2d 1033 (3d Cir 1988): Federal trial court in New Jersey adopted the continuous/triple trigger of coverage for asbestos property damage and bodily injury claims.
- (19) *Hancock Labs, Inc. v Admiral Ins Co*, 777 F2d 520 (9th Cir 1985): Coverage dispute arising from allegedly defective heart valves. The United States Court of Appeals for the Ninth Circuit rejected *Keene* theory on the grounds that it was adopted because it was difficult to discern from medical evidence when and how an injury takes place from asbestos inhalation. Instead, it applied the exposure theory, holding that the bodily injury took place when the defective heart valve was implanted.

The United States Supreme Court routinely rejected appeals in coverage cases by denying writs of *certiorari* in these cases, including: *Forty-Eight*, 633 F2d 1212, *clarified*, 657 F2d 814 (6th Cir. 1981), *cert denied*, 454 US 1109 (1981); *Porter*, 641 F2d 1128 (5th Cir 1981), *cert denied*, 454 US 1109 (1981); *Keene*, 667 F2d 1034 (DC Cir 1981), *cert denied*, 455 US 1007 (1982); *Eagle-Picher*, 682 F2d 12 (1st Cir 1982), *cert denied*, 460 US 1028 (1983).

Unless adopted as a first-exposure-only trigger, this typically had the effect of activating coverage in multiple years and exposing more insurance policies to claims. Some courts adopted a ‘continuous trigger’ (sometimes referred to as ‘triple trigger’), whereby liability under each insurance policy in force from first exposure through manifestation was triggered. If a policy was triggered, then a separate question arose as to how much it should pay. On this issue, typically called ‘allocation,’ some courts were willing to adopt a ‘joint and several’ approach to payment by insurers, rather than pro-rata allocation across policy years.

Both the continuous trigger and ‘joint and several’ or ‘all sums’ allocation were adopted in the landmark decision in *Keene Corp v Insurance Co of North America*.<sup>21</sup> Two aspects of this decision were unfavourable to insurers. On trigger of coverage, *Keene*<sup>22</sup> was the first decision to hold that asbestos bodily injury takes place, and triggers coverage, not only when a person was exposed to asbestos fibres and when illness manifested itself, but also at any stage in between. Prior to *Keene* the battle appeared to be between the exposure and manifestation theories. But *Keene* encompassed both of these, and (by including any stage in between) went beyond both of them. **1.11**

Secondly, *Keene* adopted what the court called a joint-and-several basis of allocating liability among insurance policies that were triggered to cover the policyholder’s liability for continuing damage or injury over a period of years. An insurer that had issued a CGL insurance policy during any part of the period of continuing injury or damage was liable under *Keene*-type allocation for the full amount of the injury suffered by the individual who had claimed against the policyholder. Thus, the court recognized a distinction under the policy language between ‘trigger’ and ‘scope’ of coverage. The time of the bodily injury or property damage was the ‘trigger’ (the event that activated coverage)—but the policy language allowed an interpretation whereby once ‘triggered’ the scope of the policy’s coverage was determined separately. The point was starkest where some damage took place during the policy’s operative period, but substantial damage from the same cause also took place both before and after it. By separating the questions (i) whether there had been injury or damage during the policy period (trigger) and (ii) what amount of loss had taken place during the policy period (scope), the court in *Keene* concluded that an insurer whose insurance policy was triggered was liable for ‘all sums’ of the policyholder’s liability regardless of whether some of the damage took place outside of the policy **1.12**

<sup>21</sup> 667 F2d 1034 (DC Cir 1981) (*Keene*).

<sup>22</sup> There is some irony in the fact that this landmark decision involved the Keene Corporation. This company was by no means a mainstream producer of asbestos products, and had apparently only sold US \$750,000 worth of products during its entire existence. Like many asbestos producers (and, in recent years, other companies), Keene was ultimately driven into bankruptcy by asbestos liability.

period in question. This approach, commonly known as the ‘joint and several’<sup>23</sup> or ‘all sums’<sup>24</sup> allocation of liability, was not uncontroversial. It was, and has been, bitterly resented by the insurance industry, and *Keene* became shorthand not only for ‘continuous trigger,’ but also for ‘all sums’ or ‘joint and several’ allocation. The alternative approach, which was current as an alternative, treated ‘trigger’ and ‘scope’ of coverage together, so that the insurer is held liable only for such portion of the loss as may be attributed to that part of the injury or damage as took place during the policy period.<sup>25</sup> This is typically called pro rata allocation and has been adopted as the law of New York in *Consolidated Edison Co v Allstate Insurance Co.*<sup>26</sup> by the New York Court of Appeals.<sup>27</sup> The New York federal courts had also rejected *Keene’s* continuous trigger approach, in favour of an ‘injury-in-fact’ trigger, which is often considered more favourable to insurers and which remains relevant to issues that can arise under the Bermuda Form as to whether and when personal injury and property damage have taken place.<sup>28</sup>

**1.13** The result of the coverage litigation on trigger and allocation issues<sup>29</sup> was that insurers found themselves liable for massive amounts on insurance

<sup>23</sup> This terminology made all insurers whose insurance policies had been ‘triggered’ potentially liable for the full amount of the policyholder’s loss, just as ‘joint and several’ liability may make two tortfeasors each liable for the full amount of their victim’s loss arising from the combination of their torts.

<sup>24</sup> Because it made all insurers liable for the entirety of the insured’s loss on the basis of the reference to the insurance company’s insuring agreement to pay the policyholder’s liability for ‘all sums’ that the insured became liable to pay on account of bodily injury or property damage caused by an occurrence.

<sup>25</sup> *Forty-Eight*, 633 F2d 1212 (1980), *clarified*, 657 F2d 814 (6th Cir 1981).

<sup>26</sup> 46 NYS2d 622, 628–31 (NY 2002).

<sup>27</sup> Before the New York’s highest court, the New York Court of Appeals, addressed the issue of allocation in *Consolidated Edison*, various federal courts, applying New York law, had adopted pro-rata allocation. *Eg. Stonewall Ins Co v Asbestos Claims Mgmt Corp*, 73 F3d 1178 (2d Cir 1995), *modified on other grounds*, 85 F3d 49 (2d Cir 1996). *Consolidated Edison* was decided under non-standard policy language.

<sup>28</sup> *American Home Prods Corp v Liberty Mut Ins Co*, 565 F Supp 1485 (SDNY 1983), *aff’d as modified*, 748 F2d 760 (2d Cir 1984). See further Chapter 5.

<sup>29</sup> For later decisions in the 1980s, see, eg:

- (1) *Aetna Cas & Sur Co v Abbott Labs, Inc*, 636 F Supp 546 (D Conn 1986): Federal trial court in Connecticut applied an ‘injury-in-fact’ trigger of coverage to a DES case.
- (2) *Standard Asbestos Mfg & Insulating Co v Royal Indem Ins Co*, No. CV-80-14909, slip op at 9 (Mo Cir Ct 3 Apr 1986) (Mealey’s Litigation Reports, Insurance, at 2,424 (1986)): Missouri state trial court, in an unpublished decision, applied an injury-in-face trigger to activate policies in effect at the time of injurious exposure only, rejecting *Keene* and following *Forty-Eight*.
- (3) *Abex Corp v Maryland Cas Co*, 790 F2d 119 (DC Cir 1986): United States Court of Appeals for the District of Columbia Circuit applied ‘injury-in-fact’ as trigger, refusing to follow *Keene* because New York law applied to Abex’s insurance policies, following *American Home Products*.
- (4) *Zurich Ins Co v Raymark Indus, Inc*, 494 NE2d 634 (Ill App Ct 1986): Appellate Court of Illinois upheld the trial court’s decision that insurance coverage for asbestos-related claims was triggered both by exposure and by manifestation but not

policies written over the previous decades, and in respect of which insurers thought that they had closed their books. Insurers found themselves facing huge liabilities from these 'long-tail' claims for which they had not adequately reserved. The background is reflected not only in well-known decisions in the United States<sup>30</sup> but in a number of decisions of the English courts in the Lloyd's context.<sup>31</sup>

exposure in residence which some have called 'dual trigger.' The court overturned the trial court's decision that insurers had a duty to defend claims even after the limits of their policies were exhausted by the payments of judgments or settlements, even in respect of pending claims.

- (5) *In re Asbestos Ins Coverage Litig (Armstrong World Indus, GAF, Fibreboard)*, Judicial Council Coordinated Proceeding No.1072, Phase III (Cal Super Ct 24 Jan 1990), *aff'd sub nom Armstrong World Indus, Inc v Aetna Cas & Sur Co*, 52 Cal Rptr 2d 690 (Ct App 1996): California trial court applied a *Keene*-type result and broadened the period of continuous trigger found in *Keene*, to include the period from first exposure to asbestos or asbestos-containing products until date of death or date of claim, whichever takes place first. As in *Keene*, the court followed *Keene*, requiring any insurer on risk during continuous injury to pay the policyholder's liability for the entire claim up to policy limits. The court allowed the policyholders to choose which insurer would be obligated to defend and held that 'all sums' did not require the policyholder to bear responsibility for any uninsured or self-insured periods. In addition, the court held that insurers were not required to defend actions, or even to continue to defend pending cases, once policy limits have been exhausted, although the court held that the cost of providing a defence does not reduce primary policy limits.
- (6) *Zurich Ins Co v Raymark Indus, Inc*, 514 NE2d 150 (Ill 1987): Supreme Court of Illinois affirmed the lower courts' findings that coverage attaches at the time of bodily injury, which the court determined is concurrent with exposure, or disease. The trigger applied by *Raymark* has been called a 'double trigger' because the court did not explicitly find coverage for what is called 'injury-in-residence.' The court held that trigger may need to be decided on a case-by-case basis. *Ibid* at 161–62. The state high court also rejected an 'unlimited duty to defend,' upholding the appellate court's finding that the duty to defend ends when the policy's limits are exhausted.
- (7) *Pittsburgh Corning Co v Travelers Indem Co*, No. 84-3985, 1988 WL 5291 and 5301 (ED Pa 1988): In the decision reported at 1988 WL 5291, the federal trial court determined that coverage for asbestos property damage is triggered at the time of discovery of damage. In the decision reported at 1988 WL 5301, the federal trial court determined coverage for asbestos bodily injury, sickness or diseases is triggered 'if any part of the injurious process . . . from time of exposure to time of manifestation . . . occurred within' the policy period.

<sup>30</sup> For example, the decision in *Stonewall*, 73 F3d 1178 (2d Cir 1995) gives a good overview of the decisions in New York in the context of both asbestos personal injury and property damage.

<sup>31</sup> See, eg, *Henderson v Merrett* (No 2) [1997] LRLR 247, where Lloyd's Names sued their managing agent, Merrett, for negligently writing run-off contracts and negligently closing years of account by reinsurance to close; and *Society of Lloyd's v Jaffray* [2002] EWCA Civ 1101, where Lloyd's Names unsuccessfully accused Lloyd's of fraudulent misrepresentation in the context of asbestos liabilities. The judgment of Cresswell J (3 November 2000) at first instance is unreported, but available on legal databases; eg New Law Online case 2001119805. It contains a wealth of detail as to the development of asbestos claims, both bodily injury and property damage: see in particular Chapter 16 of the judgment.

## THE CREATION OF ACE AND XL

- 1.14** The interpretation of CGL occurrence insurance policies by the United States courts, and the other developments already discussed, had major repercussions for the insurance industry. Beginning around 1984, commercial buyers of excess liability and directors' and officers' liability insurance began to see a significant reduction in worldwide insurance capacity. Insurance rates skyrocketed, and this trend continued into 1985, at which time the commercial insurance market to a large extent ceased writing this coverage for most companies in the United States, particularly the perceived high-risk chemical and pharmaceutical industries. In the light of the absence of available insurance capacity in the commercial market, the major broking firm Marsh & McLennan, together with J.P. Morgan Guarantee Bank, worked to create new insurance companies to help fill this void. Both Marsh and Morgan Guarantee agreed to provide startup services to the new insurance companies to help accelerate their entrance into the market. The concept relied on the policyholders of the new insurance entities to provide the startup capital to form the companies. This new capital would come from an initial group of 'sponsor' companies, together with a required reserve premium<sup>32</sup> that non-sponsor companies would have to pay in addition to their annual premium. Whilst both Marsh and Morgan were rewarded (for example by way of options and discounted equity) for their promotional efforts, Marsh's overriding goal was to provide its brokerage clients with insurance coverage.
- 1.15** Marsh and Morgan were successful in selling this concept to their client base and other interested companies. In late 1985 ACE was formed, followed by XL in May 1986. Many sponsor companies invested US \$10 million in either or both companies.
- 1.16** Marsh led the development of the ACE and XL policy forms with the assistance of the New York law firm Cahill Gordon. The ACE policy form was introduced in late 1985, and XL was created thereafter to provide limits below the limits provided by ACE. When XL commenced writing business in May 1986, it adopted the ACE form in its entirety. The policy form sought to meet the needs of its sponsor companies and other clients,<sup>33</sup> whilst at the

<sup>32</sup> Condition V(y) of the XL 001 Form required the Named Insured to purchase stock in XL for at least 100% of the aggregate amount of the premiums for the first annual period. This requirement was sometimes deleted and replaced by an endorsement, the Reserve Premium Endorsement, which require the payment of a reserve premium equal to the aggregate premiums applicable for the first annual period. The 001 Form also contained a condition (Article V (r)) which provided for the pro-ration of certain losses: see Chapter 11.

<sup>33</sup> See, eg, XL's 1993 Annual Report: 'Part of XL's mission is providing clients with confidence in the Company's ability to meet their catastrophic liability claims needs.'

same time trying to avoid exposing the new insurers to financial ruin from the very liability catastrophe problem they were established to help solve. Marsh understood that, for these new companies to succeed, they needed to provide significant amounts of excess catastrophe liability insurance for products and other liabilities. At the same time, because XL and ACE provided only high-excess layers (XL excess of at least US \$25 million and ACE excess of at least US \$100 million), a mechanism had to be provided that would allow a policyholder to access the limits for product claims arising from a single product defect, as most individual product claims would not reach the ACE or even the lower XL layers. Therefore, the new policy had to provide a means for the aggregating claims resulting from a common defect. Policyholders also generally sought at least a limited amount of sudden and accidental pollution coverage and directors' and officers' liability insurance. In addition, policyholder companies were looking for these new insurance companies to provide coverage and premium stability over time, something which the traditional insurance market was perceived as having failed to deliver. This led to an unusual policy form that was a hybrid of occurrence, accident, discovery and claims-made concepts

The policy forms used by ACE and XL have developed over the years. The first Bermuda Form, used by both ACE and XL, was 001. The current XL form is 004, and ACE has used five forms over the years. The later forms for both companies retain most of the distinguishing features that characterise the original policy form. The XL and ACE forms diverged over the years, but the current versions are substantially the same. The Bermuda Forms pioneered by ACE and XL have been adopted by others in the insurance industry, not only in Bermuda but by companies and Lloyd's syndicates operating in the London market.<sup>34</sup> **1.17**

Originally, as stated above, ACE sold general liability insurance coverage only in excess of US \$100 million, and XL sold general liability insurance policies in excess of a US \$25 million retention with a \$75 million limit. XL initially applied higher retentions for certain classes of business, but by the late 1980's chemical and pharmaceutical companies could buy coverage attaching at US \$25 million. EXEL Ltd, the parent company of XL, went public in 1991, and ACE Limited (the parent of ACE) went public in 1993. The shares in both companies have risen significantly in value since their public offerings. **1.18**

<sup>34</sup> Some insurance companies utilise the XL Forms with no or virtually no adaptation or alteration. Other companies have made more substantial alterations. Amongst the companies which have written business on a version of the Bermuda Form are Swiss Re, Allianz, Zurich, Gerling, Starr Excess and OCIL. Both Starr Excess and OCIL publish their policy terms on their websites: [www.ocil.bm](http://www.ocil.bm), [www.starrexcess.com](http://www.starrexcess.com). The Forms have also been adopted for areas of business other than general liability: for example, XL's professional liability policy is substantially based on the Bermuda Form.

## KEY FEATURES OF THE BERMUDA FORM

**1.19** The ‘Bermuda Form’ policy, as originally drafted and issued by ACE, is properly to be regarded as a balanced policy form, aiming to hold the ring fairly between the interests of policyholders and the interests of investors, as the same industrial corporations were in both roles. The key policy provisions can frequently be traced to something that had gone wrong or proved very expensive in the liability insurance crisis of the time. The Bermuda Form is a monument to learning from unpleasant experience. The architecture of the new policy was driven by a desire to preserve key features of occurrence coverage, whilst avoiding the problem of ‘stacking.’

### Occurrence Reported

**1.20** The effect of the decisions on the CGL occurrence policies had been to present insurers with a massive but unknown ‘tail’ of liability. This is because the occurrence policies responded to bodily injury or property damage that takes place during the policy period even if the injury or damage is undetected and develops gradually over a period of years. It was for this reason that insurers who had written policies in, say, 1950, found that they were having to meet claims arising from the exposure of an individual to asbestos during 1950. Because the onset of disease was undiscovered for years or even decades, these liabilities did not emerge until the late 1970s. It is therefore not surprising that in insurance company accounts drawn up in the 1950s, 1960s and early 1970s there were no reserves for them. Insurers found that they were having to meet claims on policies on which their books had been closed.<sup>35</sup> Indeed, especially in the early days of the asbestos problems, it often proved difficult actually to trace or find the policies themselves.

**1.21** By the mid-1980s, the United States insurance drafting organisation ISO promulgated a ‘claims made’ form for general liability insurance sold to large companies in the United States.<sup>36</sup> ‘Claims made’ insurance is also now the standard basis upon which professional liability risks are written in the United Kingdom. In their simplest form, policies written on this basis respond to a claim which is made against the policyholder during the

<sup>35</sup> The problem was particularly acute for Lloyd’s ‘Names’; these were private individuals who joined the Lloyd’s market and participated in syndicates which underwrote risks in the hope of making a profit. Part of the Lloyd’s system was that the syndicate would if possible close its books by effecting a reinsurance to close; viz a contract of reinsurance with the Names who were members of the syndicate in a later year. These Names, many of whom did not join Lloyd’s until the 1980s, found themselves having to meet very substantial liabilities on old Lloyd’s policies, most of which were written before they joined, and some of which were written before they were even born.

<sup>36</sup> See, eg, *Insurance Coverage Litigation* Chs. 1 and 4.

currency of the policy. If no claim is made during the annual policy period, the insurer will keep the premium as a profit. The insurer may renew the business for the following year, and again the policy will respond if a claim is made against the insured in that year. If the insurer discontinues cover, or the policyholder goes to another insurer, without any claim having been made during an annual policy period, then there will never be a claim for which the insurer has to respond. In this way, the problem of a massive but unknown tail of claims does not arise: the insurer will know, at the end of each annual policy period or soon thereafter,<sup>37</sup> whether a claim has been made against a policyholder.

At the time of the liability crisis in the mid-1980s, however, the insurance-buying public and state insurance regulators in the United States resisted the insurance industry's adoption of a claims-made trigger for general liability insurance. The new claims-made form met with vociferous objections from corporate policyholders, brokers and regulators in the United States, and it even became the subject of major antitrust litigation.<sup>38</sup> **1.22**

The Bermuda Form policy is neither pure occurrence, nor pure claims-made, but is a hybrid of the two. The policy is at heart an occurrence policy, and indeed expressly uses the expression 'occurrence.' In broad terms, it covers occurrences that take place during the policy period, with a start-point and an end-point. The starting point is the inception date of the policy,<sup>39</sup> and the end-point is the moment when the policyholder stops buying the basic cover granted by the policy,<sup>40</sup> or the insurer stops selling it. The policy is envisaged to be a continuous policy, in the sense that it continues from year to year. In contrast, a claims-made policy stops at one **1.23**

<sup>37</sup> Claims-made policies invariably contain provisions requiring the prompt notification of losses. Such policies generally allow the insured an extended reporting period for at least a short period of time. This extended reporting period applies after the claims-made coverage expires or is cancelled and provides that a claim made during the extended reporting period is deemed to have taken place on the last day of the policy period: State insurance departments in the United States required that insurers add an extended reporting period to the proposed claims-made form before they would give the requisite regulatory approvals to the new claims-made form in the 1980s.

<sup>38</sup> *In re Ins Antitrust Litig*, 938 F2d 919 (9th Cir 1992), *aff'd in part, rev'd in part sub nom Hartford Fire Ins Co v California*, 509 US 764 (1993).

<sup>39</sup> Sometimes, a policyholder purchases retroactive coverage. A retroactive date defines the starting point of the period during which the bodily injury or property damage covered by the policy must take place. In other words, bodily injury in claims covered by the policy must commence after the retroactive date. The retroactive date may be the same as the inception date or may be a date that is earlier than the inception date. See Chapters 2 and 6 below.

<sup>40</sup> Cover is afforded in respect of the period of 'Coverage A.' When the policy would otherwise terminate, the policyholder has the option to purchase Coverage B. In substance, this provides an extended reporting period in respect of occurrences which have taken place during the Coverage A period. It does not extend to fresh occurrences which take place during Coverage B. Complications arise in respect of 'batch' or 'integrated' occurrences, and the start and end points for these; see Chapter 6 below.

year end, and starts again afresh, with a new policy period, if the policy is renewed. The policy period of a Bermuda Form policy automatically renews unless one party cancels it.<sup>41</sup> Thus, a Bermuda Form policy has a policy period that may span years with a number of Annual Periods. Each Annual Period requires a new premium and provides new limits of liability. Accordingly the start point and the end-point of a Bermuda Form policy may be many years apart.

- 1.24** Thus far, the policy has all the features of an occurrence policy. But it also has the beneficial feature, from the insurer's standpoint, that the occurrence must be reported during the policy period. Hence if the policyholder stops buying the basic cover granted by the policy, and has not reported an occurrence during the policy period, the insurer can, subject to one proviso, close its books on the policy since no claim can in future be made. The proviso is that the insured has an option to purchase an extended 'reporting' or discovery period, known as Coverage B. This buys the policyholder extra time to report occurrences which took place during the currency of the basic period of cover, referred to as Coverage A.

### **Dispute Resolution**

- 1.25** The liability insurance crisis of the mid-1980s was viewed by many insurance people at the time as largely attributable to decisions by American judges and juries which expanded tort liabilities and broadened insurance coverage, both beyond what insurers believed was contemplated when they wrote and sold the policies. To address this problem, the decision-making process on disputes with policyholders was moved from the United States court system to London arbitration. The governing law selected was that of New York, which was considered to be, as between insurers and policyholders, more developed and neutral than that of other states of the United States. By modifying New York law in some respects,<sup>42</sup> the drafters of the policy sought to correct certain perceived imbalances in favour of the policyholder under New York law, and to limit resort to materials extrinsic to the language of the policy itself.<sup>43</sup> But the Form does not go the other way, for example by providing for an interpretation favourable to the insurers' expectations or interests.
- 1.26** The removal of disputes to a London arbitral forum has benefited English legal practitioners, who have become involved (whether as counsel or arbitrators) in disputes which they might otherwise not see. However, a

<sup>41</sup> The parties will need to agree upon terms for continuation, such as the premium: see Chapter 2 below, and the discussion of the cancellation and policy extension conditions in Chapter 11.

<sup>42</sup> See Chapter 4 below.

<sup>43</sup> The extent to which this was achieved is also considered in Chapter 4 below.

more important side-effect is that no body of case law has built up in relation to the interpretation of the Bermuda Form. Although English law<sup>44</sup> does permit appeals against arbitration awards in limited circumstances, these circumstances are confined to awards where there is an error of English law. Since the substantive law applied by arbitrators in relation to the Bermuda Form is New York law, there is no possibility of an appeal<sup>45</sup> and therefore of a decision of an English court on the interpretation of the Bermuda Form. As far as the United States courts are concerned, the Bermuda Form aims to keep disputes between insurer and policyholder away from those courts. Although some United States litigation has addressed the question of the interpretation of the Bermuda Form (eg, as a result of a contribution claim by one insurer against XL or ACE), there has hitherto been no significant American decision on the Form. This may change to some extent as Bermuda Form policy provisions are used increasingly in policy forms used by other insurance companies.

### Detailed Policy Language

The drafting of the Bermuda Form reflects a concern that the language of existing policies was often too brief and vague, leaving room for the courts to construe policy language liberally. The Bermuda Form, by contrast, seeks to achieve clarity by elaboration. It may first strike a reader as over-elaborate and over-drafted. There are clearly areas where it is not easy to work out how particular clauses fit together, and also where a literal interpretation of policy language might produce a result that is at odds with what appears to be the intention of the policy. There is also duplication or surplusage in the drafting, particularly of the original policy form. These matters are more easily understood once one appreciates the climate in which the language first came to be drawn up. **1.27**

The liability insurance crisis had been, to a significant extent, caused or aggravated by the immense and dramatic mass tort liabilities for certain products, such as asbestos, DES and intrauterine devices. The Bermuda Form policy singles these out for exclusion by name. Pollution liability was beginning to be a huge problem at the time when the Form was first drafted, and the policy contains a pollution exclusion which preserves some limited cover, again reflecting the balance that needed to be struck between the interests of insurer and insured. **1.28**

<sup>44</sup> See the English Arbitration Act 1996, s 69. This largely codifies the principles as to appeals established by the case law under the English Arbitration Act 1975, s 1.

<sup>45</sup> See, eg, *Egmatra AG v Marco Trading Corp* [1999] 1 Lloyd's Rep 862; *Reliance Industries Ltd v Enron Oil and Gas India Ltd* and another [2002] 1 Lloyd's Rep 645. The 004 Form contains a waiver of any right of appeal which, under the Arbitration Act 1996, is valid even though concluded before any dispute had arisen. The earlier policy forms do not contain an equivalent waiver. See further Chapter 3 below.

### Aggregation of Claims

- 1.29** One of the many problems faced by insurers in the years prior to the liability crisis was the aggregation or ‘stacking’ of policy limits. An insurer—for example, an insurer who had written a policy to an asbestos producer for a number of years—could find that each year’s policy would be exposed and required to pay for the policyholder’s liability and mammoth defence costs. If the policy contained an aggregate limit, it would prevent claims in respect of that policy in excess of the aggregate limit. However, the limit alone did not sufficiently limit the insurer’s liability for a number of reasons. First, before the 1980s, most CGL policies, primary or excess, paid defence costs in addition to limits. These costs were high given the thousands of asbestos and other long-tail claims in states all across the country. Because the limits were exhausted *only* by payment of settlements or judgments, the insurer could be liable for hundreds of thousands or even millions of dollars in defence costs, before a dollar was paid that eroded the limits. Second, some liabilities like environmental liabilities were typically not subject to *any* aggregate limits at all. In those situations, the policy could be required to respond to many occurrences, subject to a per-occurrence limit but no aggregate limit. Third, in cases of continuing injury, all policy periods on the risk during the period of injury could be triggered. Once one policy year was exhausted, the policyholder would then simply turn to other policies or years where aggregate limits had not been exhausted. If the relevant jurisdiction took the ‘all sums’ approach,<sup>46</sup> the policyholder could pick and choose the policy years that would respond. The policies were not written on the basis that there was an overall aggregate, across policy years, in respect of a particular problem. Accordingly, all the insurers’ limits were in practice cumulative. Insurers found themselves liable on each year’s policy up to the policy limits, and thus found themselves paying on many insurance policies over many policy years in respect of similar claims.
- 1.30** ‘Anti-stacking’ was a cornerstone of the new policy form. The Bermuda Form addressed this problem in a number of ways. The key was the occurrence-first-reported trigger. A simple way to avoid cumulation of limits in a liability policy is to specify a single moment as the trigger and to sweep into the single triggered policy all the financial consequences of the underlying problem. Accordingly, the Form requires the policyholder to group related events together or ‘integrate’ them into a single year, that being the year in which the policyholder determined that the claims were likely to implicate the policy and gave notice of that occurrence to the insurer. The policy gives a measure of discretion and judgment to the insured. The

<sup>46</sup> See paragraphs 1.10–1.12 above.

policyholder does not have to report every liability claim that is made, but only those that are 'likely to involve this policy.'<sup>47</sup>

As a result, the Bermuda Form policy is at risk, in connection with a related claim or series of claims, only for one set of limits in the year in which the claim is reported. This feature of sweeping all related injuries or losses into a single policy year is commonly called 'occurrence integration' or 'batching' or 'batch occurrence.' The 'batching' provision of the Bermuda Form, however, benefits both parties, thus reflecting the balanced nature of the Form. The batching clause enables the policyholder to add together a large number of small occurrences, with the result that the policyholder can exceed the very high retention that would otherwise defeat coverage for each individual claim. The insurer is protected, in that it bears only one loss in respect of any particular problem. **1.31**

### **Expected or Intended Injury and the 'Maintenance Deductible'**

The Bermuda Form contains a clause which has come to be known in Bermuda insurance industry custom and practice as the 'maintenance deductible.'<sup>48</sup> None of the Bermuda Form policies actually uses that term. If shown the policy for the first time, even an experienced lawyer would be hard put to locate the clause to which the expression relates. In fact, the relevant clause is the part of the provision in the definition of 'occurrence' that concerns injury or damage that is expected and intended. The concept of excluding injury or damage that the policyholder expected or intended was a well-known feature of CGL insurance policies, and was carried over into the first version of the Bermuda Form. It has remained there, with some significant development, ever since. **1.32**

The idea that an insurer should not be liable for losses that the policyholder expected or intended is something which commands general acceptance. For example, few would quarrel with the notion that a policyholder who deliberately causes harm should not be able to recover from insurance; for example the policyholder who maliciously pollutes a water supply. However, the application of this basic principle becomes much harder in less obvious situations. **1.33**

A classic example involves a drugs company that manufactures a product, say a vaccine, which is beneficial to huge numbers of people. Many drugs, such as vaccines, may cause some harm to a very small number of people who for one reason or another, react adversely to the product. The vaccine may be successfully used by millions of people each year, but cause harm **1.34**

<sup>47</sup> See Chapter 8 below for discussion of the reporting clause.

<sup>48</sup> See Chapter 7 below.

to an average of 8–10 people a year, all of whom can be expected to bring claims. An impartial observer might suggest that it would be fair for the drugs manufacturer to bear the risk of paying for the ‘noise-level’ 8–10 claims per year, but that, if, for some unexpected reason, the level of claims rose significantly (perhaps to 20, 50 or 100), then the company’s insurance should respond.

- 1.35** In very broad terms, the ‘maintenance deductible’ concept in the Bermuda Form was an innovative solution to this recognised problem. These provisions are considered in Chapter 7 below, but for present purposes it is important only to note how the Bermuda Form sought to strike a balance between the legitimate interests of policyholder and insurer. Absent the revised expected or intended language and the ‘maintenance deductible’ concept, which originally operated as a proviso to the classic ‘expected/intended’ language of the policy, the insurer might have said to the policyholder that the marketing of a product with a proven history of losses meant that the policyholder expected or intended all the damage that resulted, whether or not there was a later unanticipated ‘spike’ in claims. Accordingly, this concept was aimed at preserving the existence of cover for a product with a known historical incidence of losses. At the same time, however, it was intended to put the ‘noise-level’ claims onto the shoulders of the policyholder, whilst providing the company with insurance protection for the later unexpected ‘spike’ in claims.