NO: X02-UWYCV-07-5016321	:	SUPERIOR COURT
R.T. VANDERBILT CO., INC.	:	JUDICIAL DISTRICT OF WATERBURY
V.	:	COMPLEX LITIGATION DOCKET
HARTFORD ACCIDENT & INDEMNITY CO., ET AL.	:	MARCH 28, 2014

MEMORANDUM OF DECISION
RE: PHASE II OF TRIAL

I

PROCEDURAL HISTORY

The plaintiff, R.T. Vanderbilt Company, Inc. (RTV), nka Vanderbilt Minerals, LLC[1] commenced the present declaratory judgment action against the defendants Hartford Accident & Indemnity Company (Hartford) and Continental Casualty Company, Columbia Casualty Company, and Continental Insurance Company (collectively CNA) on November 9, 2007. The plaintiff brought the action against Hartford and CNA seeking a determination of insurance coverage obligations relative to the defense and indemnity for asbestos related bodily injury actions brought against the plaintiff. The court previously set forth a detailed procedural history of this matter in its February 22, 2013 memorandum of decision as to Phase I of the trial (#889).

[1] Subsequent to the Phase I decision, the court granted the plaintiff's motion to substitute Vanderbilt Minerals, LLC as the plaintiff based upon a merger of the company. Exhibits V2059, V2060. See order #861.01. Unless otherwise specified, all docket entry numbers refer to Docket No. X02-CV-07-5016321-S. All exhibits referenced contain a prefix identifying the party that produced the exhibit. E.g., for plaintiff, V____; for Mt. McKinley Insurance Company/Everest Reinsurance Company, EV____; for Continental Casualty Company, Columbia Casualty Company, and Continental Insurance Company (collectively CNA); CNA ____; for Certain Underwriters at Lloyd's and Certain London Market Insurance Companies LMI ___; American International Specialty Lines Insurance Company; AIS ___; Pacific Employers Insurance Company (PEIC), Century Indemnity Company (Century Indemnity), and ACE Property & Casualty Insurance Company (ACE P&C) (collectively PCA), PCA ____. As with the Phase I decision, all references to any exhibits throughout this decision are for exemplary purposes and reflect only a portion of the exhibits and evidence that have been submitted to, considered and reviewed by the court.

That first phase dealt with the singular issue of the coverage block applicable to the issuance of insurance policies by the defendants and any period for which the plaintiff was obligated to contribute to the costs of defense for asbestos/talc related claims. Thereafter, on May 15, 2013, the court commenced Phase II of the trial on the plaintiff's modified seventh amended complaint (#896) to address plaintiff's declaratory judgment counts as to CNA (count one), Hartford (count two) and all excess insurers (count five) as well as all counterclaims, cross-claims and special defenses related thereto, limited to the following issues: allocation, orphan shares, exhaustion of policies and policy exclusions. See orders #496, #647.01, #701 and #908.10. The issues as to breach of contract (counts three, four and six), any claim of damages for recovery from the plaintiff for the overpayment of defense and indemnity costs by CNA and other carriers, or any claims of reimbursement between carriers, have been reserved to later phases of the trial.[2] Phase II was tried to the court over fourteen days. All testimony and evidence previously admitted in Phase I of the trial was deemed admitted for purposes of Phase II. Thereafter, the parties filed post-trial briefs and subsequent reply briefs on September 16, 2013 and October 18, 2013 respectively.[3] Following rulings on motions to seal various filed briefs, the parties submitted the

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[2] Upon motion of the parties, the court agreed to bifurcate Phase II of the trial so as to remove the issues of damages and reimbursement of any overpayment of defense and indemnity costs which the court had previously directed be addressed in Phase II. Those issues will be considered following the completion of Phase II. See order #911.01.

[3] The excess/umbrella insurer defendants who have submitted briefs in this phase of the trial are: Mt. McKinley Insurance Company (Mt. McKinley); Employers Mutual Casualty Company (Employers); First State Insurance Company (First State); Old Republic Insurance Company (Old Republic); Twin Cities Fire Insurance Company (Twin City); Certain Underwriters at Lloyd's London and Certain London Market Insurance Companies (collectively LMI); Pacific Employers Insurance Company (PEIC), Century Indemnity Company (Century Indemnity), and ACE Property & Casualty Insurance Company (ACE P&C) (collectively PCA); American International Underwriters Insurance Company (AIU) and Granite State Insurance Company (Granite State) (collectively Chartis Excess Insurers); Fireman's Fund Insurance Company and the American Insurance Company (collectively FFIC); National Casualty Company (NCC); Certain Underwriters at Lloyd's, London and Certain London Market Insurance Companies (collectively LMI); Zurich International (Bermuda) Limited (Zurich); St. Paul Fire and Marine Insurance Company (St. Paul) and Travelers Casualty and Surety Company f/k/a The Aetna

last of the redacted briefs for the court's consideration on December 6, 2013.

II

FACTS

In order to address the issues before the court, it is necessary to set forth not only the facts presented in this phase of the trial, but also to incorporate the facts found in Phase I of these proceedings. From the competent and credible testimony and evidence presented, the court finds the plaintiff is a Norwalk, Connecticut corporation founded in 1916 and is engaged in the mining and sale of various chemical and mineral products. In 1948, the plaintiff began producing industrial talc through its subsidiary, Gouverneur Talc Company. It continued to mine and sell talc through 2007 but thereafter ceased production and eventually sold or stopped selling the last of its talc inventory at the end of 2008. EV431.[4]

Beginning in the 1970's and up through 1986, there was a dramatic increase nationwide in the number of claims for injuries related to exposure to asbestos. Through 1985, insurance companies had regularly offered and provided occurrence-based defense cost and indemnity coverage for such claims. However, by 1986, such policies became generally unavailable to companies in the mining and chemical industries as the insurance industry had found the number of, and potential exposure for, long tail latency loss claims to be financially unattractive to insure. The insurance industry responded to the increase in such claims by offering policies that contained exclusions for asbestos related claims. Moreover, it moved to offer only claims-made

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Casualty and Surety Company (collectively Travelers); Westport Insurance Corporation (Westport); and Munich Reinsurance America, fka American Reinsurance Company (Munich).

[4] This exhibit, along with a number of others, were fully or partially sealed by the court pursuant to Practice Book § 11-20A.

policies rather than occurrence-based policies to companies that carried a risk of exposure to asbestos, such as those in the mining and chemical industries. Occurrence-based coverage remained available to other companies or producers that did not actively engage in the production or distribution of asbestos-containing materials, but not to those that were directly or indirectly involved. Both the plaintiff's and defendants' experts credibly testified that by 1986, insurance coverage was generally available to companies within those industries but only on a claims-made basis and with an asbestos exclusion.[5]

Over the years, thousands of claims across the country have been filed against the plaintiff alleging bodily injury caused by exposure to asbestos, through silica and/or talc mined and/or sold by the plaintiff (the underlying actions). V971. The plaintiff has always taken the position that its industrial talc does not contain asbestos. On May 29, 1992, the Occupational Safety and Health Administration (OSHA) issued a final rule that talc, such as that mined and sold by the plaintiff, would no longer be regulated under asbestos standards.[6] Stipulation #713; EV221, EV428. Nonetheless, there remain a large number of claims pending against the

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[5] A "claims made" policy provides coverage for claims made during the policy period. An "occurrence-based" policy provides coverage for any occurrences, as defined by the policy, that take place during the policy period even if the claim arising from that "occurrence" may not be made until long after the policy period has ended. See 7 L. Russ & T. Segalla, Couch on Insurance (3d Ed. 2005) § 102:20, pp. 102-43 to 102-47. Occurrence-based policies are particularly desirable to insureds where there are potential long latency losses such as those that arise well after the "occurrence" of exposure to asbestos. Terms such as "long latency loss," "long tail latency loss" and/or "long tail" claims are typically used interchangeably.

[6] "OSHA has reviewed available relevant evidence concerning the health effects of nonasbestiform tremolite, anthophyllite and actinolite and has also examined the feasibility of various regulatory options. Based on the entire rulemaking record before it, OSHA has made a determination that substantial evidence is lacking to conclude that nonasbestiform tremolite, anthophyllite and actinolite present the same type or magnitude of health effect as asbestos. Further, substantial evidence does not support a finding that exposed employees would be at a significant risk because nonasbestiform tremolite, anthophyllite or actinolite was not regulated in the asbestos standards.

OSHA hereby lifts the Administrative Stay, removes and reserves 29 CFR 1910.1101, and amends the revised asbestos standards to remove nonasbestiform tremolite, anthophyllite and actinolite from their scope." EV221; 57 Fed. Reg. 24310, Department of Labor, Occupational Safety and Health Administration (June 8, 1992).

plaintiff.

Since it started mining talc, plaintiff has purchased or attempted to purchase insurance to cover the defense and indemnity for asbestos related claims. While the plaintiff claims it purchased occurrence-based policies for asbestos related claims for the period 1948-1955, at trial there was no evidence presented either through testimony or exhibits that established by a preponderance of the evidence that it had done so. In fact, the plaintiff concedes that "thus far Vanderbilt has been unable to locate the policies or sufficient secondary evidence of the policies." #779, p. 4. As to subsequent time periods, the parties have submitted evidence through various stipulations that Hartford and/or CNA provided the plaintiff with occurrence-based primary level insurance coverage from 1956 to March 1986. See, e.g., Stipulations #712, #715, #720. While there is a dispute as to some of the terms of coverage offered by CNA for the period January 1, 1956 to January 1, 1962, there is no dispute that, collectively, both Hartford and CNA provided defense cost coverage through their primary policies for the period January 1962 to March 1986. CNA did so from January 1, 1962 to March 3, 1977 and Hartford from March 3, 1977 to March 3, 1986. V1 through V6; V14 through V22.[7] CNA also issued umbrella policies from January 1, 1965 to May 17, 1977 and an excess policy from May 17, 1977 to March 25, 1978 but disputed whether defense cost coverage was provided as part of those policies. V7 through V12. CNA also issued two other policies covering the period March 3, 1984 to March 3, 1986 as successor in interest to Harbor Insurance Company. #715. Multiple umbrella or excess polices from various defendants were also issued from 1956 through 1985.

[7] Although Stipulation #715 references an end date of March 1, 1977 on the last CNA policy, an examination of that policy submitted as exhibit V6 shows a modification of the policy to extend the end date to March 3, 1977.

In a separate evidentiary proceeding requested by the parties prior to the commencement of Phase II, the court agreed to rule on the issue of whether CNA was obligated to defend the underlying claims under its umbrella/excess policies for the period January 1, 1968 to May 17, 1977. See #978. After reviewing all of the pleadings and appended exhibits designated by the parties, the court found that CNA had no duty to defend the plaintiff under those policies (V8 through V11) and therefore had no obligation to pay its defense costs. See order #1003 and the supplemental memorandum of decision issued this date (incorporated herein by reference). The plaintiff and defendants presented expert testimony on the significant changes which took place in the insurance marketplace by 1986 as a result of the flood of asbestos related injury claims. Both the plaintiff's expert Jeffrey Posner and the defendants' expert Donald Bendure noted the shift in the nature of policies offered to companies engaged in the handling or processing of hazardous materials including those thought to contain asbestos. While offering differing opinions on whether the plaintiff was considered to be a company engaged in the handling of high risk materials that would preclude its ability to obtain occurrence-based defense cost and indemnity coverage without an exclusion for asbestos related claims, both confirmed that by 1986, the insurance industry had stopped issuing such coverage to companies likely to be subject to asbestos related claims and had shifted to the issuance of claims-made coverage with exclusions for asbestos related claims.

Beginning in 1986, because it could not find a carrier to offer it any occurrence-based indemnity policies without an asbestos exclusion, the plaintiff began purchasing claims-made policies (also with exclusions for asbestos related claims). In 2003, the plaintiff was able to purchase a policy through American International Specialty Lines Insurance Company (AISLIC)

for the period April 24, 2003 to April 24, 2004, which arguably provided indemnity coverage for asbestos related claims and for which it was also able to later obtain an extended reporting endorsement effective to April 24, 2007. V37. The policy had a $1 million per occurrence defense and indemnity cost limit with a $2 million general aggregate limit and a $250,000 deductible. The policy also contains an additional $2 million products completed operations limit which is distinct from the $2 million aggregate limit. Id. Defense costs and indemnity payments both eroded the limits of the policy. CNA 4798. The initial policy contained a "natural substances" endorsement which covered asbestos. However, after only a year, AISLIC declined to renew the policy with the natural substances endorsement which had encompassed asbestos related claims and instead issued a policy that contained an endorsement excluding natural substances. V38. In light of the exclusion, the company allowed the plaintiff to purchase the extended reporting period endorsement for a $400,000 premium. Mac Nadel (Nadel), a representative of plaintiff's insurance broker Marsh USA, Inc. (f/k/a J & H Marsh & McLennan) (Marsh), credibly testified that although the "natural substances" endorsement covering asbestos was issued in the initial AISLIC policy, since that time he had not seen such an endorsement in any other policy offered by other carriers. Other than that coverage, he was unable to secure on behalf of the plaintiff any coverage for the indemnity of asbestos related claims. There was further evidence as to the circumstances surrounding the issuance of the AISLIC policy in the deposition testimony of AISLIC's underwriter, Stacey Varner, who stated that the coverage was non-negotiable, was limited to that one policy and that it was never used for any other insured. V969.

The court finds that the terms of the AISLIC policy did provide indemnity coverage for

the period 2003 to 2004 and that the plaintiff availed itself of that coverage. Other than that single policy, the plaintiff was unable to obtain indemnity coverage for asbestos related claims between 1986 and 2008.[8]

As of the date of plaintiff's complaint, all of the claims-made reporting periods for policies purchased in 1986 or later, had expired. Additional facts will be set forth below as necessary.

III

DISCUSSION

As noted above, in the context of the declaratory judgment counts and related counterclaims, cross-claims and special defenses, the court directed the parties, in part at their own request, to present evidence addressing only the following limited issues: allocation, orphan shares, exhaustion of policies, and policy exclusions. Each will be addressed below in turn.

A

Allocation

In its February 22, 2013 memorandum of decision for Phase I, the court addressed the issue of allocation relative to defense cost coverage. The issue of the allocation of indemnity coverage amongst the insurance carriers and the plaintiff remain for the court to decide.[9] In

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[8] In the court's Phase I decision, it found that claims-made policies issued by Gerling, Commerce and Industry and AISLIC provided defense cost coverage to the plaintiff for the period 1993-2007. V198, V199, V201, V2063 as to Gerling; V30-V36, V216, V225 as to Commerce and V37 as to AISLIC, respectively.

[9] Except as otherwise noted herein, and with reference to footnote 2, any specific ruling as to the exact financial obligation for defense or indemnity costs under the individual policies issued by each carrier is left to Phase III of this trial as part of the calculation of damages and reimbursement of such costs. Certain insurers such as Munich Reinsurance America and Old Republic had advised the court that they intended to address the issues of defense obligations and payment of defense costs in Phase II post-trial briefing. #1091, #1085. However, such issues are beyond the limited scope of issues considered in Phase II and are better suited to be fully addressed in Phase III. That latter phase shall necessarily determine the scope of any defense or indemnity obligations in order to

making a determination of whether the plaintiff bears any portion of the responsibility for the indemnity claims brought against it, it will be useful to separate the analysis into the periods 1948 to 1985 and 1986 to 2008.

As previously noted, the insurance industry ceased offering occurrence-based indemnity coverage for asbestos related claims after 1985. Instead, the industry offered only policies on a claims-made basis which contained asbestos exclusions. In light of this fact, the plaintiff has already conceded that it should be considered self-insured for purposes of indemnity with respect to claims alleging a date of first exposure after March 3, 1986; see #1077, p. 24 n.17; which, except for the AISLIC policy, is the date their last policy with indemnity coverage expired. Therefore, the indemnity coverage issue is limited to what periods, if any, the plaintiff should be treated as self-insured for purposes of indemnity on claims with a date of first exposure on or before March 3, 1986.

In *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, Superior Court, judicial district of New Britain, Docket No. CV-96-0475565-S (May 9, 2001, *Graham, J.*) (29 Conn. L. Rptr. 694), aff'd in part and rev'd in part, 264 Conn. 688, 826 A.2d 107 (2003), the trial court, in the absence of Appellate or Supreme Court case law on the issue, adopted the continuous trigger method of determining which insurance policies were implicated and applied the pro rata allocation method to such situations. In doing so, the court relied upon *Stonewall Ins. Co.* v. *Asbestos Claims Management Corp.*, 73 F.3d 1178, 1204 (2d Cir. 1995), modified 85 F.3d 49 (2d Cir. 1996). The *Stonewall* court, in turn, drew its pro rata allocation approach to

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determine the amounts due, if any, under any policy not already addressed by the court in this phase. Any other issues set forth in their briefs that are properly before the court in this phase, for example, pollution exclusions, have been considered by the court.

continuous trigger situations from the decision of the New Jersey Supreme Court in *Owens-Illinois, Inc.* v. *United Ins. Co.*, 138 N.J. 437, 650 A.2d 974 (1994), superseded by statute as stated in *Farmers Mutual Fire Ins. Co. of Salem* v. *New Jersey Property-Liability Ins. Guaranty Assn.*, 215 N.J. 522, 74 A.3d 860 (2013),[10] which had adopted the continuous trigger approach after finding it to be the best judicial response to the unique problems posed by claims arising from asbestos-related diseases. In addition, *Owens-Illinois*, for its part, drew the pro rata allocation method from the Sixth Circuit's decision in *Ins. Co. of North America* v. *Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir.), cert. denied, 454 U.S. 1109 (1981). The *Owens-Illinois* court also rejected the joint and several allocation method adopted by the District of Columbia Circuit in *Keene Corp.* v. *Ins. Co. of North America*, 667 F.2d 1034 (D.C. Cir. 1981), having found that joint and several allocation method produced inconsistent results because it focused excessively upon the language of the insurance policies involved, which were woefully inadequate to manage a mass toxic tort like asbestos exposure. *Owens-Illinois, Inc.* v. *United Ins. Co.*, supra, 138 N.J. 471.

Regarding the availability of insurance, the trial court in *Security* also reaffirmed its conclusion in a prior decision that the plaintiff was "not responsible for an equitable share of defense costs proportionate to the period of time after 1985 when asbestos exposure coverage was not available." *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 29 Conn. L. Rptr. 694, citing, *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.* Superior Court, judicial district of New Britain, Docket No. CV-96-0475565-S (July 12, 1999,

[10] The New Jersey legislature has carved out a specific exception to pro rata allocation, which requires exhaustion of solvent carriers' policies before the New Jersey Property Liability Insurance Guaranty Association's reimbursement commitments are triggered. See New Jersey Statutes 17:30A-5. This statute has no bearing on this court's analysis.

Graham, J.), aff'd in part and rev'd in part, 264 Conn. 688, 826 A.2d 107 (2003). Notably, the court also concluded that there is no meaningful distinction between claims for defense costs and claims for indemnity in so far as the pro rata allocation method is concerned. *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, Superior Court, Docket No. CV-96-0475565-S (July 12, 1999, *Graham, J.*); see also *Security Ins. Co. of Hartford* v. *Lumbermens*, supra, 264 Conn. 706 and 712.

As with continuous trigger and pro rata allocation, the notion that an insured is not self-insured for periods during which insurance was unavailable traces its origin back to *Owens-Illinois*. Specifically, *Stonewall* relied upon *Owens-Illinois* for the proposition that an insured should not be considered self-insured for "periods when coverage for a risk is not available." (Internal quotation marks omitted.)[11] *Stonewall Ins. Co.* v. *Asbestos Claims Management Corp.*, supra, 77 F.3d 1204.

At trial, on the issue of indemnity coverage, Joseph Denaro, plaintiff's chief financial officer, along with Nadel and Paul Vanderbilt, the plaintiff's executive vice-president, testified collectively and credibly that, except in the limited circumstance discussed below, the plaintiff was unable to purchase policies in 1986 and thereafter that contained indemnity coverage for asbestos related claims because such coverage was not generally available. This remained so even after the plaintiff stopped selling talc. The unavailability of indemnity coverage for that time period was also credibly testified to by plaintiff's expert Jeffrey Posner. While Donald Bendure, Mt. McKinley's expert, credibly testified that occurrence-based indemnity coverage

[11] The *Stonewall* court noted that *Forty-Eight Insulations* did not "consider the proration issue in periods when insurance was no longer available, since the case was decided in 1980, prior to the arrival of the asbestos exclusion clauses in 1985." *Stonewall Ins. Co.* v. *Asbestos Claims Management Corp.*, supra, 73 F.3d 1204, n.18.

was generally available from 1948 through the mid-2000s for claims regarding non-asbestos particulates, he offered no opinion on the availability of such coverage for asbestos related claims. Nonetheless, he did note that the only indemnity asbestos coverage available from 1986 forward that he was aware of was in the context of coverage offered to asbestos abatement contractors and that otherwise it was "virtually impossible" to get coverage in that time period.

Moreover, there was collective evidence before the court through the credible testimony of Thomas Radcliffe, plaintiff's national coordinating counsel for underlying actions, John Kelse, plaintiff's corporate hygienist, Jeffrey Brohel, plaintiff's general counsel, and Paul Vanderbilt that all the underlying actions and claims, whether on their face or through subsequent discovery and/or investigation, involved claims of exposure to asbestos. Support for this conclusion is found in Mt. McKinley's post-trial brief which states that "[w]hile the Underlying Claims allege exposure to asbestos-containing talc under different factual scenarios, they all generally allege RTV's talc products contained asbestos dust and fibers that were 'discharged into the air' and inhaled by the claimants, exposing them to dangerous and hazardous materials and causing bodily harm."[12] #1083, p. 45.

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[12] Several other Underlying Complaints were also admitted into evidence at trial. See, e.g., EV810.1; EV810.2; EV1433; EV1463; EV1472; EV1481; EV1492; EV1933; EV1943; EV195V6; EV1972; EV1976-1978; EV1996; EV2003; EV2006; EV2013; EV2028; EV2029; EV2039; EV2049; EV2055; EV2067; EV2204; EV2305; EV2370; EV2455; EV2544; V1028-2; V1113-2; V1226-3; V1240-2; V1303-3; V1310-3; V1312-3; V1333-4; V1343-4; V1368-3; V1378-4; V1394-4; V1400-4; V1435-3; V1436-3; V1469-3; V1471-3; V1473-3; V1481-7; V1515-10; V1520-4; V1527-5; V1647-2; V1673-2; V1720-2; V1726-2; V1751-2; V1808-2; V1819-2; V1830-2; V1860-2; V1864-2; V1882-2; V1890-2; V1899-2; V1903-2; V1944-2; V1947-2; V1979-2; V1985-2; V2022-2; V2025-2; V273-6-3; V279-30-3; V280-15-2; V285-1377-28; V707-94; V974-11; V976-100; V976-103; V976-108; V976-112; V976-116; V976-119; V976-121; V976-135; V976-139; V976-143; V976-148; V976-153; V976-156; V976-158; V976-161; V976-163; V976-166; V976-171; V976-177; V976-181; V976-183; V976-197; V976-206; V976-210; V976-213; V976-223; V976-227; V976-230; V976-234; V976-237; V976-240; V976-243; V976-245; V976-252; V976-254; V976-256; V976-258; V976-261; V976-264; V976-266; V976-268; V976-271; V976-273; V976-275; V976-277; V976-30; V976-32; V976-36; V976-37; V976-39; V976-41; V976-46; V976-49; V976-52; V976-54; V976-60; V976-62; V976-65; V976-67; V976-69; V976-73; V976-75; V976-77; V976-79; V976-83; V976-85.

The evidence presented at trial establishes that the only policy available to the plaintiff following 1985 that may have provided indemnity coverage was a claims-made policy offered by AISLIC. In 2003, the plaintiff was able to purchase a policy through AISLIC for the period April 24, 2003 to April 24, 2004, which provided coverage for natural substances (which included asbestos) and for which it was able to later obtain an extended reporting endorsement effective to April 24, 2007. V37. However, the endorsement was only offered due to the insurer electing to exclude any asbestos coverage at the end of the initial term of the policy.

In seeking coverage, all other policies available to the plaintiff contained asbestos exclusions. Therefore, by purchasing the AISLIC policy, the court finds that the plaintiff purchased all available indemnity insurance for asbestos related claims following 1985.

From the direct and circumstantial evidence before it, the court finds that occurrence-based insurance policies providing indemnity coverage for asbestos related claims were not generally available in the marketplace after 1985 for companies in the mining and chemical industries such as the plaintiff. Nonetheless, as noted in its Phase I decision, the parties vigorously argued over whether the standard for the court's determination of the issue before it should be the unavailability to the plaintiff, or the *general* unavailability, of insurance coverage. There the court found that despite the plaintiff's efforts to characterize the issue as one of whether such coverage was generally unavailable, there appears to be no precedent for the adoption of such a position. Rather, the question is one of whether indemnity coverage was available to *this* plaintiff. As noted by both a lay witness and the experts in their testimony,

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See also the following complaints which were admitted by agreement: EV1298; EV1340; EV1435; EV1439; EV1452; EV1461; EV1471; EV1498; EV1523; EV1547; EV1587; EV1615; EV1616; EV1623; EV1626; EV1627; EV1631; EV1661; EV1665; EV1673; EV1678; EV1736; EV1737; EV1743; EV1789; EV1864.

deciding to offer insurance coverage, whether for defense costs or indemnity, is an individual determination based on several factors specific to that insured. Their credible collective testimony in this regard is confirmed by the issuance of the 2003-04 AISLIC policy providing indemnity coverage which was done based upon circumstances, representations and conditions specific to the plaintiff. The evidence is sufficient to establish by a preponderance of the evidence that indemnity coverage was unavailable to the plaintiff but for that one policy. Conversely, there was no evidence presented that there was indemnity coverage available to the plaintiff that it elected not to purchase.

"[W]e note that judges who have endorsed proration to the insured have done so only to oblige a manufacturer to accept a proportionate share of the risk that it elected to assume, either by declining to purchase available insurance or by purchasing what turned out to be an insufficient amount." *Stonewall Ins. Co. v. Asbestos Claims Management Corp.*, supra, 73 F.3d 1204. Citing to the reasoning of *Stonewall* in ruling on the plaintiff's summary judgment motion, the trial court in *Security* aptly noted "[t]he proration-to-the-insured approach, which requires contribution from a self-insured entity for those periods in time in which insurance coverage is available, is inapplicable to those periods of time in which coverage for a particular risk cannot be acquired. The element of choice, and in turn, the conscious decision of an insured to assume the risks of being self-insured is lost if the insured cannot realistically acquire the particular coverage desired." (Internal quotation marks omitted.) *Security Insurance Company of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, Superior Court, Docket No. CV-96-0475565-S (July 12, 1999 *Graham, J.*) Here, the collective evidence, while much of it circumstantial, points to the conclusion that but for the AISLIC policy the plaintiff was unable to realistically acquire

indemnity coverage in the period 1986-2008.

As to the period after the expiration of the AISLIC policy in April 2004, direct evidence, such as the credible testimony of Denaro, Nadel, Stephen Matteo (another broker of Marsh) and the deposition testimony of Stacey Varner, coupled with circumstantial evidence, demonstrates that there was no other indemnity coverage available to the plaintiff.

Accordingly, the plaintiff shall not be considered as self-insured as to indemnity for the period March 1986 through December 2008 as indemnity insurance for asbestos related claims was either unavailable to it or it purchased the only such insurance that was available.

At trial, and in its post-trial brief, the defendant Mt. McKinley raised three arguments relating to the unavailability of insurance which the court is compelled to address. First, it argues that the "unavailability of insurance" rule is not the law applicable to this case because it has not been adopted by our Appellate or Supreme Courts. Second, that because the plaintiff has always maintained that its products did not contain asbestos, and because indemnity policies for non-asbestos containing products were available, the court should find that the plaintiff was self-insured following 1985. Third, Mt. McKinley argues that principles of equity nonetheless require the court to find that the plaintiff was self-insured following 1985.[13]

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[13]The following defendants have joined Mt. McKinley's argument as to this issue: FFIC (#1105); NCC (#1107); LMI (#1097); Chartis Excess Insurers (#1093); PCA defendants (#1082); Zurich (#1098); Travelers (#1086); Westport (#1115); Employers (#1089) and Munich (#1091).

Although not expressly adopting Mt. McKinley's brief, Old Republic Insurance Company ("Old Republic") has stated that "the insurance layers beneath Old Republic Policies must be properly exhausted before Old Republic can have any such obligations [to indemnify], and to date Vanderbilt has yet to establish the same. #1085, p. 3 n.3 Westport additionally argues: "to the extent that the Court grants MMIC relief on the non-cumulation provision contained in the MMIC umbrella policies, Westport would be entitled to the same relief, since its policies contain a noncumulation of liability provision reducing the amounts due under each Westport Policy by amounts covered under any other excess policy issued to the insured prior to the inception date of the Westport Policy." #1115. Mt. McKinley issued six umbrella policies to RTV from March 3, 1979 through March 3, 1985. V23-V28. Those policies sit above Hartford's primary coverage in each of the policy years. Additionally, Mt. McKinley/Everest Re issued ten excess policies from March 1, 1977 through March 3, 1985. V62-V65, V103-V108.

Mt. McKinley is correct that the Supreme Court in *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 264 Conn. 688, did not specifically reference an "unavailability of insurance" rule by name. However, the authority upon which the *Security* line of cases relies, including the *Security* trial court, did in effect adopt such a rule without using that particular language. Indeed, our Supreme Court specifically cited language from *Owens-Illinois* to that effect. See *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 264 Conn. 709 ("When periods of no insurance reflect a decision by an actor to assume or retain a risk, *as opposed to periods when coverage for a risk is not available*, to expect the risk-bearer to share in the allocation is reasonable. . . . Because insurance companies can spread costs throughout an industry and thus achieve cost efficiency, the law should, at a minimum, not provide disincentives to parties to acquire insurance *when available* to cover their risks." [citation omitted; emphasis added; internal quotation marks omitted]). Thus, thirty years of precedent support the rule and though it has no specific moniker, it has been adopted by several courts.

Second, Mt. McKinley is incorrect that indemnity insurance was available to the plaintiff because the plaintiff has always maintained that its products did not contain asbestos, i.e., it could obtain such insurance for non-asbestos products and materials. The relevant inquiry before this court does not focus on the position taken by the plaintiff that its product did not contain asbestos. Rather, the relevant inquiry is whether the individual causes of action and claims asserted against the plaintiff allege liability on the basis of asbestos exposure. See, e.g., *Capstone Building Corp.* v. *American Motorists Ins. Co.*, 308 Conn. 760, 807, 67 A.3d 961 (2013) ("insurer's duty is triggered when the demand is sufficiently detailed for the defendant to

discern whether the allegations . . . [are] within the scope of the plaintiff's insurance coverage" [internal quotation marks omitted]), quoting *R.T. Vanderbilt Co., Inc.* v. *Continental Casualty Co.*, 273 Conn. 448, 471, 870 A.2d 1048 (2005). Here the court finds the underlying actions and claims to allege such exposure. See, e.g., #1041, #1061, #1062.[14]

Third, Mt. McKinley specifically contends that, even if the so-called unavailability of insurance exception is applicable, defense and indemnity costs should be allocated to the plaintiff from March 3, 1986 through the end of 2008, the date on which the plaintiff ceased selling its talc products. It contends that because the declaratory judgment action originally brought by the plaintiff is an equitable action, the court is bound to consider evidence of the plaintiff's conduct from 1986 to 2008 in the sale of a product that would likely generate liability claims of asbestos exposure whether or not such claims were viable. Mt. McKinley put on considerable credible evidence of the plaintiff's business decision to continue selling talc, as well as of the plaintiff's concern about claims continuing to be brought against it after it could no longer obtain indemnity insurance. See, e.g., EV363, EV376, EV430. Mt. McKinley argues that in doing so, the plaintiff "assumed the risk" that it would be sued for asbestos exposure during uncovered periods and, therefore, should be considered self-insured for such period of time. It further argues that the plaintiff's continued marketing of its talc distinguishes the plaintiff's behavior from the insureds

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[14] #1041 stipulation of May 10, 2013 regarding underlying cases that were admitted as exhibits: V1673-2, V1720-2, V1830-2, V1899-2, V1903-2, V1630 (p. 33), V1726-2, V1808-2, V1890-2, V1944-2, V1630 (p. 22), V1985-2, V1864-2, V1882-2, V1979-2, V2025-2, V1819-2 and V1630 (p. 6).

#1061 stipulation of June 19, 2013 regarding underlying cases that were admitted as exhibits; EV1463, V1303-3, V1113-2, V1310-3, V1312-3, V1860-2, V1240-2, V2022-2, V974-111, V1333-4, V273-6-3, V1028-2, V279-30-3, EV2455, V1343-4, V1368-3, V1378-4, V1751-2, V1394-4, V1400-4, V1810-2, V1435-3, V1436-3, V1947-2, V1469-3, V1471-3, V1473-3, V1481-7, V707-94, V1515-10, V1520-4, V1527-5, V1226-3, EV1492, EV1433, EV1481, EV1472, V280-15-2 and V285-1377-28. See also V1647-2.

#1062 stipulation of June 21, 2013 regarding underlying cases that the parties would refer to in arguments regarding the occupational disease exclusions.

in *Stonewall*, *Owens-Illinois*, and *Security*, each of which stopped selling allegedly asbestos-containing products years before the unavailability of asbestos indemnity coverage. It points to cases such as *Reichhold Chemicals, Inc.* v. *Hartford Accident & Indemnity Co.*, Superior Court, judicial district of New Britain, Complex Litigation Docket, Docket No. X03-CV-88-0085884-S (February 11, 1999, *Aurigemma, J.*), rev'd on other grounds, 252 Conn. 774 (2000) and *Steadfast Ins. Co.* v. *Purdue Frederick*, Superior Court, judicial district of Stamford-Norwalk, Complex Litigation Docket, Docket No. X08-CV-02-0191697-S (May 18, 2006, *Adams, J.*) (41 Conn. L. Rptr. 604) to illustrate the difference.

Based on the evidence, Mt. McKinley's equitable argument possesses appeal. The plaintiff is seeking, in part, a declaratory judgment that its excess and umbrella insurance carriers must provide indemnity coverage relative to underlying claims and lawsuits for personal injuries allegedly resulting from the exposure to asbestos through contact with its talc. The policy underlying pro rata allocation would seem, at first glance, to support Mt McKinley's position regarding long latency loss claims due to such exposure. Our Supreme Court has stated, "the theory of insurance is that of transferring risks. Insurance companies accept risks from manufacturers and either retain the risks or spread the risks through reinsurance. . . . Because insurance companies can spread costs throughout an industry and thus achieve cost efficiency, the law should, at a minimum, not provide disincentives to parties to acquire insurance when available to cover their risks. Spreading the risk is conceptually more efficient." (Internal quotation marks omitted.) *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 264 Conn. 709, quoting *Owens-Illinois, Inc.* v. *United Ins. Co.*, supra, 138 N.J. 472-73.

Nevertheless, in *Stonewall Ins. Co.* v. *Asbestos Claims Management Corp.*, supra, 73 F.3d 1203, the Second Circuit distinguished between "periods of no insurance [that] reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available . . . ." The *Stonewall* court also noted that "judges who have endorsed proration-to-the-insured have done so only to oblige a manufacturer to accept a proportionate share of a risk that it *elected* to assume, either by declining to purchase available insurance or by purchasing what turned out to be an insufficient amount of insurance." (Emphasis added.) Id., 1204. As found previously, the plaintiff neither elected to decline to purchase available indemnity insurance, nor did it purchase an insufficient amount of (available) insurance. Thus, Mt. McKinley's position is not supported in the law.

Regarding *Steadfast*, this court, in its Phase I decision, distinguished that case because "it involved neither long latency loss claims nor asbestos exposure." #889.00. Likewise, our Supreme Court criticized the *Reichhold* trial court's reliance upon a repealed New York statute to extrapolate a New York public policy against the applicability of the unavailability of insurance exception in the pollution context. *Reichhold Chemicals, Inc.* v. *Hartford Accident & Indemnity Co.*, 252 Conn. 774, 785-86, 750 A.2d 1051 (2000). The present case is factually and legally distinguishable from *Reichhold*.

Furthermore, the courts in *Security*, *Owens-Illinois*, and *Stonewall* did not consider the insured's conduct in analyzing whether an insured should be consider self-insured under a pro rata allocation. Mt. McKinley has presented no appellate authority supporting the notion that this court should. "A trial court is required to follow the prior decisions of an appellate court to the extent that they are applicable to facts and issues in the case before it, and the trial court may

not overturn or disregard binding precedent." *Potvin* v. *Lincoln Service and Equipment Co.*, 298 Conn. 620, 650, 6 A.3d 60 (2010). Therefore, this court is not bound to consider equitable considerations, such as the plaintiff's conduct following 1985, as there is no Connecticut appellate authority for doing so.

Mt. McKinley's equity argument fails to dispose of the issues presented in this case for another compelling reason. This is a declaratory judgment action to which Phases I and II of this trial are primarily addressed. In considering the declaratory judgment action in counts one, two, and five of the plaintiff's complaint, and the related declaratory judgment counts contained in various counterclaims and cross-claims, the court must simply determine the scope of the contractual obligations between the parties. To determine whether an underlying claim falls within a policy, the parties only must identify the claimant's alleged date of first exposure to asbestos through plaintiff's talc. The plaintiff has acknowledged that it is responsible for any claim where the date of first exposure is after March 3, 1986 because it had no occurrence-based indemnity coverage from that point on. #1077, p. 24, n.17. The fact that the plaintiff decided to continue sell talc from 1986 forward did not alter a claimant's date of first exposure, nor did it affect the inability of the plaintiff to obtain occurrence-based indemnity insurance coverage for asbestos related claims. It is the date of first exposure allegation that dictates the applicability of an insurer's policy, not the plaintiff's decision to use or market talc. Moreover, the court finds no evidence of an exclusion in any policy which would preclude coverage as a result of the plaintiff's marketing of a product which might lead to claims against it. Lastly, there was no evidence that at any point prior to the institution of this action, that any insurer notified the

plaintiff that its continued talc sales might preclude or diminish coverage under the policy it had issued and thereby put plaintiff's future conduct into issue.

Mt. McKinley also argues, however, that the plaintiff "assumed the risk" in being exposed to claims by continuing to market talc after occurrence-based indemnity insurance for asbestos claims became unavailable and therefore, pursuant to *Security*, the plaintiff should be treated as self-insured. Mt. McKinley misreads *Security.* The "assumption of the risk" referred to in Security occurs not when there is a sale or manufacture of a product that might lead to a claim of exposure to asbestos, but rather, occurs when an insured fails to purchase insurance that was available. See *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 29 Conn. L. Rptr. 696-97; *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 264 Conn. 709. In the present case the evidence is clear, supported in part by expert testimony, that there was no occurrence-based indemnity insurance for asbestos related claims available to the plaintiff for purchase after 1985.[15] The plaintiff, therefore, did not "assume the risk" as it did not fail or decline to purchase any indemnity insurance that was available to it.

Finally, even if this court considered equitable factors in analyzing the question of whether the plaintiff was to be considered self-insured, the excess/umbrella insurers have failed to demonstrate that the equities compel the plaintiff to be allocated indemnity costs for the period from 1986-2008, when there was no available occurrence-based indemnity coverage for asbestos related claims. No party to this action has claimed that the talc sold by the plaintiff after 1985 actually contained asbestos.[16] Indeed, the plaintiff has demonstrated through the credible

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[15] As noted above, the 2003-04 AISLIC policy which the plaintiff did purchase was a claims-made policy.

[16] Mt. McKinley notes in its post-trial brief: "To be clear, Mt. McKinley/Everest Re do not contend that

testimony of its officers Denaro and Vanderbilt that although it was concerned about ongoing asbestos exposure claims, it undertook great efforts to establish there was no asbestos in its talc. This culminated in the 1992 ruling by OSHA that excluded talc from its asbestos regulation. #713; EV221, EV428. In fact, the plaintiff's position that its talc did not contain asbestos was consistent both before and after the availability of occurrence-based policies without asbestos exclusions (i.e., 1985). Therefore, the present case is distinguishable from *Steadfast* and *Reichhold* because, here, the plaintiff had a good faith basis upon which to continue to market its product and assert that the claims against it were without merit through the period 1986 to 2008. Although claims continued to be filed against it throughout that period, the plaintiff had no control over the allegations brought.[17] In effect, Mt. McKinley argues that so long as there was even a threat or possibility that an asbestos related claim or lawsuit might be brought, the plaintiff should be precluded from marketing its product.[18] Moreover, if it elected to proceed in light of those threats when no insurance was available (or it had purchased all it could find), that it should be considered self-insured. The court has found no appellate authority so holding. Moreover, the credible testimony of plaintiff's insurance broker Nadel, and its officers Denaro and Vanderbilt, established that even after the plaintiff ceased the sale of its talc at the end of 2008, it remained true that it could not obtain indemnity coverage without an asbestos exclusion as no such coverage was available after that date.

RTV's [the plaintiff's] talc contains asbestos. That is an issue which was not the subject of this trial, to be tried in the Underlying Claims." #1083 p. 2 n.4.

[17] This is true even if the claims were brought to trial and resulted in a plaintiff's verdict. While some trials did result in a verdict in favor of a claimant, other trials resulted in a defendant's verdict. E.g., EV840, EV806.

[18] Yet elsewhere in its post-trial brief, Mt. McKinley acknowledges that "contrary to what [plaintiff] might suggest, Mt. McKinley/Everest had no reason, or right, to tell [plaintiff] to stop selling its talc." #1083, p. 27 n.37.

B

Orphan Shares

In addressing the issue of what periods of time the plaintiff should be considered as self-insured under a pro rata allocation, the court must also address those policies or periods which would constitute "orphan shares." These are commonly defined as periods covered by lost or destroyed general corporate liability policies or, in the alternative, policies issued by insurers who subsequently became insolvent. As previously noted, the insured is responsible for periods of time when it elected to be self-insured. *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 264 Conn. 716; see also *Stonewall Ins. Co.* v. *Asbestos Claims Management Corp.*, supra, 73 F.3d 1202 (insured responsible for period of time when it elected to be self-insured); *Owens-Illinois, Inc.* v. *United Ins. Co.*, supra, 138 N.J. 462-63 (same); *Ins. Co. of North America* v. *Forty-Eight Insulations, Inc.*, supra, 633 F.2d 1215 n.4 (same). This is because "there [is] no distinction between an insured that has chosen to forego insurance for a certain period of time and an insured that cannot identify its claimed insurers from a certain period of time." *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 264 Conn. 719. Rather, the insured "is the party which could have prevented the loss or destruction of the policies." (Internal quotation marks omitted.) Id., quoting, *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 29 Conn. L. Rptr. 694.

In the present case, there are several orphan shares at issue. First, although the plaintiff contends that from 1948 through 1955 it purchased general corporate liability occurrence-based policies for both defense and indemnity which would cover asbestos related claims, it concedes that it cannot locate those policies. There was no evidence presented either in Phase I or Phase II,

through testimony or exhibits, which establishes by a preponderance of the evidence that it had done so. As noted in the court's Phase I decision, the plaintiff conceded that "thus far Vanderbilt has been unable to locate the policies or sufficient secondary evidence of the policies." #779, p. 4. Consistent with the court's finding in Phase I relative to defense costs, the plaintiff shall be considered self-insured relative to indemnity coverage for the period 1948 through 1955 as the plaintiff has failed to meet its burden under *Security* to establish the existence and terms of those lost policies.

Second, the plaintiff claims that it was covered by primary policies issued by CNA from January 1, 1956 to January 1, 1962. However, neither the plaintiff nor CNA has been able to locate copies of those policies. Nevertheless, the plaintiff and CNA have stipulated that two such policies did exist, the first running from January 1, 1956 to January 1, 1959 and the second from January 1, 1960 to January 1, 1962. See Stipulations #720 and #1050. Collectively those stipulations set out that the terms of these two policies used the same form as the 1962-1965 CNA policy (V1) and contained the same endorsement number four. They have further stipulated that each policy has annualized indemnity limits of $100,000 per person, $300,000 per occurrence, and $300,000 in the aggregate. In its Phase I decision, the court found that it was appropriate to consider extrinsic evidence in addressing the issue of the existence of the policies and that the evidence was sufficient to conclude that the policies existed and provided defense cost coverage. The same finding, particularly in light of the stipulations, is warranted as to the existence of indemnity coverage by CNA for asbestos related claims. See, e.g., #720, Tab 2; V784-17, V963-10, V963-24. Therefore, based on the credible testimony, reliable evidence and stipulations presented to the court both in Phase I and Phase II, the plaintiff shall not be

considered self-insured as to indemnity for the period January 1, 1956 through January 1, 1962.

Third, the parties dispute whether there is a "gap" in insurance between certain of the plaintiff's primary policies and excess policies between March 25, 1978 and April 26, 1978. During this time the plaintiff possessed an excess policy (LMI3) through Certain Underwriters at Lloyd's, London and Certain London Market Insurance Companies (LMI) bearing policy number 77/18053/PNB21250D in the amount of $1 million excess to the underlying insurance consisting of a $300,000 primary policy through Hartford and an umbrella policy through CNA for $700,000. The CNA policy expired on March 25, 1978 (V12) leaving a gap of $700,000 in coverage until April 26, 1978 when the plaintiff was able to increase its coverage under the Hartford policy to $1 million to close the gap. V15.

The plaintiff presented evidence through its expert witness Posner that there is no gap because the pro rata allocation method would, at most, allocate $140,000 to the period of March 25, 1978 to April 26, 1978, and that the Hartford policy in force during that time provided $300,000 in coverage, resulting in a situation where the excess policy was not triggered leaving only a "theoretical gap" at best. LMI contends that because the evidence at trial establishes that there was a gap in fact, they ought not to be obligated to pay for claims allocated to that period.

The court finds that there is conflicting evidence on the issue but that the weightier evidence compels a conclusion that there was a real gap of $700,000 in indemnity coverage for the period March 25, 1978 to April 26, 1978. As such, the plaintiff is to be considered self-insured for that period of time up to $700,000. V722; CNA5314.

Fourth, certain of the plaintiff's insurers are insolvent, leading to the issue of whether the plaintiff should be treated as self-insured for liability that would have been covered by such

policies. Specifically, the plaintiff, Chartis Excess Insurers and LMI have stipulated to the following: Midland Insurance Company, which issued successive excess policies to the plaintiff for the period of March 16, 1977 through March 3, 1985, is wholly insolvent.[19] #1059.00. In addition, Integrity Insurance Company, which issued a single excess insurance policy XL210438 to the plaintiff covering the period from March 3, 1985 to March 3, 1986, is wholly insolvent. #1059.00.

Complicating matters further, several LMI policies are composed of multiple subscribers some of whom became insolvent during the relevant time period begging the question of whether the solvent subscribers should provide coverage in place of the insolvent subscribers. Specifically, as to LMI policy 77/18053/1/PNB21250D, 44.348% of the subscribers remained solvent; as to LMI policy 707/NL6544B, 5.45% remained solvent and as to LMI policy 707NL6545B, there were no remaining solvent subscribers (i.e., it was totally insolvent). #736; LMI116. There is no directly applicable Connecticut Supreme or Appellate Court precedent to guide the court.

The plaintiff has not presented any argument on this issue. The Chartis Excess Insurers contend that the plaintiff ought to be treated as self-insured for periods covered by an insolvent insurer. LMI similarly argues that, pursuant to the language contained in its policies, which gives the policies a "several nature," individual subscribers are liable for their individual shares only, not the shares of other subscribers who have become insolvent. Mt. McKinley argues that

[19] The Midland policies bear the following numbers, beginning with the 1977 policy: XL152357; XL148293; XL147587; XL706866; XL724205; XL725088; XL748786; and XL770191, respectively. #1059.00.

the policy considerations underlying the rule that an insured is treated as self-insured for lost or destroyed policies applies equally to the situation in which an insurer has become insolvent.

To address these arguments, the court must analyze the insolvency of the plaintiff's insurers within two separate contexts. First, the court will consider how the plaintiff is to be treated when a given insurer is wholly insolvent. Second, it will address those periods covered by partially insolvent insurers.

Regarding wholly insolvent insurers, the principles underlying *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 264 Conn. 718-20, and the cases upon which it relies, support the conclusion that the plaintiff should be treated as self-insured for periods corresponding to wholly insolvent insurers. Chief among the *Security* court's rationale behind treating an insured as self-insured for periods covered by lost or destroyed policies was the theory that the insured was in the best position to avoid such loss or destruction and, therefore, it was fair to slate the insured with liability allocated to those periods, as opposed to the insured's other insurers. Id., 719-20, citing *Ins. Co. of North America* v. *Forty-Eight Insulations, Inc.*, supra, 633 F.2d 1215 n.4.

This case presents a slightly different situation because, unlike *Security*, here the plaintiff did not directly cause the insolvency of the subscribers. Nevertheless, the court sees no reason why the policy rationale underlying *Security's* treatment of other orphan shares should not apply equally to periods of insolvency. With the exception of the insolvent insurers themselves, which are of necessity unable to provide coverage, the insured is the party in the best position to avoid the effects of complete insolvency. This is because the insured has the ability, both prior to and following the purchase of a policy, to evaluate the financial stability of a given insurer to

determine the likelihood that it will remain solvent to pay potential claims. It may also seek an insurer that would expressly allow for coverage to be extended upon the occurrence of the insolvency of an underlying carrier. It is the insured, rather than the insurer, who has control over which insurers are selected, how much total insurance is purchased and what terms it is willing to accept in a policy.

The court recognizes that in some instances there may be only one carrier making a policy available which, under the reasoning of this court, would require a potential insured to purchase the policy regardless of the financial stability of, or terms offered by, a carrier so as to avoid being found to be self-insured. In some instances, the only data available relative to the carriers' financial stability would be that found by virtue of governmental disclosure requirements. Nonetheless, to remain consistent with the policies set forth in *Security*, the court cannot support a scenario in which the *potential* future financial insolvency of a carrier is allowed to excuse a company from the requirement that it purchase all available insurance or otherwise be found to be self-insured.

Furthermore, requiring the plaintiff's other insurers to make up for periods of insolvency, unless expressly provided for in a policy, would run contrary to the results of similar cases in Connecticut. For example, in *Veteran's Memorial Medical Center* v. *Connecticut Ins. Guarantee Association*, Superior Court, judicial district of New Haven at Meriden, Docket No. CV-94-0246878-S (October 23, 1996, *Silbert, J.*) (18 Conn. L. Rptr. 39), the court refused to require the plaintiff's excess insurer to "drop down" and provide coverage corresponding to an insolvent insurer based upon the language of the policy, finding a policy that provided "drop down" coverage to be a limited exception that was inapplicable to insolvency. According to the

court, "[o]n the national level . . . the only type of policy language which has been found to trigger 'drop-down' coverage involves policies where the excess insurer provided that it would cover the loss where the primary insurance policy was 'inapplicable,' but not when it was 'uncollectible' or 'unrecoverable' as in the case of an insolvency." Id., 41; see also *England* v. *Reliance Ins. Co.*, Superior Court, judicial district of Ansonia-Milford, Docket No. CV-02-0079606-S (February 24, 2004, *Carroll, J.*) (36 Conn. L. Rptr. 586) (same); *Mission National Ins. Co.* v. *Duke Transportation Co.*, 792 F.2d 550 (5th Cir. 1986) (same). Similarly, in *Dexter Corp.* v. *National Union Fire Ins. Co. of Pittsburgh PA*, United States District Court, Docket No. 3:95CV00702 (WWE) (D. Conn. March 12, 1997), aff'd 131 F.3d 130 (2d Cir. 1997), the court declined to require an excess insurer to "drop down" and provide coverage in place of an insolvent insurer because the court concluded that such a result would violate the terms of the excess insurers' contract. The contract, in turn, provided that the insurer would only be liable when all underlying limits, including underlying excess insurance was exhausted via payment.[20] Id.

With respect to partially insolvent insurers, this issue is best addressed by looking to the language of the policies themselves, as well as persuasive authority from other states. "[T]he

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[20] The courts in *Veteran's Memorial*, *Reliance Ins. Co.* and *Dexter Corp.* noted that other jurisdictions have treated this situation similarly, pointing to the following cases: *North Carolina Ins. Guarantee Assn.* v. *Century Indemnity Co.*, 115 N.C. App. 175, 444 S.E.2d 464, cert. denied, 337 N.C. 696, 448 S.E.2d 532 (1994) (based upon language in policy, excess insurer not required to "drop down" in place of insolvent primary insurer); *Wells Fargo Bank* v. *California Ins. Guarantee Association*, 38 Cal. App. 4th 936, 45 Cal. Rptr. 2d 537 (1995) (same); *Linares* v. *Louisiana Dept. of Transportation and Development*, 582 So.2d 879 (La. App. 4th Cir. 1991) (same); *J. Kinderman & Sons, Inc.* v. *United National Ins. Co.*, 406 Pa. Super. 37, 593 A.2d 857 (1991) (same), aff'd, 533 Pa. 87, 619 A.2d 1058 (1993); *Southeast Atlantic Cargo Operators* v. *First State Ins. Co.*, 197 Ga. App. 371, 398 S.E.2d 264 (1990) (same), cert. denied, 1995 Ga. LEXIS 765 (1995) (same). See also, *Arkansas-Oklahoma Gas Corp.* v. *Lukis Steward Price Forbes & Co. Ltd.*, 306 Ark. 425, 816 S.W.2d 571 (1991) (solvent subscribers to "several" policy not liable for insolvent subscribers).

interpretation of an insurance policy presents a question of law . . . ." *New London County Mutual Ins. Co.* v. *Nantes*, 303 Conn. 737, 753, 36 A.3d 224 (2012). "[A]n insurance policy is a contract that is construed to effectuate the intent of the parties as expressed by their words and purposes. . . . [U]nambiguous terms are to be given their plain and ordinary meaning. . . . As with contracts generally, a provision in an insurance policy is ambiguous when it is reasonably susceptible to more than one reading. . . . The determination of whether an insurance policy is ambiguous is a matter of law for the court to decide. . . . If the policy is ambiguous, extrinsic evidence may be introduced to support a particular interpretation. . . . If the extrinsic evidence presents issues of credibility or a choice among reasonable inferences, the decision on the intent of the parties is a job for the trier of fact. . . . Ordinarily, if an ambiguity arises that cannot be resolved by examining the parties' intentions . . . the ambiguous language should be construed in accordance with the reasonable expectations of the insured when he entered into the contract. . . . Courts in such situations often apply the contra proferentem rule and interpret a policy against the insurer." (Citations omitted; internal quotation marks omitted.) *Metropolitan Life Ins. Co.* v. *Aetna Casualty & Surety Co.*, 255 Conn. 295, 305-06, 765 A.2d 891 (2001). Finally, in any interpretation of contract analysis, "[i]t is an abiding principle of jurisprudence that common sense does not take flight when one enters a courtroom." (Internal quotation marks omitted.) *Community Renewal Team, Inc.* v. *United States Liability Ins. Co.*, 128 Conn. App. 174, 180, 17 A.3d 88 (2011).

LMI issued a policy that ultimately was partially insolvent. In this case, LMI's policy number 707/NL6544B provides, in relevant part:

> "**Now Know Ye** that We, the Underwriters, Members of the Syndicates whose definitive numbers in the aforementioned List of Underwriting Members of Lloyd's are set out in the attached Table, hereby bind ourselves *each for his own part and not for another* . . . in respect of his due proportion only, to insure against any loss as more fully specified herein, whether a total or a partial loss, as well as associated costs specified herein, if any, which shall be sustained under this Policy, to the extent and in the manner hereinafter provided." (Emphasis altered.) V125.[21]

The terms of the policy thus plainly provide that each of the individual subscribers has assumed liability for its individual share of liability only. Connecticut law governing the interpretation of insurance contracts provides that unambiguous terms, such as these, are to be given effect according to their plain meaning.

Although there is no Connecticut law addressing partially insolvent policies, the above result is supported by authority from at least one other state. For example, in *Arkansas-Oklahoma Gas Corp.* v. *Lukis Steward Price Forbes & Co. Ltd.*, supra, 306 Ark. 425, 16 S.W. 2d 571 (1991), the Arkansas Supreme Court upheld a trial court's conclusion that, pursuant to

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[21] Similarly, LMI's policy number: 77/18053/1/PNB21250D provides, in pertinent part:

> "**In Consideration** of the Assured named in the Schedule hereto having paid premium set forth in the said Schedule to the Assures named herein
>
> **The Assurers hereby severally agree** *each for the proportion set against its name* to indemnify the Assured or the Assured's . . . Assigns against loss as set forth herein during the period of Insurance stated in the said Schedule or during any subsequent period as may be mutually agreed between the Assured and the Assurers payment to be made within Seven Days after such loss is proved.
>
> **Provided that:—**
> * * *
> (2) *the liability of each of the Assurers individually in respect of such loss shall be limited to the proportion set against its name* or such other proportion as may be substituted therefor by memorandum hereon or attached hereto by or on behalf of the Assurers." (Emphasis altered.) V13.

the same language and interpreted in accordance with Arkansas law, solvent subscribers were not liable for the proportionate share of insolvent subscribers.[22]

In sum, the plaintiff shall be treated as self-insured for an insurer's insolvency, whether complete or partial. To be specific, the insolvencies for which the plaintiff is self-insured are as follows: Midland Insurance Company, which issued successive annual excess policies XL152357; XL148293; XL147587; XL706866; XL724205; XL725088; XL748786 and XL770191, each in the amount of $5,000,000, the first of which commenced March 16, 1977 and the last of which ended March 3, 1985[23]; Integrity Insurance Company, excess policy XL210438 in the amount of $3,000,000 covering the period March 3, 1985 to March 3, 1986; and, LMI excess policy 707NL6545B LMI for the period March 3, 1985 to March 3, 1986. As to LMI excess policy 77/18053/1/PNB21250D for the period May 17, 1977 to March 3, 1979, because 44.348% of the subscribers to that policy remained solvent, the plaintiff shall be self-insured for 55.652% of that policy. As to LMI policy 707/NL6544B for the period March 3, 1985 to March 3, 1986, because 5.45% of the subscribers to that policy remained solvent, the plaintiff shall be self-insured for 94.55% of that policy. See Stipulations #1059, #736 and Exhibits V13 and V125.

[22] In that case, the court concluded that the law of Arkansas was different with respect to surplus lines insurance than it was to excess or primary insurance such that a relevant Arkansas statute that required approval by the state insurance commissioner prior to the issuance of certain policies did not apply.

[23] The first policy commenced on March 16, 1977 and ended on March 3, 1978. All the following policies had a commencement date of March 3rd.

C

Exhaustion of Policies

1

Background

In its Phase I decision, this court found that, relative to the issue of defense cost coverage, the plaintiff "shall be considered self-insured for the period January 1, 1948 to December 31, 1955." #889.00. There has been no evidence found in either the Phase I or Phase II proceedings to contradict a similar finding on the issue of indemnity coverage. In fact, the plaintiff has effectively conceded as much, having previously stated in relation to Phase I "thus far Vanderbilt has been unable to locate the policies or sufficient secondary evidence of the policies." #779, p. 4. Similarly, in its memorandum for Phase II, the plaintiff states "for the period 1948 through 1955 . . . Vanderbilt has acknowledged that it cannot locate its policies . . . ." #1077, p. 45. Therefore, this court holds that the plaintiff is also to be considered self-insured and responsible for its pro rata share of indemnity for that period.

Also, as noted in the section above, the court has found that the plaintiff shall not be considered as self-insured for the period January 1, 1956 to January 1, 1962 because of the existence of the two CNA primary policies issued covering that period. #720, #1050.

Moreover, there is no dispute that CNA provided occurrence-based primary coverage to the plaintiff from January 1, 1962 until March 3, 1977, and that Hartford provided the plaintiff occurrence-based primary coverage from March 3, 1977 until March 3, 1986. As a result, the plaintiff shall not be considered self-insured for that period of time.

During those years and in the decades that followed, Hartford and CNA defended and indemnified the plaintiff in the underlying actions alleging bodily injury by reason of exposure to asbestos contained in its talc. Hartford and CNA now claim that certain of their primary occurrence-based policies are exhausted and are seeking a declaratory judgment to that effect. Specifically, CNA seeks a declaratory judgment that its 1968-77 primary occurrence-based policies have been exhausted and Hartford seeks a declaratory judgment that all of its primary occurrence-based policies have been exhausted. #1060 as to CNA; #283 as to Hartford. See also, #1109.05, p. 24 as to CNA and #1108.05, p.22 as to Hartford. The plaintiff simply seeks a declaratory judgment on whether or not each of those referenced policies have been exhausted. It is not disputed that exhaustion of underlying coverage is required to trigger the excess and umbrella insurance policies.[24]

In 1995, CNA filed an action against Hartford seeking contribution for defense and indemnity payments CNA made on underlying claims submitted solely to it. In 2002, the parties settled that action and allocated a portion of the overall settlement funds to cover indemnity costs. Going forward, Hartford and CNA executed an agreement allocating 100% of the plaintiff's defense and indemnity payments between them on a pro rata time on the risk basis up to March 3, 1986 (allocation agreement) V2067. Critically, the allocation agreement provided that where the underlying claimant's date of first exposure to the plaintiff's product was before January 1, 1962 or was unknown, the pro rata allocation coverage block for their purposes would be from January 1, 1962 to March 3, 1986. Where the date of first exposure was between

[24] A thorough discussion of exhaustion is set forth in Section IIIC3 below.

January 1, 1962 and March 3, 1986, Hartford and CNA agreed to allocate pro rata from the date of first exposure to March 3, 1986.

2

Reasonableness of the Allocation Agreement Between Hartford and CNA for pre-1986 Claims

The umbrella/excess insurers, led by Mt. McKinley, contend that the allocation agreement between Hartford and CNA wrongfully failed to allocate indemnity payments to CNA for the January 1, 1956 to January 1, 1962 period, thereby "compressing" the allocation block and prematurely exhausting Hartford's policies. According to this argument, Hartford could not possibly have exhausted all of its policies because Hartford and CNA failed to allocate indemnity payments to that period. Hartford maintains that the allocation agreement was reasonable, consistent with then existing Connecticut law, and made in good faith given the facts and circumstances of the underlying claims.

"[I]t is the sound public policy of Connecticut to encourage parties to settle their disputes and to avoid protracted litigation." *Monti* v. *Wenkert*, 287 Conn. 101, 125, 947 A.2d 261 (2008). This court can find no binding authority addressing whether an allocation agreement between primary insurers should be reallocated based upon the subsequent establishment of legal precedent and the verification of the existence of prior insurance policies after the settlement was made. In a slightly different fact scenario than the one now before the court, our Supreme Court has held: "[w]here . . . an insured alleges that an insurer improperly has failed to defend and provide coverage for underlying claims that the insured has settled the insured has the burden of proving that the claims were within the policy's coverage and that the settlements were reasonable. . . . *The reasonableness of the settlement, in turn, should be examined under an*

objective standard. Reasonableness is determined according to factors such as, but not limited to, whether there is a significant prospect of an adverse judgment, whether settlement is generally advisable, [whether] the action is taken in good faith, and [whether it is] not excessive in amount. . . ." (Citations omitted; emphasis added; footnote omitted; internal quotation marks omitted.) *Metropolitan Life Ins. Co.* v. *Aetna Casualty & Surety Co.*, 249 Conn. 36, 55-56, 730 A.2d 51 (1999).[25] While dealing with the settlement of underlying claims by an insurer on behalf of its insured, several of the factors set forth in *Metropolitan Life Ins. Co.* are relevant and applicable to an evaluation of the settlement agreement between Hartford and CNA which allocated their obligations on the underlying claims against the plaintiff. The court will therefore examine the objective facts known to Hartford and CNA at the time the allocation agreement was made to determine the reasonableness of that agreement.

First, both witnesses Lawrence Farber of Hartford, and Peter Pogue, the claims consultant for Resolute Management, Inc. who monitored and evaluated claims for the plaintiff, presented credible testimony and evidence that, even before the allocation agreement was entered into, CNA's allocation start date was 1962 because that was the first policy that CNA had a complete copy of to confirm and verify coverage. CNA's expert Donald Huffer credibly testified that the allocation method employed by CNA, and in turn Hartford, was reasonable and consistent with

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[25] In reaching this conclusion, the court in *Metropolitan Life* cited: "*Luria Bros. & Co.* v. *Alliance Assurance Co., Ltd.*, 780 F.2d 1082, 1091 (2d Cir.1986) (examined objective facts known to plaintiff at time of settlement in order to determine its reasonableness); *Black* v. *Goodwin, Loomis & Britton, Inc.* . . . 239 Conn. [144,] 160–61, [681 A.2d 293 (1996)] (examined objective facts known to plaintiff at time of settlement and expert testimony to determine reasonableness of settlement). Other jurisdictions have reached a similar conclusion: *United Services Automobile Assn.* v. *Morris*, 154 Ariz. 113, 121, 741 P.2d 246 (1987) ('test as to whether the settlement was reasonable and prudent is what a reasonably prudent person in the insureds' position would have settled for on the *merits* of the claimant's case' [emphasis in original]); *Alton M. Johnson Co.* v. *M.A.I. Co.*, 463 N.W.2d 277, 279 (Minn. 1990) (setting forth objective test to determine whether settlement is reasonable in insurance coverage dispute); see also 7C J. Appleman, Insurance Law and Practice (1979) § 4690, pp. 229-33; J. Stempel, Law of Insurance Contract Disputes (2d Ed. 1999) § 9.02 [b], pp. 9-50 through 9-51." *Metropolitan Ins. Co.* v. *Aetna Casualty & Surety Co.*, supra, 249 Conn. 55-56 n.21.

industry standards. Plaintiff's expert, Jeffrey Posner, credibly testified that although he believed the allocation was not in strict compliance with what he understood the law to be for pro rata allocation, he also concluded that the allocation by Hartford and CNA was reasonable and within industry standards. He based his opinion in part on his review of the underlying cases and the loss run sheets for both Hartford and CNA. V781-285, V722, V2035, CNA 5314.

Testimony was also presented by Lillian Philburn as the manager of the claims department for Everest Global Services on behalf of Mt. McKinley. In her capacity, she reviewed claims presented against the plaintiff for which Mt. McKinley and Everest Reinsurance had issued policies. She credibly testified that in evaluating the claims her company used the same allocation block as employed by Hartford and CNA, though subject to a reservation of rights on what the proper allocation block should be.

Moreover, while there was evidence provided which has enabled the court to reasonably infer that the January 1, 1956 to January 1, 1962 CNA policies existed, at the time that the allocation agreement was executed, the existence of those policies and any obligations thereunder was an unresolved and disputed factual issue which was not determined until addressed by this court in both the Phase I decision and again in this Phase II decision. #720, Tab-2; V963-24, V963-10. Also, there was no evidence that CNA took any action to conceal their existence from Hartford, the plaintiff, or any other party.

Third, Mt. McKinley's argument that the allocation block utilized by Hartford and CNA led to the premature exhaustion of the primary policies is based entirely upon Hartford and CNA's purported failure to follow *Security Ins. Co. of Hartford* v. *Lumbermens Mutual Casualty Co.*, supra, 264 Conn. 688. Although the expert witnesses testified that the allocation agreement

did not strictly conform to the protocols set forth by *Security*, the Supreme Court's precedential decision relative to the adoption of the pro rata allocation standard had not been released until after the allocation agreement was made. Therefore, the parties did not have the benefit of Connecticut appellate authority when the allocation agreement was executed.

Notably, it is the defendant Mt. McKinley that has made the loudest argument against the allocation agreement between Hartford and CNA. However, in this case, the lack of a direct contractual relationship between primary carriers and an umbrella/excess carrier cannot be ignored. There is no logic that compels a conclusion that an umbrella/excess carrier whose contractual relationship is with its insured, can, in retrospect, dictate to a primary carrier what allocation method the primary carrier should have followed. The indemnity payments made by Hartford and CNA, regardless of the manner and allocation, were for the benefit of the insured. Neither Hartford nor CNA had any contractual or other legal obligation to consult with any umbrella/excess carrier prior to payment about the allocation methodology that the umbrella/excess carrier may have wished to use.

Finally, thousands of underlying actions have been filed against the plaintiff over the course of several decades. It is not disputed that the primary insurers have expended millions of dollars of defense and indemnity payments relative to the claims brought against the plaintiff. This court will not compel Hartford and CNA to retroactively re-allocate their indemnity payments at this point. See *Owens-Illinois, Inc.* v. *United Ins. Co.*, supra, 138 N.J. 477. ("[W]e are informed that Aetna has paid its policy limits for the years 1963 to 1977, so that Aetna's policy proceeds will not be called on for future contribution. If that be so, rather than go back to revisit Aetna's contributions, we shall start forward and treat pending matters from the

perspective of one having a long view of the entire occurrence."). To effectuate a reallocation to include, for example, the period 1956-1962 would require the court and the parties to engage in mathematical calculations that would not only be extremely arduous, time consuming and to some degree subjective, they would also be of marginal utility and ultimately undermine the prior significant efforts of the parties to compromise their differences over the allocation of the payments between themselves and which were made for the benefit of their insured. Beyond the issue of such recalculations, to reopen the limits of the allocation agreement would work contrary to this state's public policy in favor of the settlement of civil litigation. See, e.g., *Allstate Ins. Co.* v. *Mottolese*, 261 Conn. 521, 531, 803 A.2d 311 (2002).

The court finds that, on an objective basis, the settlement between Hartford and CNA was reasonable at the time it was entered into given that it was generally advisable and was taken in good faith. Because the allocation method utilized by Hartford and CNA was objectively reasonable at that time, this court will not force those parties to reallocate indemnity payments already made and done.

3

Hartford and CNA Policies

One of the principal issues necessary to ultimately render a determination by the court of the declaratory judgment counts and counterclaims is the exhaustion of the primary policies issued by Hartford and CNA. The plaintiff argues that it is the insurers' burden to prove that their policies are exhausted, but agrees that "it would not be unreasonable to conclude that the CNA primary policies from January 1, 1968 to January 1, 1977 and that all of the Hartford primary

policies from March 3, 1977 through March 3, 1986 have been exhausted."[26] #1077, p. 35. As to CNA, the plaintiff argues that each of the CNA policies purchased by the plaintiff between 1962 and 1977 had an annual aggregate limit of $300,000 and that CNA has paid throughout the years a collective amount in indemnity in excess of those limits. With respect to Hartford, the plaintiff contends that between March 3, 1977 and March 3, 1986, the first Hartford policy had an annual aggregate limit of $300,000, that all other policies had annual aggregate limits of $1 million and that Hartford has paid a collective amount in indemnity in excess of those limits.[27]

In its pleadings, Hartford has correctly noted that normally the burden is on the insured to establish that a primary policy has been exhausted. However, it has agreed to assume the burden for Phase II of the trial only. Hartford contends that the only evidence presented in Phase II established that Hartford had exhausted its policy limits and that no evidence presented suggests otherwise. It further notes that under Connecticut law it has both the duty to defend and the right to settle claims against the plaintiff, and that it exercised its duty reasonably and in good faith.

CNA argues that the allocation method utilized by it and Hartford was reasonable and, in fact, was highly similar to the allocation method that was eventually adopted by the court in *Security*. CNA contends, and the court finds, that it has paid on behalf of the plaintiff amounts considerably in excess of its indemnity limits for the primary policies it issued between 1968 and 1977, each of which had an annual aggregate limit of $300,000.[28] E.g., CNA 5314, CNA 5328.

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[26] The plaintiff notes, however, that one "stub" policy issued by CNA for the period January 1, 1977 to March 3, 1977 may not be exhausted. V6.

[27] The exact figures paid by CNA and Hartford have been sealed by the court pursuant to Practice Book § 11-20A.

[28] CNA also has presented evidence that it has paid significant sums in defense costs. The exact amounts of indemnity or defense costs paid have been sealed by the court.

Regarding whether allocation should have been made to the period before 1962, CNA contends that it was reasonable for it to refuse to do so. Although it has now stipulated for the purposes of trial to certain terms and specific amounts of the policies it issued for the period January 1, 1956 through January 1, 1962; #720, #1050; the very existence and terms of the policies had previously been uncertain and, accordingly, it did not have a reliable way to calculate an appropriate allocation to include that period.

Of the defendants, Mt. McKinley presents the most comprehensive opposition to the plaintiff and primary insurers' exhaustion arguments. It argues that the Hartford and CNA policies are not exhausted as, over time, Hartford and CNA failed to allocate to the pre-1962 period because CNA was unwilling to confirm its coverage of the plaintiff.[29] Mt. McKinley contends that had Hartford and CNA allocated payments to the pre-1962 time period, the policies would not have been exhausted because proper allocation is not a matter of merely totaling the amounts paid by the insurers but, rather, requires properly assigning amounts paid to each policy period. Mt. McKinley also challenges Hartford's decision to allocate to indemnity a specific sum of money from a confidential settlement between Hartford and CNA because Hartford was "without any basis for determining that the amount was properly deemed to constitute indemnity payments."[30]

LMI also has addressed the issue of exhaustion arguing that neither the Hartford nor the CNA policies are exhausted. Specifically, it contends that Hartford and CNA did not exactly

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[29] Mt. McKinley also criticizes the "injury-in-fact" trigger and "injurious exposure" trigger methods that were initially used by Hartford to determine the date of first exposure for a given claim.

[30] Hartford responds that Mt. McKinley has not presented any actual evidence suggesting that the allocation was in any way unreasonable and that both Hartford and CNA considered the sum to be reasonable. The specific amount has been sealed by the court.

follow the pro rata allocation method adopted by *Security* and that Hartford and CNA did not allocate claims to the pre-1962 period. LMI thus asserts that the court should reject CNA's claims as to exhaustion because they are based upon the premise that it is permissible for CNA to have ignored the fact that it did provide the plaintiff coverage prior to 1962.[31]

PCA has extensively argued that under the evidence submitted at trial its policy provides only for defense and that it does not possess a duty to "drop down" unless and until all other intervening policies are exhausted. PCA also argues that its policies provide term limits, rather than annualized limits.[32]

To determine whether the primary policies have been exhausted one must begin by examining the language of the policies themselves.

Hartford's policy number 10 JPR B46801 E provides, in pertinent part:

> "The company will pay on behalf of the *insured* all sums which the *insured* shall become legally obligated to pay as damages because of
>
> **Coverage A,** *bodily injury* or
>
> **Coverage B,** *property damage*
>
> To which this insurance applies, caused by an *occurrence*, if the *bodily injury* or *property damage* is included within the *completed operations hazard* or the *products hazard*, and the company shall have the right and duty to defend any suit against the *insured* seeking damages on account of such *bodily injury* or *property damages*, even if any of the allegations of the suit are groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient, but the company shall not be obligated to pay any claim or judgment or to defend any suit after the

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[31] LMI also argues that there is an additional PEIC umbrella policy between the LMI policy and the Hartford policy for the period March 3, 1985 to March 3, 1986.

[32] Such limits apply to the entire term of the policy (in this case three years), as opposed to a new limit each year the policy is in force.

applicable limit of the company's liability has been exhausted by payment of judgments or settlements." (Emphasis in original.) V14.[33]

As previously noted, the initial Hartford policy carried a limit of $300,000. The remaining policies carried limits of $1 million each.

CNA policy CCP 4138373 R, covering the period January 1, 1968 to January 1, 1971, mirrors the pertinent language from Hartford policy 10 JPR B46801 E (cited above) and includes a provision that CNA "shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company's liability has been exhausted by payment of judgments or settlements." V3. A review of the subsequent CNA primary policies CCP 854 87 48 R (V4), CCP 902 40 38 R (V5) and CCP 300 01 12 (V6) reveals that these policies contain this same language. Each of the respective CNA primary policies carried an aggregate limit of $300,000 for bodily injury liability. See V3 through V6.[34]

The language of both the Hartford and CNA policies plainly provides that their obligations to the insured, in this case the plaintiff, terminate upon the exhaustion of the respective policy limits. Based upon the language of the policies, and applying *Security's* pro rata continuous trigger approach, the court finds that the Hartford primary policies for the period March 3, 1977 to March 3, 1986 and the CNA primary policies for the period January 1, 1968 to March 3, 1977 to be exhausted. Although there was conflicting testimony on this issue, the court

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[33] After review, the court concludes that each of the Hartford primary policies contains this same language.

[34] The CNA policies prior to these had somewhat different language. CNA primary policy CL 4292747 R covering the period January 1, 1962 to January 1, 1965 provided that CNA shall "pay on behalf of the insured all sums which the injured shall become legally obligated to pay as damages because of bodily injury, sickness or disease, including death at any time resulting therefrom, sustained by any person and caused by accident." V1. That policy provided that CNA will indemnify the plaintiff "subject to the limits of liability . . . ." and that the limits of CNA's liability for bodily injury is "the total limits of [CNA's] liability for all damages . . . ." CNA primary policy CL 4298781 R for the period January 1, 1965 to January 1, 1968 contains this same language. V2. Both policies also carried aggregate limits of $300,000.

finds the weightier credible testimony and evidence to compel this conclusion. For the period referenced, CNA provided primary coverage to the plaintiff with annualized limits of $300,000 for a total of $2.7 million in coverage across its policies. V3 through V6. Peter Pogue credibly testified that CNA has paid indemnity well in excess of that amount throughout the years. Donald Huffer, CNA's expert, also credibly testified as to his opinion that those CNA primary policies were exhausted. Hartford, for its part, provided policies with total annualized limits of $8.3 million and there was credible testimony of Hartford's employee, Lawrence Farber, that it had paid indemnity in excess of that amount throughout the years. V14 through V22. Accordingly, both Hartford and CNA have paid the limits of their primary policies for the periods March 3, 1977 to March 3, 1986 and January 1, 1968 to March 3, 1977, respectively.

In addressing the exhaustion issue and the potential liability of the umbrella or excess carriers which sit atop those primary policies, the court is faced with the unique context of mass long-latency losses, a situation which courts around the country, including in Connecticut, have concluded requires a specialized response insofar as allocation is concerned. *Security* addresses a number of concerns that are uniquely posed by long-latency loss claims. Specifically, an individual with such a claim may not know of the existence of the claim for years or even decades, and the injury suffered by a claimant may be attributable to multiple causes over the course of numerous years covered by numerous different coverage periods. Moreover, the etiology of asbestos based diseases makes pinning down the precise time of "injury" for such diseases nearly impossible. Finally, thousands of such claimants exist.

Accordingly, in an attempt to most efficiently address long-latency loss claims of the type present here, *Security* adopted a pro rata allocation approach combined with a continuous trigger

method in order to allocate according to an insurer's time on the risk and proportion of the risk assumed. The allocation method prescribed by *Security* best suits the ultimate determination of the degree of liability of the umbrella and excess carriers in this context. Any other method would require courts and litigants to go back and recalculate precisely what amounts were paid on which claims, during which periods of time, whether allocation to that time frame was appropriate, and whether the payments were made reasonably and in good faith. Such an undertaking would lie between arduous and Sisyphean.

For this same reason, the court is unwilling to second guess Hartford's allocation to indemnity of a portion of the settlement between it and CNA. The testimony of Hartford's Lawrence Farber was credible and persuasive in demonstrating both that the indemnity allocation made pursuant to the settlement was done reasonably and in good faith, and that the total amount of indemnity payments made by Hartford were sufficient to exhaust its policies for the period March 3, 1977 to March 3, 1986. Moreover, CNA's and Hartford's loss runs provided evidence that both insurers determined the monies from the settlement allocated to indemnity represented a good faith estimation of the indemnity payments Hartford owed to CNA. V722, V731, V2035, CNA 5314, CNA 5328, EV299, EV579. No evidence contradicted either Farber's testimony or Hartford and CNA's loss runs. Indeed, there was insufficient credible evidence presented by the excess and/or umbrella insurers to demonstrate that Hartford's allocation of the settlement amount was improper or that Hartford failed to pay its primary policy limits to settle claims against the plaintiff. There is no suggestion anywhere on the record that Hartford and CNA did anything other than act reasonably and in good faith throughout the duration of their defense and indemnity of the plaintiff. The fact that they initially did so in the absence of the Supreme

Court's guidance on *Security* and with methods utilized that were highly similar to the methods ultimately adopted by *Security* with respect to defense costs further leads the court to its conclusion that the polices have been exhausted.

In sum, as to each of the sections above related to exhaustion, the court finds that the Hartford and CNA primary policies for the periods March 3, 1977 to March 3, 1986 and January 1, 1968 to March 3, 1977, respectively, are exhausted and that the liability of any umbrella or excess carriers above those policies are to be determined consistently with the pro rata allocation principles set forth in *Security*.

4

AISLIC

AISLIC contends that it has met its obligation under the claims-made policy it issued to the plaintiff in 2003.[35] Specifically, AISLIC argues that the policy possessed a $2 million products completed operations aggregate limit with a $250,000 deductible,[36] and there is no dispute that it has paid $2 million toward such claims as evidenced by testimony (EV1922) and a stipulation between the plaintiff, itself, and CNA (AIS73).

AISLIC policy number EG 3779185 provides, in Section I, Coverage A, in pertinent part:

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[35] In contrast to an occurrence-based policy, which provides coverage for any occurrence occurring during the policy period regardless of when the claim is actually brought, a claims-made policy provides coverage for claims brought against the insured only if brought during the policy period. AISLIC's policy number EG 3779185 provides, in relevant part, in Section I, Coverage A, subsection 1 b: "This insurance applies to **bodily injury** and **property damage** only if: . . . (3) A **claim** for damages because of **the bodily injury** or **property damage** is first made against the insured . . . during the **policy period** or any **extended reporting period** we provide under EXTENDED REPORTING PERIODS (Section V)." (Emphasis in original.) V37.

[36] As defined, in relevant part, by AISLIC policy number EG 3779185, "**Products – completed operations hazard** includes all **bodily injury** and **property damage** occurring away from premises you own or rent and arising out of **your product** or **your work** . . . ." (Emphasis in original.) V37.

"COVERAGE A. – BODILIY INJURY AND PROPERTY DAMAGE LIABILITY

1. Insuring Agreement

a. We will pay those sums that the insured becomes legally obligated to pay as damages because of **bodily injury** or **property damage** to which this Coverage applies. We will have the right and duty to defend any suit seeking those damages. However, we will have no duty to defend the insured against any **suit** seeking damages for **bodily injury** or **property damage** to which this Coverage does not apply. We may, at our discretion, investigate any **occurrence** and settle any **claim** or **suit** that may result.

But:

(1) The amount we will pay for damages is limited as described in LIMITS OF INSURANCE AND DEDUCITIBLE (Section III); . . ." (Emphasis in original.). V37.

Endorsement 6 of the policy provides, in relevant part:

"1. **Section VI. – Definitions is amended to include the following**:

Natural Substance means any and all substances, component substances or re-engineered substances which were originally mined from the earth including but not limited to Asbestos, Silica, Talc including your product which is any of the foregoing." V37

Section III of AISLIC's policy provides for $2 million in products-completed aggregation limits. Though there was conflicting testimony on the issue of coverage and exhaustion, in addition to the stipulation itself, the competent and credible evidence at trial established by a preponderance of the evidence that AISLIC paid $2 million or more between defense costs and indemnity payments relative to coverable claims brought against the plaintiff. This was established through the credible testimony of Joseph Denaro who also noted that as to certain claims covered by the AISLIC policy, the plaintiff had made payments contributing toward their settlement well in excess of its deductible as to each claim, and that AISLIC thereafter never sought recovery from the plaintiff of any of the deductible amount. This was also supported by both the deposition testimony of AISLIC's claims representative Dale Hunte Goldman who

acknowledged the plaintiff's payments satisfied the deductible (EV1922, AIS74) and the credible trial testimony of Stephen DeMatteo who noted that there were discussions about the deductible between AISLIC and the plaintiff but that AISLIC never issued a bill or otherwise sought reimbursement of it. CNA 4798, CNA 4799.[37]

Some of the excess and/or umbrella insurers also point out that AISLIC, in making these payments, failed to collect from the plaintiff the $250,000 deductible due under the policy.[38] They take the position that the policy should not be considered exhausted because AISLIC unnecessarily and effectively advanced the plaintiff the amount of the deductible and, in so doing, improperly counted that amount against the limits of the policy. This argument does not change the court's analysis as it finds that the amounts paid were for indemnity and/or defense in accordance with the terms of the policy up to the amount of its limits and therefore the policy is deemed exhausted.[39]

Before leaving this issue, the court must address CNA's cross-claim seeking equitable contribution from AISLIC under the policy referenced above. #1060. The basis of the claim is that the plaintiff remains liable for the payment of the $250,000 deductible under the policy. In a related pleading, AISLIC has brought a counterclaim against the plaintiff to recover that

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[37] Exhibit CNA 4799 was admitted limited to those entries made on or after March 21, 2003. Any hearsay within the document has not been considered by the court.

[38] AISLIC has, however, filed a counterclaim against the plaintiff as part of this action seeking recovery of its deductible. #952. That claim will be more fully addressed as part of Phase III of the trial.

[39] Because the court has found the Hartford, CNA, and AISLIC policies to be exhausted, it need not attempt to resolve any dispute regarding which party carries the burden of proof in this regard. See also #710, "Agreed to Stipulation Regarding Impairment Charts" wherein the parties stipulated to the accuracy of the Hartford loss run admitted into evidence as exhibit V722. See also V2035, "Stipulation Regarding Impairment Charts" relative to CNA.

deductible.[40] #501, #952. CNA concedes that AISLIC has paid $2 million in defense and indemnity for the underlying claims against the plaintiff. #712; AIS73. However, CNA argues that despite AISLIC's payment of $2 million, that policy has not been exhausted because the $2 million includes amounts paid to cover the $250,000 deductible owed by the plaintiff as to each claim made under the policy.

AISLIC contends that CNA has no standing to assert a claim against either AISLIC or the plaintiff because CNA is not a party to the policy nor is it a third party beneficiary thereof. It also contends that Connecticut courts do not recognize a duty between a primary insurer and an excess insurer. The court agrees that CNA does not have standing to make this claim.

By way of background, AISLIC policy EG 3779185 provides, in Endorsement 7, in pertinent part:

> "1. Our obligation under the Bodily Injury Liability and Property Damage Liability Coverages to pay damages on your behalf applies only to the amount of damages in excess of any deductible amounts states [sic] in the Schedule above as applicable to such coverages.
>
> * * *
>
> 4. We may pay any part or all of the deductible amount to effect settlement of any 'claim' or 'suit' and upon notification of the action taken, you shall promptly reimburse us for such part of the deductible amount as has been paid by us." V37.

Endorsement 7 provides a $250,000 per occurrence deductible as to Bodily Injury caused by natural substances. Asbestos is defined by the policy as a natural substance.

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[40] Though the claims set forth in CNA's cross-claim and AISLIC's counterclaim are matters intended to be left for a later phase of the trial dealing with claims of reimbursement for overpayment of indemnity/defense costs/expenses, the standing issue is a threshold issue that must be addressed before the court can make such a determination. "Appellate courts, as well as trial courts, must examine an issue implicating subject matter jurisdiction. The question of standing may be raised by any of the parties, or by the court, sua sponte, at any time during judicial proceedings." (Internal quotation marks omitted.) *Connecticut Carpenters Benefit Funds* v. *Burkhard Hotel Properties II, LLC*, 83 Conn. App. 352, 355, 849 A.2d 922 (2004).

"[J]usticiability comprises several related doctrines, namely, standing, ripeness, mootness and the political question doctrine, that implicate a court's subject matter jurisdiction and its competency to adjudicate a particular matter." (Internal quotation marks omitted.) *Coalition for Justice in Education Funding, Inc.* v. *Rell*, 295 Conn. 240, 254, 990 A.2d 206 (2010). "[S]tanding is not a technical rule intended to keep aggrieved parties out of court; nor is it a test of substantive rights. Rather it is a practical concept designed to ensure that courts and parties are not vexed by suits brought to vindicate nonjusticiable interests and that judicial decisions which may affect the rights of others are forged in hot controversy, with each view fairly and vigorously represented. . . . Classical aggrievement requires a two part showing. First, a party must demonstrate a specific, personal and legal interest in the subject matter of the decision, as opposed to a general interest that all members of the community share. . . . Second, the party must also show that the [party's] decision has specially and injuriously affected that specific personal or legal interest. . . . Aggrievement does not demand certainty, only the possibility of an adverse effect on a legally protected interest. . . . Where a party is found to lack standing, the court is consequently without subject matter jurisdiction to determine the cause." (Citations omitted; internal quotation marks omitted.) *Canty* v. *Otto*, 304 Conn. 546, 556-57, 41 A.3d 280 (2012).

"It is axiomatic that an action upon a contract or for breach of a contract can be brought and maintained by one who is a party to the contract sued upon . . . ." (Internal quotation marks omitted.) *Wilcox* v. *Webster Ins., Inc.*, 294 Conn. 206, 215, 982 A.2d 1053 (2009). Such a party is classically aggrieved. Id. The opposite is also a true, such that "[i]t is well settled that one

who [is] neither a party to a contract nor a contemplated beneficiary thereof cannot sue to enforce the promises of the contract . . . ." (Internal quotation marks omitted.) Id., 215 n.12.

CNA is not a party to the agreement between AISLIC and the plaintiff. Further, CNA cannot claim standing as an intended third-party beneficiary. "[T]he ultimate test to be applied [in determining whether a person has a right of action as a third party beneficiary] is whether the intent of the parties to the contract was that the promisor should assume a direct obligation to the third party [beneficiary]. . . ." (Internal quotation marks omitted.) Id., 217. Here, the evidence submitted during Phase II of the trial establishes that neither AISLIC nor the plaintiff assumed a direct obligation to CNA that the plaintiff would pay its deductible to AISLIC. Accordingly, CNA does not possess standing to challenge the plaintiff's failure to pay the AISLIC deductible.

D

Policy Exclusions

The court now turns to the issue of policy exclusions raised in this phase of the trial. "It is the function of the court to construe the provisions of the contract of insurance." (Internal quotation marks omitted.) *Misiti, LLC* v. *Travelers Property Casualty Co. of America*, 308 Conn. 146, 154, 61 A.3d 485 (2013). "Under our law, the terms of an insurance policy are to be construed according to the general rules of contract construction. . . . The determinative question is the intent of the parties, that is, what coverage the . . . [insured] expected to receive and what the [insurer] was to provide, as disclosed by the provisions of the policy. . . . If the terms of the policy are clear and unambiguous, then the language, from which the intention of the parties is to be deduced, must be accorded its natural and ordinary meaning. . . . However, [w]hen the words of an insurance contract are, without violence, susceptible of two [equally reasonable]

interpretations, that which will sustain the claim and cover the loss must, in preference, be adopted. . . . *[T]his rule of construction favorable to the insured extends to exclusion clauses.*" (Emphasis added; internal quotation marks omitted.) *Allstate Ins. Co.* v. *Barron*, 269 Conn. 394, 406, 848 A.2d 1165 (2004).

"The burden of proving that an exclusion applies is on the insurer . . . but the insured has the burden of proving that an exception to an exclusion reinstates coverage." *Capstone Building Corp.* v. *American Motorists Ins. Co.*, supra, 308 Conn. 788 n.24. "[A]n exclusion can only affect a claim covered in the insuring agreement, and an exception can only reinstate coverage in the initial grant." Id., 788. "[A]lthough policy exclusions are strictly construed in favor of the insured . . . the mere fact that the parties advance different interpretations of the language in question does not necessitate a conclusion that the language is ambiguous. . . . The interpretation of an insurance policy is based on the intent of the parties, that is, the coverage that the insured expected to receive coupled with the coverage that the insurer expected to provide, as expressed by the language of the entire policy. . . . The words of the policy are given their natural and ordinary meaning, and any ambiguity is resolved in favor of the insured. . . . The court must conclude that the language should be construed in favor of the insured unless it has a high degree of certainty that the policy language clearly and unambiguously excludes the claim." (Citation omitted; internal quotation marks omitted.) *Liberty Mutual Ins. Co.* v. *Lone Star Industries, Inc.*, 290 Conn. 767, 796, 967 A.2d 1 (2009).

"In determining whether the terms of an insurance policy are clear and unambiguous, [a] court will not torture words to import ambiguity where the ordinary meaning leaves no room for ambiguity. . . . Similarly, any ambiguity in a contract must emanate from the language used in

the contract rather than from one party's subjective perception of the terms. . . . As with contracts generally, a provision in an insurance policy is ambiguous when it is reasonably susceptible to more than one reading. . . . Under those circumstances, any ambiguity in the terms of an insurance policy must be construed in favor of the insured because the insurance company drafted the policy." (Internal quotation marks omitted.) *Lexington Ins. Co.* v. *Lexington Healthcare Group., Inc.*, 310 Conn. 29, 38, ___ A.3d ___ (2014).

1

Pollution Exclusions

Several excess and umbrella insurer defendants have asserted that the pollution exclusions contained or incorporated in their respective policies exclude coverage. In the present case, the plaintiff acquired excess and umbrella insurance policies containing or incorporating two categories of pollution exclusions: (a) standard and absolute pollution exclusions, which preclude coverage for bodily injuries resulting from the "discharge, dispersal, release or escape of" pollutants; and (b) exclusions that contain no language concerning how the material is released. Each type of exclusion will be examined separately.

a

Standard and Absolute Pollution Exclusions

Numerous insurers provided the plaintiff policies that excluded coverage resulting from the "discharge, dispersal, release, or escape" of pollutants. Mt. McKinley's umbrella policy, which is an example of a "standard pollution exclusion," provides: "This policy shall not apply to personal injury or property damage arising out of the *discharge, dispersal, release, or escape* of: 1) smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste

materials or other irritants, contaminants or pollutants into or upon land, the atmosphere or any watercourse or body of water; but this exclusion does not apply if such discharge, dispersal, release or escape is sudden and accidental." [41] (Emphasis added.) V23. Other policies include "absolute pollution exclusions," which are materially identical to standard pollution exclusions but do not include an exception for "sudden or accidental" release or escape of pollutants. [42] See, e.g., V29.

Several excess insurers whose policies include or follow the form of policies with standard and absolute pollution exclusions maintain that coverage is precluded, despite this court's previous decision denying summary judgment,[43] because additional underlying complaints were admitted into evidence during Phase II of the trial, thus addressing the court's previous concern that the moving defendants failed to establish common characteristics between the underlying actions in the motions for summary judgment. The plaintiff contends that this court has already held that the standard and absolute pollution exclusions are ambiguous with

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[41] The language in this exclusion will herein after be referred to as the "standard pollution exclusion." Numerous excess and umbrella policies include standard pollution exclusions or follow form to policies that include such exclusions. Standard pollution exclusions can be found in, but are not limited to, the following policies at issue in the present case: Gibraltar Casualty Company (nka Mt. McKinley) (V23 to V28); FFIC (V51 to V53); AETNA Casualty and Surety Company (AETNA) (V66 to V76); Puritan Insurance Company aka Everest Reinsurance (V81 to V83); and Employers (V85 to V90), and CNA's excess policies (V9 to V12).

[42] An example of an absolute pollution exclusion is found in PEIC's policy, which precludes coverage with respect "to bodily injury or property damage arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land, the atmosphere or any watercourse or body of water." V29.

Although the plaintiff has reserved its right to argue the applicability of the "sudden or accidental" release exception, it has presented no argument relevant to that exception. Therefore, the court finds that, for the purposes of this decision, there is no material difference between both standard and absolute pollution exclusions containing "discharge, dispersal, release, or escape" language.

[43] Mt. McKinley (#333), Westport Insurance Corporation (Westport) (#371), Employers (#602), and PEIC (#620) moved for summary judgment in 2010 on the ground that the pollution exclusions in their policies precluded coverage for the underlying claims brought against the plaintiff. See #333, #371, #602, #620; Docket No. CV-07-5007875-S. This court denied those motions. See #156; Docket No. X02-CV-07-5016213-S.

respect to the nature of the underlying actions and that they apply only to traditional environmental pollution.

To determine whether the pollution exclusions preclude coverage, this court "first must determine whether the defendants met their burden of establishing the applicability of the pollution exclusion clauses in the insurance policies." *Schilberg Integrated Metals Corp.* v. *Continental Casualty Co.*, 263 Conn. 245, 260, 819 A.2d 773 (2003). "[O]nce an insurer has satisfied its burden of establishing that the underlying complaint alleges damages attributable to the discharge or release of a pollutant into the environment, thereby satisfying the basic requirement for application of the pollution coverage exclusion provision, the burden shifts to the insured to demonstrate a reasonable interpretation of the underlying complaint potentially bringing the claims within the sudden and accidental discharge exception to exclusion of pollution coverage, or to show that extrinsic evidence exists that the discharge was in fact sudden and accidental." (Internal quotation marks omitted.) Id., 259.

The excess and/or umbrella insurers in this case maintain that *Liberty Mutual Ins. Co.* v. *Lone Star Industries, Inc.*, Superior Court, complex litigation docket at Waterbury, Docket No. X02-CV-044001208-S (January 25, 2007, *Eveleigh, J.*), rev'd in part on other grounds, 290 Conn. 767, 967 A.2d 1 (2009), and *Yale University* v. *CIGNA Ins. Co.*, 224 F. Supp. 2d 402 (D. Conn 2002), demonstrate that the standard and absolute pollution exclusions preclude coverage to the plaintiff. This court extensively analyzed the applicability of standard and absolute pollution exclusions to the underlying complaints in addressing the summary judgment motions. See, #156, p 16; Docket No. X02-CV-07-5016213-S. That analysis will not be repeated here except to note that the court differentiated both *Lone Star* and *Yale* from the facts in present

case.[44] As will be noted in more detail below, the court remains persuaded by the reasoning set forth in *Danbury Ins. Co.* v. *Novella*, 45 Conn. Supp. 551, 727 A.2d 279 (1998), *National Grange Mutual Ins. Co.* v. *Caraker*, Superior Court, judicial district of Windham, Docket No. CV-03-0070715-S (August 6, 2004, *Foley, J.*) (37 Conn. L. Rptr. 616), and *National Grange Mutual Ins. Co.* v. *Caraker*, Superior Court, judicial district of Windham, Docket No. CV-03-0070715-S (February 28, 2006, *Riley, J.*) (41 Conn. L. Rptr. 49).

In the declaratory judgment counts, the plaintiff alleges that "Vanderbilt has been sued in several hundred pending and unresolved actions in which plaintiffs have alleged bodily injury, caused as a result of exposure to silica, asbestos and/or talc allegedly contained in products sold by Vanderbilt." #896, ¶ 97. After reviewing the record, the court finds that the claims brought against the plaintiff, whether they were brought by written notice, claim or demand, or as contained in the allegations of an underlying complaint, directly or indirectly alleged exposure to asbestos through the plaintiff's talc or products containing its talc. Although the excess/umbrella insurers are correct that this court previously denied summary judgment, in part, because the moving defendants failed to establish common characteristics among the underlying actions; #156, p. 15; Docket No. X02-CV-07-5016213-S; the court did not stop its analysis there.

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[44] *Lone Star* was not applicable because "[i]t did not address whether the bodily injury claims for which coverage was sought clearly and unambiguously arose from 'the discharge, dispersal, release or escape' of asbestos and/or silica 'into or upon land, the atmosphere or any watercourse or body of water.' " #156, p.15 n.1; Docket No. X02-CV-07-5016213-S. Rather, it dealt with the language of a "Silicosis Hazard Exclusion Endorsement" and the difference between the terms "silicon" and "silica." It also reviewed an asbestos exclusion endorsement which is not in issue here.

The court also differentiated *Yale* in that "the *Yale* court did not address whether the asbestos-related costs for which coverage was sought clearly and ambiguously resulted from the 'actual or alleged or threatened release, discharge, escape or dispersal' of asbestos. The court also notes that the language at issue in *Yale* is broader than the language at issue in the present action, because the language at issue in Yale did not qualify 'release, discharge, escape or dispersal' with 'into or upon land, the atmosphere or any watercourse or body of water.' Finally, the court notes that 'Yale [did] not [point] to any language within the Contaminant Exclusion, or the policies generally, that render[ed] the exclusion ambiguous,' whereas the plaintiff in the present action does point to such language in the moving defendants' pollution exclusions." #156, p.14-15 n.1; Docket No. X02-CV-07-5016213-S.

Instead, it continued to analyze the applicability of the standard and absolute pollution exclusions and "look[ed] to how all of the underlying actions generally have been characterized in determining whether the moving defendants have met their burdens . . . ." Id., 16. This court, therefore, declines the defendants' invitation to alter its previous analysis based upon the admittance of additional underlying complaints during Phase II of the trial.

Whether the standard and absolute pollution exclusion clauses at issue are clear and unambiguous "as applied to the particular facts of this case" are the issue for the court. *Heyman Associates No. 1* v. *Ins. Co. of Pennsylvania*, 231 Conn. 756, 775, 653 A.2d 122 (1995). As previously noted, the excess and/or umbrella insurers claim that standard and absolute pollution exclusions clearly encompass claims for asbestos exposure from talc. The plaintiff argues that those exclusions unambiguously refer to traditional environmental pollution and, at the very least, are ambiguous with respect to the underlying actions. After reviewing the underlying complaints, the court is convinced that competing interpretations of "discharge, dispersal, release, or escape . . . into or upon . . . the atmosphere" are both viable.

There is no Connecticut appellate authority ascertaining the applicability of standard and absolute pollution exclusion clauses in the context of asbestos exposure claims.[45] Superior Court decisions are split, holding that such clauses are either unambiguous or susceptible to more than one interpretation. Compare *Liberty Mutual Ins. Co.* v. *Lone Star Industries, Inc.*, supra, Superior Court, Docket No. X02-CV-044001208-S ("[t]here can be no question that silica and

[45] The only new decision cited to by any excess and/or umbrella insurer is *Woodcliff Lake Board of Education* v. *Zurich American Ins. Co.*, Superior Court of New Jersey, Appellate Division, Docket No. L-3124-11 (2013). In that case, however, the New Jersey court merely analyzed "how the pollution exclusion is interpreted and applied in light of the [sudden and accidental discharge] 'exception' to the exclusion." Id. That exception is not relevant to the facts of the present case. The *Woodcliff* court never interpreted the "discharge, dispersal, release, or escape" language in relation to the underlying claim. Therefore, the *Woodcliff* decision gives this court no basis to alter its prior analysis.

asbestos are 'pollutants'" within the meaning of standard pollution exclusion), with *National Grange Mutual Ins. Co.* v. *Caraker*, supra, 41 Conn. L. Rptr. 53 ("language referencing the manner in which the pollutant is released is . . . ambiguous with respect to whether the exclusion clause bars coverage for indoor exposure to asbestos").

This court remains convinced by the reasoning set forth in the *Caraker* decisions. In particular, the phrase "discharge, dispersal, release, or escape," which is found in standard and absolute pollution exclusions, is ambiguous with regard to alleged asbestos exposure through talc or talc containing products. As the *Caraker* trial court, *Riley, J.*, observed, courts in other jurisdictions that have held such exclusions to be ambiguous have found that "[t]he terms used in the exclusion to describe the method of pollution–such as discharge and dispersal–are terms of art in environmental law used with reference to damage or injury caused by disposal or containment of hazardous waste." (Internal quotation marks omitted.) *National Grange Mutual Ins. Co.* v. *Caraker*, supra, 41 Conn. L. Rptr. 53. "[T]he exclusion, if read broadly, would be virtually boundless and thus, would impact the scope of coverage far beyond the reasonable expectations of the insured . . . an insurer that wishes to exclude everyday activities gone slightly awry from coverage cannot rely on a broad reading of a pollution exclusion clause." (Internal quotation marks omitted.) Id. Moreover, as noted in *Danbury Ins. Co.* v. *Novella*, supra, 45 Conn. Supp. 555, "[t]he reach of the pollution exclusion clause must be circumscribed by reasonableness, lest the contractual promise of coverage be reduced to a dead letter." (Internal quotation marks omitted.)

In sum, the court finds the language contained in the absolute and standard pollution exclusions to be ambiguous. It cannot be said with a high degree of certainty that the policy

language clearly and unambiguously excludes the claim. While one could construe those clauses to encompass the underlying claims, such clauses could also reasonably be interpreted to apply only to traditional environmental pollution. In fact, the court can infer that the parties interpreted the language of the policies to address traditional environmental pollution in that there was no evidence presented of any insurer that had issued a policy with such an exclusion during the period 1956-2007 had invoked the language of that exclusion for any actions or claims brought. Moreover, the very adoption of separate asbestos exclusions in policies beginning in 1986 is in itself evidence that the insurance industry did not consider the pollution exclusion language to be clear enough to exclude such claims. To argue the pollution exclusion was unambiguous and therefore excluded asbestos related claims would render the asbestos exclusion redundant and unnecessary. Consequently, the defendants have failed to meet their burden of demonstrating the applicability of the standard and absolute pollution exclusions in their policies.[46] Therefore, standard and absolute pollution exclusions contained in excess and/or umbrella insurance policies, which contain language referring to "discharge, dispersal, release or escape" of pollutants, do not preclude coverage.[47]

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[46] Because this court holds that standard and absolute pollution exclusions are ambiguous due to language referring to the manner in which the pollutant was released (e.g., "discharge, dispersal, release or escape" language), there is no need for this court to address whether asbestos must unambiguously be considered an "irritant," "contaminant" or "pollutant" in the context of standard and absolute pollution exclusions.

[47] Some policies do not contain the language precluding coverage for pollutants released "into the atmosphere." See, e.g., AETNA's 1985-86 policy (V77); NCC's 1985-86 policy (V130). These policies include "discharge, dispersal, release or escape" language, however, and are therefore ambiguous as to whether they encompass asbestos exposure claims as alleged in the underlying actions.

b

Pollution Exclusions Without "Discharge, Dispersal, Release or Escape" Language

While the court has determined that absolute and standard pollution exclusions are ambiguous due to the vagueness of the "discharge, dispersal, release or escape" language in those policies containing such language, it must still address the applicability of those pollution exclusion clauses in those policies that contain no language addressing how the pollutants are released. The parties have put into issue the following policies that do not include language concerning how pollutants are released: LMI policy 77/18053/PNB21250D,[48] LMI policy 707/NL6544B and Hartford policy 10JPR P19431E. The policies are addressed below.

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[48] The plaintiff and LMI have presented different versions of LMI policy 77/18053/PNB21250D which was issued by LMI to the plaintiff for the period May 17, 1977 to March 3, 1979. LMI3. Multiple defendants claim to provide policies that follow form to that policy. The version of policy 77/18053/PNB21250D presented by the plaintiff (V13) does not include a pollution exclusion. The policy presented by LMI includes an exclusion entitled "Industries, Seepage, Pollution and Contamination Clause No. 3." At trial the parties disputed which policy should be considered to be in force and of effect. "Although the burden to prove that a claim falls within a policy's coverage is on the insured, the insurer has the burden of proving that the claim for which coverage is sought falls within a policy's exclusion." *Lancia* v. *State National Ins. Co.*, 134 Conn. App. 682, 690, 41 A.3d 308, cert. denied, 305 Conn. 904, 44 A.3d 181 (2012). "The determinative question is the intent of the parties, that is, what coverage the . . . [insured] expected to receive and what the [insurer] was to provide, as disclosed by the provisions of the policy." (Internal quotation marks omitted.) *Allstate Ins. Co.* v. *Barron*, supra, 269 Conn. 406. "[I]t is well established that [i]t is within the province of the trial court, when sitting as the fact finder, to weigh the evidence presented and determine the credibility and effect to be given the evidence." (Internal quotation marks omitted.) *Rutka* v. *Meriden*, 145 Conn. App. 202, 211-12, 75 A.3d 722 (2013).

Here the issue is not just a claim relative to the policy, but rather the terms of the policy itself. Credible evidence was presented through the deposition testimony of John R. Fitzgerald, the Direct Claims Account Manager at Resolute Management, Inc. who had responsibility for the plaintiff's account, that the copy of the LMI policy introduced into evidence (LMI3) was the complete version of the LMI policy issued to the plaintiff. LMI123. That version of the policy contained a pollution exclusion that was generally consistent with the other policies issued by the carriers involved in this action. Denaro credibly testified on behalf of the plaintiff that it had a copy of the policy in its files but its version of the policy did not contain a pollution exclusion (V13). He acknowledged on cross-examination that not only did plaintiff's copy of the policy not have a pollution exclusion, but that other sections of text or endorsements found in LMI's version of the policy were not found in plaintiff's version. For example, he credibly noted that absent were portions of text from the limit of liability section, the exclusion relative to liability arising out of violations of statute, law, ordinance or regulation, the "Special Conditions Applicable to Occupational Disease," conditions relating to appeals, service and suit, and the entire provision regarding assignment of the policy. There was no evidence presented indicating that the plaintiff and LMI had negotiated an agreement that the pollution exclusion, which was a standard feature of insurance contracts at the time, or any other specific language be omitted from the policy. The court finds the weightier evidence to be that the policy presented by LMI (LMI3) is the policy that was intended to be entered into between the parties and therefore the court will use that policy for its

LMI policy 77/18053/PNB21250D provides coverage to the plaintiff for the period 1977-1979. LMI3. It includes a pollution exclusion labeled "Industries, Seepage, Pollution and Contamination Clause No. 3." That exclusion precludes coverage for "Personal Injury or Bodily Injury or loss of, damage to, or loss of use of Property *directly* caused by *seepage, pollution or contamination*, provided always that this paragraph (1) shall not apply to liability for Personal Injury or Bodily injury or loss of use of property damaged or destroyed, where such seepage, pollution or contamination is caused by a sudden, unintended and unexpected happening during the period of this insurance." (Emphasis added.) LMI3. As to the LMI policy 707/NL6544B, which provides coverage to the plaintiff for the 1985-86 period, it contains a pollution exclusion precluding coverage for "Personal Injury or Bodily Injury or loss of, damage to, or loss of use of property *directly or indirectly* caused by seepage, *pollution* or *contamination*." (Emphasis added.) V125.[49]

Both LMI pollution exclusions preclude bodily injury coverage caused by "seepage, pollution or contamination." Neither LMI policy contains a definition of seepage, pollution, or contamination, however. LMI does claim that asbestos or silica manufactured by the plaintiff constitutes a "pollutant" or "contaminant" within the plain meaning of LMI's policy. The plaintiff contends that such pollution exclusions must be construed to encompass only traditional environmental pollution, and not the underlying actions, which are product liability claims. This court, therefore, must address whether the exposure to asbestos that claimants allege to be in the

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analysis.

[49] First State's 1985-86 policy, which no party has claimed is applicable, also precludes coverage for "seepage, pollution or contamination." V102 (policy does not apply to any claim "brought about or contributed to by any *seepage, pollution or contamination* of any substance either directly or indirectly attributable to the insured." [Emphasis added.])

plaintiff's talc arises clearly and unambiguously from "seepage," "pollution," or "contamination" under the pollution exclusions in LMI policies 77/18053/PNB21250D and 707/NL6544B.

Where an insurance policy does not define a term, the Supreme Court has ascertained the natural and ordinary meaning from dictionary definitions. See *Connecticut Ins. Guaranty Assn.* v. *Fontaine*, 278 Conn. 779, 784-85, 787, 900 A.2d 18 (2006). "To ascertain the commonly approved usage of a word, it is appropriate to look to the dictionary definition of the term." (Internal quotation marks omitted.) *Buell Industries, Inc.* v. *Greater New York Mutual Ins. Co.*, 259 Conn. 527, 539, 791 A.2d 489 (2002).

LMI has not claimed that asbestos is unambiguously "seepage" under the terms of its policy. Consequently, this court will not address whether the asbestos claimed to be in the plaintiff's talc products is "seepage." The dictionary defined "pollution" as "the act of polluting," "the condition of being polluted," or "pollutant." Webster's Ninth New Collegiate Dictionary (1986) p. 911.[50] "Pollute" was defined as "to make physically impure or unclean" or "to contaminate *(an environment) esp[ecially] with man-made waste.*" (Emphasis added.) Id.[51] The definition of "pollute" indicates that the natural and ordinary meaning of "pollution" could apply to either solely traditional environmental pollution, or in the alternative, to asbestos

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[50]LMI claims that the pollution exclusion in its policy applies because asbestos and silica are "pollutants" or "contaminants." However, the pollution exclusion in LMI policies 77/18053/PNB21250D and 707/NL6544B precludes coverage for personal or bodily injury caused by "pollution" or "contamination." These terms have different meanings than "pollutant" or "contaminant." For example, "pollution" is defined in a newer edition dictionary as "the action of polluting, *esp[ecially] by environmental contamination* with man-made waste." (Emphasis added.) Miriam-Webster's Collegiate Dictionary (11th Ed. 2005), p. 961.

[51]The example of "pollute" used in the dictionary at the time the exclusion was entered into also demonstrates that a reasonable reading could construe the term to refer to traditional environmental pollution: "implying the process which begins with contamination is complete and that what was pure or clean has been made foul, poisoned, or filthy [the *polluted* waters of the lake in parts no better than an open cesspool]." (Emphasis in original.) Webster's Ninth New Collegiate Dictionary, supra, p. 283.

exposure through talc products, as alleged in the underlying actions. Consequently, this court finds the term "pollution" is susceptible to more than one reasonable interpretation and is ambiguous with respect to whether it encompasses alleged asbestos exposure through talc or talc products.

The court now turns to whether the asbestos alleged to be in the plaintiff's talc in the underlying actions is clearly and unambiguously considered "contamination" under the exclusions in LMI policies 77/18053/PNB21250D and 707/NL6544B. The dictionary defined "contamination" as "a process of contaminating" or "a state of being contaminated." Webster's Ninth New Collegiate Dictionary, supra, p. 283. "Contaminate" is defined as "to soil, stain, corrupt, or infect by contact or association," "to make inferior or impure by admixture" or "to make unfit for use by the introduction of unwholesome or undesirable elements." Id.

There is no Connecticut appellate authority addressing whether asbestos is "contamination" under a pollution exclusion clause.[52] Superior Court cases provide no consensus. In *Caraker*, the trial court considered whether asbestos released from removing floor tiles was "a pollutant, irritant, *contaminant* or waste." (Emphasis added.) *National Grange Mutual Ins. Co.* v. *Caraker*, supra, 41 Conn. L. Rptr. 51. After considering the definitions of the terms and various decisions holding both ways on whether pollution exclusions were applicable in similar circumstances, the court, *Riley, J.,* held: "[O]ne could reasonably conclude that asbestos when released into the home is an 'irritant,' 'contaminant' or 'waste' and therefore

[52]Our Supreme Court in *Lone Star* dismissed the appeal of the trial court's decision granting summary judgment based on a standard pollution exclusion for lack of subject matter jurisdiction. *Liberty Mutual Ins. Co.* v. *Lone Star Industries, Inc.*, supra, 290 Conn. 795. The Supreme Court held that it lacked jurisdiction to consider the appeal because there was no final judgment entered for the claims against the insurer who issued the policy with the pollution exclusion when the appeal was filed. Id., 791-95. Therefore, our Supreme Court did not address the issue of whether the pollution exclusion precluded coverage for bodily injury claims arising from asbestos exposure.

constitutes a 'pollutant.' One could also reasonably conclude that asbestos when released into a home does not meet the definition of an 'irritant,' 'contaminant' or waste contemplated by the policy and is therefore not a 'pollutant.' The exclusion clause is therefore ambiguous with respect to whether asbestos released as described in the complaint can be properly classified as a pollutant." Id.

Lone Star addressed insurance coverage for asbestos exposure claims against a manufacturer of alleged silica containing products – in that case those products included cement, sand, and construction materials. The court, *Eveleigh, J.*, granted summary judgment to one insurer on the ground that its standard pollution exclusion, which excluded coverage for bodily injury arising from "irritants, *contaminants*, or pollutants" precluded coverage. The *Lone Star* court, without providing analysis, explained: "there can be no question that silica and asbestos are 'pollutants' within the meaning of the policy." *Liberty Mutual Ins. Co.* v. *Lone Star Industries Inc.*, supra, Superior Court, Docket No. X02-044001208-S (relying on *Peerless Ins. Co.* v. *Gonzalez*, 241 Conn. 476, 483, 697 A.2d 680 [1997] for proposition that there "is no specific requirement that a policy exclusion be cast in specific rather than general terms"). In another case, *Yale* v. *CIGNA Ins. Co.*, supra, 224 F. Supp. 2d 402, the court held that the "Contaminant Exclusion" in the operative policy "clearly and unambiguously precluded coverage for Yale's asbestos-related claims." In *Yale*, however, the insurers merely moved for summary judgment on the policies' property damage coverage related to expenditures Yale University incurred to address the presence of asbestos in buildings it owned. That court specifically found it relevant that the asbestos made the buildings "unfit for use by the introduction of unwholesome or undesirable elements" and/or "physically impure or unclean."

Although the *Yale* court found the exclusion to apply in the context of property damage, this court finds such language ambiguous in the context of personal injury claims arising from exposure to asbestos.[53]

This court remains persuaded by the *Caraker* decision, which reviewed dictionary definitions to ascertain the natural and ordinary meanings of "pollute" and "contamination" and finds that "contamination," as set forth in the pollution exclusions in LMI policies 77/18053/PNB21250D and 707/NL6544B, is susceptible to more than one reasonable interpretation and is ambiguous with respect to whether it encompasses asbestos that is alleged to be contained in talc. Consequently, the pollution exclusions found in both LMI policy 77/18053/PNB21250D and 707/NL6544B do not preclude coverage for the underlying claims.[54]

As to Hartford Policy 10JPR P19431E (V22), the court need not address the pollution exclusion found in that policy, which is a primary policy, as no party has claimed to follow form to this exclusion and a review of the excess/umbrella policies have found none that do. Nor has Hartford itself ever claimed that this exclusion was applicable.

In sum, those policies containing standard and absolute pollution exclusions, which preclude coverage for injuries arising from the "discharge, dispersal, release or escape" of

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[53] Regardless, neither *Lone Star* nor *Yale* dealt with allegations of exposure to asbestos through talc such as that mined and sold by the plaintiff. As noted above, by 1992 OSHA had determined such talc did not warrant regulation under standards set out for asbestos. EV221, EV428.

[54] The court also notes that the pollution exclusions in the LMI policies contain provisions that preclude from coverage "[t]he cost of removing, nullifying or cleaning up seeping, polluting or contaminating substances" and "[f]ines, penalties, punitive or exemplary damages." LMI3, V125. This court "must interpret the insurance contract as a whole with all relevant provisions considered together." *Schultz* v. *Hartford Fire Ins. Co.*, 213 Conn. 696, 705, 569 A.2d 1131 (1990). "Removing, nullifying, or cleaning up . . . polluting or contaminating substances" can reasonably be read to denote costs associated with counteracting traditional environmental pollution and not costs that arise from bodily injury through exposure to asbestos such as that alleged in the underlying actions. Reading the exclusions as a whole thus indicates that the pollution exclusions at issue are ambiguous and do not preclude coverage for the underlying claims.

pollutants, are ambiguous regarding the underlying actions and, therefore, do not preclude coverage. The pollution exclusions found in LMI policies 77/18053/PNB21250D and 707/NL6544B, which precludes coverage resulting from "seepage, pollution or contamination," are ambiguous concerning the underlying actions and therefore does not preclude coverage. Finally, the court need not address the pollution exclusion in Hartford policy 10JPR 19431E as no claim has been made under the exclusion of that policy.

2

Occupational Disease Exclusions[55]

Several insurers seek declaratory judgments and/or have raised a special defense or claim that coverage is precluded due to the occupational disease exclusion of their policy. More specifically, the issue presented upon the completion of the submission of evidence and stipulations is whether the occupational disease exclusion in certain umbrella and excess policies applies only to claims brought by the plaintiff's own employees.

A typical exclusion claimed by one of the defendants provides as follows: "This policy does not apply to any liability arising out of: Occupational Disease."[56] The parties have

[55] Those insurers whose policies carried such an exclusion stipulated on the record at the April 9, 2013 status conference held by the court that the issue of the application of the exclusions would be tried to the court.

[56] Although numerous defendants claim an occupational disease exclusion, the majority do so by virtue of the fact that they are excess insurers whose policies follow form to an underlying umbrella policy. Accordingly, only the language of two policies is actually in issue — PEIC Policy number XMO 01 75 35, Endorsement 4, and LMI's policy number 77/18503/PNB21250D, Endorsement 5 (a). PEIC policy number XMO 01 75 35, Endorsement 4, provides: "This policy does not apply to any liability arising out of: Occupational Disease." Lloyd's policy number 77/18503/PNB21250D, Endorsement 5 provides: "Notwithstanding anything contained herein to the contrary, it is hereby understood and agreed that this Policy shall not apply: . . . (a) to Personal Injury (fatal or non-fatal) by Occupational Disease." Although there is slight variation in the language of the two policies, the variation is immaterial to the resolution of the present dispute. Neither policy defines "occupational disease" and there is no reason, and no party has argued, that the phrase should be interpreted differently for different policies.

stipulated that none of the underlying claimants are or were employees of the plaintiff. Stipulation #1401. Certain claimants allege exposure while in the course of their employment with a company other than the plaintiff.

National Casualty Company (NCC) presents the most comprehensive argument regarding this issue and is joined by several other insurers.[57] It argues that the language of the occupational disease exclusion unambiguously encompasses all diseases contracted through workplace exposure. In support of this argument, NCC contends that the Connecticut Supreme Court has interpreted the phrase "occupational disease" in accordance with the definition given by the Workers' Compensation Act, General Statutes § 31-275 (15), and interpreted the phrase to refer to diseases in which there is a direct causal connection between the claimant's duties of employment and the disease contracted. NCC argues further that the presence of a separate employer's liability exclusion in its policy establishes that the occupational disease exclusion applies to claims by claimants who are not the plaintiff's employees because any other interpretation would render the policy redundant. NCC also argues that a finding that the exclusion does not apply would turn NCC into a workers' compensation insurer, which it is not.

Westport Insurance Corporation (Westport) also argues that the occupational disease exclusion is not limited only to claimants who are the plaintiff's employees.[58] It presents an argument very similar to that of NCC, arguing that the employer's liability exclusion

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[57] NCC's policy number XU 000233 follows form to PEIC policy XMO 01 75 35. Zurich policy number ZIB 72 482 85 C follows form to PEIC's policy number XMO 01 75 354. Zurich joins NCC's arguments as to the occupational disease exclusion. LMI, which has its own occupational disease exclusion in policy number 77/18053/PNB21250D, joins NCC's arguments and also attempts to join PEIC's arguments, although PEIC does not present any arguments concerning its own occupational disease exclusion.

[58] FFIC joins the arguments made by Westport as to occupational disease. FFIC policy number XLX 136 28 69 and Westport policy number ML 65 12 07 both follow form to LMI's policy number 77/18053/PNB21250D.

encompasses the plaintiff's own employees, and the occupational disease exclusion encompasses all other claimants alleging workplace exposure.

Within the context of the stipulation that none of the underlying claimants are the plaintiff's employees, the plaintiff presents three arguments in opposition. First, that the occupational disease exclusions do not apply by their own terms because such an exclusion is designed to apply to claims brought by an insured's own employee. It points out that the only Connecticut case law that does interpret the phrase has done so in the context of the Workers' Compensation Act, and that the phrase serves the purpose of signifying a distinction between sudden personal injury and those diseases and infirmities which develop gradually and imperceptibly. The plaintiff also points out that the insurance industry has defined the phrase to apply to claims brought by an insured's own employee.

Second, that if occupational disease is to be interpreted outside the context of workers' compensation law, then the phrase becomes ambiguous because it cannot be divorced from its derivation in workers' compensation law without becoming so. According to the plaintiff's argument, because courts must construe such an ambiguous phrase against the drafter, in this case the insurer, the exclusion must not apply.

Third, that the defendants have waived their right to disclaim liability on the basis of the exclusions by failing to raise them before now. The plaintiff notes that the defendants have had notice of the various claims for decades and yet never attempted to reserve their rights under the exclusion.

The court agrees with the plaintiff that the plain meaning of the phrase "occupational disease" is unambiguous, being defined by statute. The Connecticut Workers' Compensation

Act defines the phrase "occupational disease" as: "any disease peculiar to the occupation in which the employee was engaged and due to causes in excess of the ordinary hazards of employment as such, and includes any disease due to or attributable to exposure to or contact with any radioactive material by an employee in the course of his employment." General Statutes § 31-275 (15). In addition, the Workers' Compensation Act separately and distinctly defines "personal injury" as follows: "'Personal injury' or 'injury' includes, *in addition to accidental injury that may be definitely located as to the time when and the place where the accident occurred*, an injury to an employee that is causally connected with the employee's employment and is the direct result of repetitive trauma or repetitive acts incident to such employment, and occupational disease." (Emphasis added.) General Statutes § 31-275 (16) (A). See also, 9A Couch, Insurance (3d. Ed. 2005) § 136-12, p. 136-27 ("A disease-wrought 'accident' in the compensation law sense is distinguishable from a statutory 'occupational disease' in that the former features a disabling event occurring on a definite date while the latter involves disability, the onset of which is gradual and unheralded by any identifiable occurrence."). The juxtaposition of the two definitions in subsections 15 and 16 of § 31-275 dispositively supports the notion that the Legislature was aware of the fact that it was defining the two phrases to refer to different types of injuries, both of which occur within the context of workers' compensation.

A review of the policies themselves is enlightening. PEIC policy number XMO 01 75 35 provides in relevant part, in a section headed "Exclusions": "This policy does not apply: (a) to any obligation for which the Insured or any carrier as his insurer may be held liable under any workmen's compensation, unemployment compensation or disability benefits law, or under any

similar law . . . ." V29. Endorsement 3 of the policy provides further: "EMPLOYERS' LIABILITY EXCLUSION THIS POLICY DOES NOT APPLY TO PERSONAL INJURY TO ANY EMPLOYEE OF THE INSURED ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT BY THE INSURED OR TO ANY OBLIGATION OF THE INSURED TO INDEMNIFY ANOTHER BECAUSE OF DAMAGES ARISING OUT OF SUCH INJURY." (Emphasis in original.) Id. Finally, Endorsement 4 provides: "THIS POLICY DOES NOT APPLY TO ANY LIABILITY ARISING OUT OF: OCCUPATIONAL DISEASE." (Emphasis in original.) Id.

LMI policy number 77/18053/PNB21250D provides in section 11: "THIS POLICY IS SUBJECT TO THE FOLLOWING EXCLUSIONS: This policy shall not apply:— (a) to any obligation for which the Assured and any company as its insurer may be held liable under any Workmen's Compensation, unemployment compensation or disability benefits law provided, however, that this exclusion does not apply to liability of others assured by the Named Assured under contract or agreement . . . ." (Emphasis in original.) V13. LMI's policy provides, in Endorsement 5, in relevant part: "Notwithstanding anything to the contrary, it is hereby understood and agreed that this Policy shall not apply:— (a) to Personal Injury (fatal or non-fatal) by Occupational Disease." Id.

The meaning of the phrase "occupational disease" is unambiguous and is defined within the context of the Workers' Compensation Act. As worded, the exclusions referenced apply only to claims that are brought by the plaintiff's own employees. It does not render the policies redundant to interpret both the employer's liability exclusion and the occupational disease exclusion to apply to the plaintiff's own employees. Rather, each exclusion refers to a different

type of injury that is covered by the workers' compensation laws, an interpretation that is supported by the language of the policies themselves.[59]

The court finds that language of the occupational disease exclusions unambiguous and that they apply only to claims brought by the plaintiff's own employees, and not non-employee claims alleging workplace exposure. Because the parties have stipulated that the claimants are not employees of the plaintiff, the exclusions are inapplicable to those claims. Because the court has found the terms to be unambiguous, the court need not address the parties' other arguments.

E

The Special Defense of Misrepresentation

During the trial, the court also took evidence from PEIC relative to its special defense which alleged that coverage under its umbrella and excess policies should be rescinded because the plaintiff had made a material misrepresentation on its application for insurance by not affirmatively stating that it was involved with claims of exposure to asbestos.[60] The application for the 1985 PEIC umbrella/excess policies that are in issue had a question directed to pending litigation. PCA1, PCA2, PCA62, PCA147; #719. The inquiry was as to whether the insured had claims against it in excess of $50,000 and read as follows:

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[59] In addition, it is significant that, despite PEIC's argument concerning redundancy, PEIC's policy nevertheless contains a specific workers' compensation exclusion, in the main body of the policy, *in addition to* a separate "employer's liability" exclusion via special Endorsement 4.

[60] PEIC specifically claims: "Coverage is or would be barred under the PEIC policies to the extent that the insured, its agents or representatives misrepresented or failed to disclose or omitted material information in connection with any application for insurance in connection with the issuance or renewal of the PEIC policies." #972.00, Special Defense 23. See #1139.

NCC, which has an excess policy that follows form to PEIC's umbrella policy, joins in this argument. AISLIC, Employers, Mt. McKinley, Old Republic, AIU, Granite State, Arrowood, ACE, Travelers, FFIC, Munich, Westport and Century also raised the same or similar special defense. Only PEIC put on evidence on the issue during the trial.

12. State loss record during past five years, specifying:

(a) Full details of all claims (whether insured or not) in excess of $50,000. Enter full amount from first dollar in each case.

(b) In respect of products liability, the aggregate amount of losses (from first dollar) for each year.

PCA147. The plaintiff disclosed six claims involving such losses and described five of the six as "alleged exposure to dust claims." Id. The sixth claim was an unrelated property damage claim.

George Patitucci, a former head of PEIC's in-house underwriting department, credibly testified that it was PEIC's practice not to insure companies that had been the subject of asbestos claims. However, a review of the application reveals that despite this clearly stated position, there was no pointed inquiry on the application as to whether the plaintiff had been subject to such claims. He noted that at the time of the review of the application he had concerns about the claims as listed. As was customary, rather than ask the plaintiff directly, he inquired further of an insurance broker, Jytta Vanderpool, to provide more information about the claims though he did not ask to see a copy of any complaint relative to them. The broker then provided the additional information as requested both verbally and in writing. Upon receipt of the additional information obtained through Vanderpool, he ultimately approved coverage for the plaintiff.

"[M]aterial representations . . . relied on by the [insurance] company, which were untrue, and *known by the assured to be untrue when made*, invalidate the policy without further proof of actual conscious design to defraud." (Emphasis in original; internal quotation marks omitted.) *Middlesex Mutual Assurance Co.* v. *Walsh*, 218 Conn. 681, 692, 590 A.2d 957 (1991). "Unlike a party asserting a cause of action for common law fraud, an insurer who raises the special defense

of concealment or misrepresentation does not have to prove that the insurer actually relied on the concealment or misrepresentation or that the insurer suffered injury. . . . [I]n the case of an insurance contract, the consequence of the alleged concealment or misrepresentation is the forfeiture of a contractual benefit, and therefore the burden of proof normally applicable to contractual claims, the preponderance of the evidence standard, should control." (Citation omitted; internal quotation marks omitted.) *Rego* v. *Connecticut Ins. Placement Facility*, 219 Conn. 339, 346-47, 593 A.2d 491 (1991).

Our Supreme Court has noted that "a statement cannot be knowingly false . . . and thus cannot be a misrepresentation in this context, unless it is in fact false. Whether a response to a question in an insurance application is false must be determined in light of the question asked. . . . If the question is so framed as to leave room for two constructions, the words used in it should be interpreted most strongly against the insurer. . . .

"[I]f the inquiry is so framed that it does not clearly inform the insured of its meaning, and he may have been honestly mistaken as to what was intended, and his answer, by fair and reasonable construction, may be considered a true one in response to the question as he understood it, such interpretation will be given, and a forfeiture precluded." (Citations omitted; internal quotation marks omitted.) *Middlesex Mutual Assurance Co.* v. *Walsh*, supra, 218 Conn. 693-95, citing 7 G. Couch, Cyclopedia of Insurance Law (2d Ed.) § 35:115.

PEIC claims that the reference in the application to the five claims as "dust claims" constitutes such a misrepresentation. There is no question that at the time of the application, the plaintiff was aware of asbestos related claims being brought against it. PCA1013. PEIC has referenced circumstantial evidence such as plaintiff's concerns about the rising number of

asbestos claims, regulatory concerns with OSHA and loss of customers due to asbestos allegations. See EV420. It claims that the difficulty in finding insurance coverage, along with other facts, should lead to an inference that the plaintiff had a motive to make misrepresentations to PEIC. However, this is an insufficient evidentiary basis for concluding that the information provided by the plaintiff was either false or knowingly false. The dust claims description was consistent with the plaintiff's long held position that its talc did not contain asbestos.[61] In the context of the question, the plaintiff's response was of a fair and reasonable construction. Had PEIC wished to inquire about something so central to their underwriting requirements, it certainly could have simply and expressly asked about asbestos claims leaving no ambiguity on the issue. The court finds that PEIC has not met its burden of proof as to its special defense.

IV

CONCLUSION

1. As to the issue of allocation, the court finds as follows: that the plaintiff shall be considered self-insured as to indemnity coverage for the period 1948-1955, but that it shall not be considered as self-insured for the period 1956-2008 except for those additional obligations arising from the existence of orphan shares, an insurer's insolvency whether complete or partial, or gaps in coverage during that time period arising from:

[61] In the 1970s the plaintiff had warning labels on certain grades of its talc which read "CAUTION – THIS PRODUCT CONTAINS ASBESTOS FIBERS. AVOID CREATING DUST. BREATHING ASBESTOS DUST MAY CAUSE SERIOUS BODILY HARM." EV1112. However, this was due to federal regulatory requirements. During this time the plaintiff continued to take the position that its talc did not contain asbestos and, as noted above, by 1992 OSHA ceased its regulation of plaintiff's talc. EV221, EV420, EV428.

(a) The gap in coverage from March 25, 1978 to April 26, 1978 in the amount of $700,000;

(b) The full insolvency of Midland Insurance Company as to policies issued for the period March 16, 1977 through March 3, 1985;

(c) The full insolvency of Integrity Insurance Company as to policy #XL210438 for the period March 3, 1985 to March 3, 1986;

(d) The full insolvency of LMI as to policy #707NL6545B for the period March 3, 1985 to March 3, 1986, and

(e) The partial insolvency of LMI policy #707NL6544B for the period March 3, 1985 to March 3, 1986 and policy #77/18053/1/PNB21250D for the period May 17, 1977 to March 3, 1979.

Any liability or financial obligation of the plaintiff on any specific policy issued by a carrier which is partially or fully insolvent shall not arise until those policies sitting below such policy have been exhausted consistent with the principles set forth in *Security*.

No excess carrier which sits above a partially or fully insolvent carrier shall be obligated to act upon a request for coverage from the plaintiff until such time as the plaintiff has met its self-insured financial obligation arising from the insolvency of such carrier.

2. As to the issue of exhaustion, the CNA primary policies for the period January 1, 1968 to March 3, 1977 are exhausted. The Hartford and AISLIC primary policies are exhausted.

3. As to any claims which have an unknown date of first exposure, the default date of first exposure shall be January 1, 1962 consistent with the allocation agreement entered into by and between Hartford and CNA, which agreement the court has found to be reasonable.

4. As to the pollution exclusions claimed by various insurers, the court finds the language contained in the absolute and standard pollution exclusions to be ambiguous and as such is to be construed against the insurer. Therefore, coverage is not precluded.[62]

5. As to the occupational disease exclusions, the court finds the language to be unambiguous and applicable only to claims brought by plaintiff's own employees. In that the parties have stipulated that none of the claims pending against the plaintiff have been brought by any of its own employees, the exclusion is inapplicable to any such claims and therefore coverage is not precluded.

6. As to the special defense of misrepresentation, the defendants have failed to meet their burden of proof in this regard.

7. The court's findings in Phases I and II leads the court to the conclusion that the allocation of defense and indemnity costs shall be applied prospectively, and consistent with the principles set forth in *Security*, in proportions based on a period of 720 months (1948-2008):

(a) As to defense costs, plaintiff shall be liable for 265 of the 720 months;

(b) As to indemnity costs, plaintiff shall be liable for 96 of the 720 months;

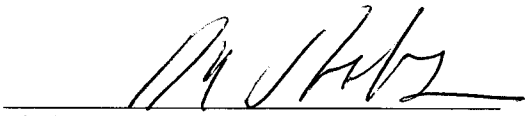
(c) Plaintiff's responsibility as to both defense and indemnity is to be adjusted upward for those applicable periods and levels where there is a gap in coverage or a partially or fully insolvent carrier. Although the issues of gaps in coverage and insolvency were not addressed in the Phase I decision, this

[62] While there was evidence to establish that all of the underlying claims involve some level of allegation of asbestos exposure, which effectively addressed the court's concern raised at the summary judgment stage, the issue of ambiguity remained to be addressed.

ruling shall be applicable to the findings made in that Phase as to defense costs.

Consistent with the court's prior order, #911.01, Phase III of this trial on the issue of damages, including the liability for and amount of reimbursement and/or overpayment of indemnity and defense costs, shall commence no later than forty-five days from the date hereof.

BY THE COURT



Shaban, J.