Paying to Play

What Does It Mean to "Exhaust" Underlying Insurance?

By Michael F. Aylward

For the most part, courts have only followed *Qualcomm* in situations in which policies explicitly required actual payment of limits.

Most new ideas in insurance litigation seem to start on the West Coast. Certainly this is true regarding whether excess insurers may insist on full payment of underlying policy limits as a condition of exhaustion, an issue that has steadily gathered steam since the opinion of the California Court of Appeal in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 73 Cal. Rptr. 3d 770 (2008). In this article, I will discuss the historical origins of this dispute and the manner in which courts around the country have adopted, distinguished, or rejected *Qualcomm* during the past few years.

Excess "Exhaustion" Controversies

Excess insurers have long contested when underlying insurance becomes exhausted and, indeed, whether "underlying insurance" merely refers to those policies listed in an excess policy's "Schedule of Underlying Insurance" or sweeps more broadly to encompass lower layer policies in other years that would also apply to a loss. *See, e.g., Federal-Mogul U.S. Asbestos Personal Injury Trust v. Continental Cas. Co.*, 2011 WL 2652232 (6th Cir. July 8, 2011) (reference to "underlying policies" when read in context clearly meant all primary insurance applicable to the loss not just those listed on the "Schedule of Underlying Insurance").

Part of the controversy reflects the diverse wording that these policies contain governing an excess insurer's involvement. In addition to a "Maintenance of Underlying Insurance" clause requiring the insured to maintain the insurance coverage listed on the "Schedule of Underlying Insurance," an excess policy will separately require an insured to exhaust the underlying insurance before the excess insurer's policy obligations are triggered. Thus, such policies variously state that

- The Company will pay on behalf of its insured those sums in excess of the "Retained Limit" that the insured becomes legally obligated to pay by reason of liability imposed by law or assumed by the insured under an "insured contract" because of "bodily injury," "property damage," "personal injury," or "advertising injury" that takes place during the Policy Period and is caused by an "occurrence" happening anywhere.

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- In the event of the depletion of the limit(s) of liability of the "Underlying Insurance" solely as a result of actual payment of loss thereunder by the applicable insurers, this Policy… shall continue to apply to loss as excess over the amount of insurance remaining…. In the event of the exhaustion of the limit(s) of liability of such "Underlying Insurance" solely as a result of payment of loss thereunder, the remaining limits available under this Policy shall continue… for subsequent loss as primary insurance.
- In the event of… exhaustion of the aggregate limits of liability under "scheduled underlying insurance" solely by reason of payments of a combination of covered [settlements or judgments] paid thereunder as a result of "incidents"… this policy shall, subject to this limit of liability provision and to the remaining terms and provisions and conditions of this policy… apply in place of the exhausted amount of "scheduled underlying insurance."
- Coverage attaches only after "(a) all Underlying Insurance carriers have paid in cash the full amount of their respective liabilities, (b) the full amount of the Underlying Insurance policies have been collected by the plaintiffs, the Insureds or the Insureds' counsel, and (c) all Underlying Insurance has been exhausted."
- The Insurer shall only be liable to make payment under this policy after the total amount of the Underlying Limit of Liability has been paid in legal currency by the insurers of the Underlying Insurance as covered loss thereunder.
- Coverage attaches only after any Insurer subscribing to any Underlying Policy shall have agreed to pay or have been held liable to pay the full amount of its respective limits of liability as set forth in Item 5. of the Declarations.

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"Exhausting" Insurance

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In *Yaffe Companies, Inc. v. Great American Ins. Co., Inc.*, 499 F.3d 1182 (10th Cir. 2007), the owner of a scrap yard in Muskogee, Oklahoma, sought coverage for nearly $1.8 million that it had paid to settle bodily injury and property damage claims resulting from an explosion at its scrap yard. Yaffe sought coverage for these claims under a general commercial liability (CGL) policy issued by ACE American and an umbrella liability policy issued by Great American. The ACE CGL policy had limits of $1 million per occurrence and a general aggregate of $2 million. Notably, however, the policy contained a $10,000 deductible that was written on a "per claim" Basis. Over that coverage was Great American's umbrella policy with a limit of $25 million for each occurrence and in the aggregate. As a result, ACE ultimately only paid $497,999.10, less than half the total primary policy limit.

Despite Great American's argument that its excess obligations only arose after exhaustion of the $1 million ACE limit, the Tenth Circuit held that the triggering event for an excess insurer's obligations was the point in time when the insured's liability exceeded the retained limit ($1 million), not when that amount was actually paid the primary insurer. The court focused on the insuring language in the Great American policy, which stated that the insurer would pay on the insured's behalf "those sums in excess of the retained limit that the insured becomes legally obligated to pay by reason of liability imposed by law or assumed by the insured under an insured contract because of bodily injury, property damage, personal injury or advertising injury that takes place during the Policy Period and is caused by an occurrence happening anywhere." Despite Great American's argument that it was unreasonable to interpret its coverage as being prematurely triggered merely because the insured had saved premium by purchasing primary insurance with a "per claim" deductible rather than the more common "per occurrence" deductible term, the Tenth Circuit held that "Yaffe's bargain with ACE should be irrelevant to the construction of the language of the Great American policy and that, in any event, any savings that Yaffe had achieved with respect to the premium that it paid to ACE was more than off-set by the fact that it ultimately paid half a million dollars in uninsured losses."

These arguments were disputed by Justice Brisco in a dissenting opinion. Brisco argued that the majority had erred in determining that the umbrella policy's reference to "the applicable limits in the underlying policies" merely set the threshold amount over which the umbrella policy would pay and failed to take into account the requirement that the primary insurer actually had to pay the $1 million retained limit. The dissent criticized the majority for ignoring the "key introductory language" of the policy, which stated that Great American "will be liable only for that portion…. in excess of the retained limit which is the greater of… $1 million." While acknowledging that this language could perhaps have been clearer, Justice Brisco contended that its reference to "the applicable limits of the underlying policies" was obviously intended to mean that those policies had to become exhausted before the umbrella policy coverage would begin to contribute.

A dispute over when the underlying "retained limit" is deemed satisfied was also at the heart of the opinion from the U.S. Court of Appeals for the Eighth Circuit in *Waste Management of Minnesota, Inc. v. Transcontinental Ins. Co.*, 502 F.3d 769 (8th Cir. 2007). In that case, a garbage truck loaded by Waste Management of Minnesota, Inc., and driven by one Chad Trenhile jumped a highway median and struck the car of Brian and Ellen Ross. injuring both the Rosses and Trenhile. The Rosses sued Waste Management, Trenhile, and various trucking defendants. At the time, Waste Management had in place a $1 mil-

lion primary policy with Reliance Insurance Company, which, during the course of the proceedings, was declared insolvent. Over the Reliance policy was an excess policy issued by Transcontinental.

The Rosses ultimately settled the claims for $2.3 million, of which Transcontinental contributed slightly more than $1.3 million. However, the Ross settlement did not resolve the pending Trenhile personal injury lawsuit against Waste Management and other parties. The issue arose, therefore, whether the $1 million that the other parties had paid to settle the Ross lawsuit satisfied the underlying $1 million retained limit necessary to trigger Transcontinental's excess obligations to the Trenhile claim.

The Ross lawsuit settlement consisted of $555,000 paid by the Minnesota Insurance Guaranty Association on behalf of Reliance, $250,000 paid by the Rosses' uninsured motorist's carrier, $150,000 paid by Waste Management itself, and an agreement on the part of the Rosses to reduce their judgment by $30,000. Since the total payments by the insured and the Guaranty Association only amounted to $705,000, Transcontinental disputed that it had an obligation to accept coverage for the Trenhile claims as the $1 million underlying retained limit had not been satisfied.

In the ensuing coverage litigation, the Minnesota District Court held that the Ross settlement payments had, in fact, exhausted the $1 million underlying limits, thereby triggering Transcontinental's duty to defend and indemnify Waste Management for the Trenhile claim. On appeal, the Eighth Circuit affirmed.

First, the Eighth Circuit rejected Transcontinental's argument that the district court's decision violated the "Financial Impairment" condition in its policy, which stated that the bankruptcy of an underlying insurer would not increase the excess insurer's obligations. The court observed that if Reliance had remained solvent, it would have paid its full $1 million limit with the result that Transcontinental would have paid exactly the same amount toward the $2 million settlement, as it ultimately did with the assistance of other parties. As a result, the court ruled that the district court's decision was "true to the mandate" of the anti-drop-down language contained in the policy and did not either relieve or increase Transcontinental's obligations as an excess insurer of Waste Management. The court declared, therefore, that this argument was a "red herring."

The court next turned to Transcontinental's argument that only payments actually made by the underlying insurer or its policyholder counted to meet the underlying limits necessary to trigger Transcontinental's excess obligations. The Eighth Circuit noted, however, that the Transcontinental policies called for the excess carrier to pay any "ultimate net loss" in excess of the Reliance policy limit and that "ultimate net loss" was defined not as the amounts paid by Reliance or Waste Management but as the damages for which Waste Management was "legally obligated to pay." In keeping with its earlier opinion in *Reliance Ins. Co. in Liquidation v. Chitwood*, 433 F.3d 660, 664 (8th Cir. 2006), the court held that exhaustion does not require an underlying insurer to pay the full-dollar value of a policy but only requires the insured to prove that the claims aggregating the full amount of the specific policy have been settled.

The court also rejected Transcontinental's argument that this analysis was contrary to the exhaustion clause in the Transcontinental policy, which stated that the excess policy would continue in place of the exhausted amount of scheduled underlying insurance in the event that exhaustion occurred by reason of payments of a combination of covered settlements or judgments. The Eighth Circuit held that this language did not require the underlying insurers to have actually paid their limits as long as their obligations to do so had been finally determined.

In *Polygon Northwest Co. v. American Nat. Fire Ins. Co.*, 189 P. 3d 777 (Wash. App. 2008), *review denied*, 197 P. 3d 1184 (Wash. 2008), various primary and umbrella carriers sued another umbrella excess insurance carrier, Great American, demanding that it pay a share of a $7.8 million construction defect settlement. Great American had refused to pay because United Capitol, the primary insurer with $1 million limits underlying the two years of excess coverage provided by Great American, didn't contribute to the settlement due to insolvency. While agreeing that Great American did not have a duty to "drop down" to pay what United Capitol would have owed, the Washington Court of Appeals nonetheless rejected Great American's argument that it did not have a duty to pay that portion of the overall settlement of the construction defect litigation impacting its layer of insurance over the $1 million insolvent United Capital policies. Since Great American merely was asked to pay what it otherwise would have been obliged to pay had United Capital still been solvent, the court of appeals ruled that the claims in question properly triggered this excess insurance notwithstanding Great American's argument that its policy should only respond if the underlying limits were actually "exhausted" by the primary insurer's loss payments.

Most of the arguments and case law favoring a policyholder's ability to access excess coverage without full payment of the underlying limits of coverage flow from the Second Circuit's opinion in *Zeig*.

Earlier, in *ABT Building Products Corp. v National Union Fire Ins. Co. of Pittsburgh*, 472 F.3d 99 (4th Cir. 2006), the Fourth Circuit Court of Appeals rejected National Union's contention that a $1.5 million settlement negotiated by the primary insurer, Wausau, did not constitute the "payment of claims" to meet the exhaustion requirement of the policies. Despite National Union's argument that the requirement of exhaustion could not be satisfied by a mere commitment to pay future claims, the Fourth Circuit held that the reference to "payment of claims" in the National Union policy was ambiguous and did not preclude a finding that this commitment constituted exhaustion. The court criticized National Union's position, observing that the settlement funded by Wausau promised to min-

imize the costs incurred by the insured and its carriers, including National Union. The court also observed that National Union's argument would eliminate it from ever having a duty to defend in a situation such as this one in which a policyholder opted to resolve multiple actions in a single settlement for all outstanding claims thus obviating the need for a further defense.

Some courts declared that *Zeig* required excess insurers to contribute coverage under all circumstances, regardless of the conditions established in the corresponding policies.

In a 32-page dissent, Judge Niemeyer contended that reviewing the actual sums paid by ABT and its primary insurer had confirmed that the total damages paid amounted to just under $276,000, less than a tenth of the underlying primary limits and far less than the $1 million primary limit for any single year. Judge Niemeyer also stated that the common and ordinary meaning of "payment of claims" required the actual payment of such losses rather than a mere commitment to do so. Nor could the primary insurer exhaust its obligations by paying its limit to the policyholder since the plain language of the policy required that the primary insurer could only exhaust its limits with payments to injured parties for their claims. Further, the court found that Wausau's $1.5 million settlement payment could not have exhausted its primary limits since it owed three separate $1 million primary limits.

Must Underlying Limits Be Actually Paid?

Notwithstanding the generally liberal attitude of courts that find ways for policyholders to access higher layers of excess coverage, should the same rules apply when the policies seemingly require the underlying insurer actually to pay its full limit as a precondition to activating the payment duties of higher layer carriers? In particular, will courts enforce wording such as the following:

> It is expressly agreed that liability shall attach to the Company only after the Underlying Umbrella Insurers have paid or have been held liable to pay the full amount of their respective ultimate net loss….
>
> Reading the clause straightforwardly would seem to require the underlying insurers to have "actually paid" their limits or a court to have held them liable and ordered them to pay. Although, nothing is straightforward in the heady realm of high-level excess insurance.

The Argument for Coverage—*Zeig v. Massachusetts Bay*

Most of the arguments and case law favoring a policyholder's ability to access excess coverage without full payment of the underlying limits of coverage flow from the Second Circuit's opinion in *Zeig v. Massachusetts Bonding & Ins. Co.*, 23 F.2d 665 (2nd Cir. 1928). The dispute in *Zeig* involved a first-party burglary loss. At the time of the loss, the insured had four policies stacked one on top of the other. The excess policy on which the case turned topped three underlying policies with limits totaling $15,000. Zeig settled his claims against the underlying insurers for a total of only $6,000. In affirming the policyholder's right to compel coverage from the remaining excess insurer, Judge Augustus Hand, not to be confused with Judge Learned Hand, wrote,

> The clause provides only that it be 'exhausted in the payment of claims to the full amount of the expressed limits.' The claims are paid to the full amount of the policies, if they are settled and discharged, and the primary insurance is thereby exhausted. There is no need of interpreting the word 'payment' as only relating to payment in cash. It often is used as meaning the satisfaction of a claim by compromise, or in other ways. To render the policy in suit applicable, claims had to be and were satisfied and paid to the full amount of the primary policies. Only such portion of the loss as exceeded, not the cash settlement, but the limits of these policies, is covered by the excess policy.

Id. at 666.

In rejecting the excess insurer's argument that the underlying insurers must have actually paid their limits before the defendant, the top-most-level excess coverage insurer, had to contribute, the Second Circuit declared,

> The defendant argues that it was necessary for the plaintiff actually to collect the full amount of the policies for $15,000, in order to "exhaust" that insurance. Such a construction of the policy sued on seems unnecessarily stringent. It is doubtless true that the parties could impose such condition precedent to liability upon the policy, if they chose to do so. But the defendant had no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in excess of the limits of those policies. To require an absolute collection of the primary insurance to its full limit would in many, if not most, cases involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable. A result harmful to the insured, and of no rational advantage to the insurer, ought only to be reached when the terms of the contract demand it.

Id.

Despite the fact that the Second Circuit's analysis in *Zeig* was specific to the language in question and explicitly left open the possibility of a different result if contracted for, most courts have relied on it in the intervening decades to compel excess carriers to pay losses in far less narrow circumstances. *See Reliance Ins. Co. v. Transamerica Ins. Co.*, 826 So. 2d 998 (Fla. Dist. Ct. App. 2001) (explaining that based on the holding in *Zeig*, the primary insurance does not have to be fully "exhausted" where the primary insurer paid $15,000 less than its limit, even though the excess insurer's policy language provided coverage "only after all primary insurance is exhausted"); *Pereira v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 2006 WL 1982789 (S.D.N.Y July 12, 2006) (supporting *Zeig*'s reasoning and concluding that "[i]nterpreting the policy to excuse the excess insurers from

providing coverage within their respective layers on account of the unrelated insolvency of an intermediary insurer would work a similar hardship on the insureds who have already been deprived of a layer of coverage by the insolvency, and provide a windfall to the excess insurers"); *Rummel v. Lexington Ins. Co.*, 123 N.M. 752, 945 P.2d 970 (N.M. 1997) (holding that "[t]here are strong public policy reasons for permitting the underlying insurer to settle for less than its policy limits. For example, the excess insurer has no rational interest in whether the primary policies are collected in full, as long as it is only required to pay the loss for which it would otherwise have been liable under the terms of the contract."). Indeed, some courts declared that *Zeig* required excess insurers to contribute coverage under all circumstances, regardless of the conditions established in the corresponding policies. *See Drake v. Ryan*, 514 N.W.2d 785, 789 (Minn. 1994).

The Empire Strikes Back—*Comerica* and *Qualcomm*

Starting about five years ago, however, *Zeig* came under serious attack, beginning with opinions arising from excess disputes in Michigan and California.

In *Comerica, Inc. v. Zurich Am. Ins. Co.*, 489 F. Supp. 2d 1019 (E.D. Mich. 2007), the insured settled five class actions for a total of $21 million. Its primary insurer disputed coverage on several grounds but ultimately contributed $14 million of its $20 million limits toward the settlement. The insured paid the balance and then sought coverage from its excess insurer. On cross-motions for summary judgment, the district court held that the plain language of the excess policy required exhaustion of the primary limit by the actual payment of losses "by the primary insurer" before the excess policy obligations began. *Id.* at 1028–29. As a result, the court declared that when a policy requires "payment" to trigger coverage, the insurer must make actual payments, and settlement does not meet this payment requirement. *Id.* at 1032.

The court expressly rejected the insured's argument that paying the difference between the primary insurer's actual payment and the policy limit was the "functional equivalent" of exhaustion. *Id.* at 1030. The excess policy specifically required exhausting the primary policy by "actual payment of losses by the underlying insurer," and the court held that an agreement to give the excess insurer a "credit" against a judgment or settlement up to the primary insurer's liability limit was not the same as "actual payment." *Id.*

The court noted that the insured could litigate its coverage dispute with its primary insurer and either win, and thus recover the full limits of the primary policy and properly trigger coverage under the excess policy, or lose and risk taking nothing. *Id.* at 1032. But "Comerica [the insured] seeks the certainty that its settlement bought and the benefit of coverage from its excess insurer as if it had won its dispute with the primary insurer, despite language in the excess policy to the contrary. No public policy argument says that Comerica may have its cake and eat it too." *Id.*

A year later, the California Court of Appeal adopted these same arguments in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's*, 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770 (2008). In *Qualcomm*, the California Court of Appeal ruled that the phrase "have paid the full amount" of the underlying limits "particularly when read in the context of the entire excess policy and its function as arising upon exhaustion of primary insurance, cannot have any other reasonable meaning than actual payment of no less than the [underlying limits.]" 161 Cal. App. 4th at 196. Likewise, the California Court of Appeal explained that the alternative exhaustion requirement that the underlying insurers "have been held liable to pay the full amount" of the underlying limits did not require cash payments but instead implied a situation in which the insured had entered into a settlement agreement that the insurers were required to indemnify by paying their full limits of coverage. *Id.* According to the court, "[w]hatever merit there may be to conflicting social and economic considerations, they have nothing whatsoever to do with our interpretation of the unambiguous contractual terms. If contractual language in an insurance contract is clear and unambiguous, it governs, and we do not rewrite it 'for any purpose.'" *Id.* at 204 (citation omitted).

Recent Case Law Applying *Qualcomm*

In *Great Am. Ins. Co. v. Bally Total Fitness Holding Corp.*, 2010 WL 2542191 (N.D. Ill. June 22, 2010), a federal district court in Chicago was called upon to interpret the exhaustion clauses in third and fourth layer excess insurance policies. The third layer policy established the condition that

> It is expressly agreed that liability for any covered Loss shall attach to the Insurer only after the insurers of the Underlying Policies shall have paid… the full amount of the Underlying Limit and the Insureds shall have paid the full amount of the uninsured retention, if any, applicable to the primary Underlying Policy.

The fourth layer excess policy established the condition that

> The insurance coverage afforded by the Policy shall apply (1) only in excess of all Underlying Insurance and (2) only after all Underlying Insurance has been exhausted by payment of the total underlying limit of insurance and (3) if each and every Underlying Insurance Policy has responded by payment of loss as a result of any wrongful act.

The federal district court rejected the insureds' argument that these provisions were ambiguous, declaring that the "parties are free to clearly define how an underlying policy must be exhausted." *Id.* at *16. The federal district court also wrote that it "must enforce the plain language as written." *Id.* at *4. In distinguishing *Zeig* and its progeny, Judge Andersen explained that

Although the influence of *Zeig* has diminished greatly in the four years… since… *Qualcomm*, policyholders continue to repeat the themes underpinning this decision in seeking to compel coverage from their higher layer excess insurers.

> [c]ases following *Zeig*'s line of reasoning typically examine whether an excess insurance policy clearly defines how the underlying policies must be exhausted… If an excess insurance policy ambiguously defines exhaustion, as in *Zeig*, courts generally find that settlement with an underlying insurer exhausts the underlying policies…. However, in cases when the policy language clearly defines exhaustion, the courts tend to enforce the policy as written.

Bally, 2010 WL 2542191, at *4.

As even the *Zeig* court conceded, an excess policy can make full payment of the underlying limits a precondition to its coverage if it clearly states it.

In 2011, the U.S. Court of Appeals for the Fifth Circuit rejected *Zeig* and followed *Qualcomm* in a Texas case, *Citigroup, Inc. v. Federal Ins. Co.*, 649 F.3d 367 (5th Cir. 2011). Citigroup, as the successor to the insured, Associates, sought coverage for two actions related to its lending practices, an administrative proceeding instituted by the Federal Trade Commission and a class action lawsuit in California. Associates had a $50 million primary policy from Lloyd's, a $25 million first excess policy from National Union Fire Insurance Company, and a $25 million second excess policy from Starr Excess Liability Insurance International. Above this $100 million in coverage, Associates had an additional $100 million in excess quota share insurance with four carriers: Federal Insurance Company, St. Paul Mercury Insurance Company, Steadfast Insurance Company, and SR International Business Company, (collectively, the quota share policies).

Citigroup eventually entered into a settlement agreement with Lloyd's under which Lloyd's paid $15 million of its $50 million in limits of liability in exchange for a release from coverage for the lawsuits. Citigroup then sued the remaining insurers in the U.S. District Court of the Southern District of Texas. National Union and Starr also settled, leaving only the quota share insurers. On cross-motions for summary judgment, the federal district court granted the insurers' motions and denied Citigroup's motion, holding that Citigroup had failed to exhaust its primary policy as required by each of the individual quota share policies. In affirming this result, the Fifth Circuit ruled that

> the plain language of Federal's, Steadfast's, SR's, and St. Paul's policies requires that Lloyd's pay Citigroup the total limits of Lloyd's liability before excess coverage attaches. Thus, Citigroup's settlement with Lloyd's for $15 million of its $50 million limits of liability… did not satisfy the requirements necessary to trigger the excess insurers' coverage.

Id. at 371.

The Steadfast exhaustion clause established the condition that coverage attached "'[i]n the event of the exhaustion of all of the limit(s) of liability of such 'Underlying Insurance' solely as a result of payment of loss thereunder.'" Citigroup argued that exhaustion occurred under the Steadfast policy on paying any loss exceeding the underlying limits. The Fifth Circuit disagreed writing that

> the Steadfast policy requires that "all" of the underlying insurer's limits of liability be exhausted before coverage attaches. Thus, settlement for less than the underlying insurer's limits of liability does not exhaust the underlying policy. Furthermore, the use of the phrase "payment of loss" establishes that the underlying insurer must make *actual* payment to the insured in order to exhaust the underlying policy.

Id. at 373.

Two recent opinions from New York have also questioned how broadly *Zeig* should be applied. In *Federal Ins. Co. v. The Estate of Irving Gould*, 2011 WL 4552381 (S.D.N.Y. Sept. 28, 2011), the former directors and officers of a computer manufacturer sought coverage under the company's directors and officers (D & O) policies. Commodore had in effect a tower of D & O insurance totaling $51 million, including a $10 million primary policy and eight layers of stacked excess coverage. The insureds' ability to access these higher layers of coverage was complicated by the fact that two of the layers were underwritten by insolvent carriers, Home and Reliance. Nevertheless, the insureds argued to the U.S. district court that they should be entitled to access coverage anyway given that the underlying claims against them exceeded the amounts of the limits underlying these carriers' retentions. In rejecting the insureds' motion for summary judgment, however, Judge Sullivan held that the policies were not triggered "solely by the aggregation" of the underlying losses as the clear and unambiguous wording of the higher layer excess policies required actual payment of the underlying limits. The policies established the condition that

> [i]n the event of the exhaustion of the limit(s) of liability of such Underlying Insurance solely as a result of payment of losses thereunder, the remaining limits available under this policy shall continue for subsequent losses as primary insurance and any retention specified in the Primary Policy shall be imposed under this policy.

Judge Sullivan noted that

> [u]nlike the facts of *Zeig*, here the Excess Insurers have a clear, bargained-for interest in insuring that the underlying policies are exhausted by actual payment. If Defendants were able to trigger the Excess Policies simply by virtue of their aggregated losses, they might be tempted to structure inflated settlements with their adversaries in the [underlying] litigation that would have the same effect as requiring the Excess Insurers to drop down and assume coverage in place of the insolvent carriers. Parties are free to impose conditions precedent to the attachment of excess policies in order to prevent such a loss. The excess insurers, demonstrating impressive foresight, obviously chose to do so here.

More recently, a state trial court in *J.P. Morgan Chase v. Indian Harbor Ins. Co.*, 2011 WL 2320087 (N.Y. App. May 26, 2011), observed that "[t]he cases that follow *Zeig* generally rely on an ambiguity in the definition of 'exhaustion' or lack of specificity in the excess contract as to how the primary insurance is to be discharged." As the policies had clearer language than that

contained in *Zeig*, the court granted a summary judgment to the insurer.

The Scope of the Current Controversy

Although the influence of *Zeig* has diminished greatly in the four years that have passed since the California Court of Appeal decided *Qualcomm*, policyholders continue to repeat the themes underpinning this decision in seeking to compel coverage from their higher layer excess insurers. These themes are (1) the excess insurer is no worse off for "exhaustion by settlement"; (2) these exhaustion requirements are ambiguous; and (3) enforcing these exhaustion requirements disregards public policy.

The Excess Insurer Is No Worse Off for "Exhaustion by Settlement"

Policyholders have argued that it is unjust to restrict a policyholder's ability to settle and negotiate with underlying carriers if the insurer does not suffer prejudice. They contend that excess insurers do not suffer prejudice since they are no worse off if the insured absorbs the difference between the full policy limit and the amount for which the policyholder settled. In fact, this argument misses a crucial aspect of excess insurance.

In general, excess insurers receive only a small premium relative to the large limits of insurance that they underwrite. To earn a profit, therefore, excess insurers largely rely on the underwriting judgment of underlying insurers as well as the protections that they receive due to the fact that their layer of coverage will not come into play until such time as the policyholder needs a defense to liability claims or the policy otherwise resolves them in a manner that requires the payment of these higher layers. When an insured pretermits this process and commutes the underlying insurers' obligations in return for payment of substantially less than the actual limits that the excess insurer has relied on, the excess insurer loses these contractual protections.

The remote nature of an excess insurer's exposure reflects two different considerations; however, only one is addressed by the insured's promise to pay the difference between the full policy limit and a settled amount.

Excess insurers can provide significant policy limits at relatively low cost for two reasons. First, insureds need to turn to their policies less often than those of underlying insurers meaning that they will generally only respond in the event of catastrophic losses or, in limited circumstances, a series of large losses that erode applicable underlying aggregates. A second consideration that the case law and commentaries have developed less fully is the assumption that the claims that penetrate the excess layer will already have been processed through the underlying layers. This process guarantees not only that the amounts tendered to the high-level excess insurance reflect an insured's actual liability after it has received a defense and undergone an evaluation while proceeding through the underlying layers, but it also reflects a determination by the underlying insurers that the claims are covered.

If, however, an insured can tender a large liability loss to its high-level excess insurers without the claims first being vetted both for liability and damages as well as for insurance coverage, it deprives the excess insurers of those protections. An excess insurer's sole protection is the insured's willingness to contribute its own funds to facilitate the involvement of the excess carrier. It is in this way that claims under excess liability policies differ dramatically from the sort of static, fixed first-party loss that was at issue in *Zeig*.

These Exhaustion Requirements Are Ambiguous

As even the *Zeig* court conceded, an excess policy can make full payment of the underlying limits a precondition to its coverage if it clearly states it. *Zeig*, 23 F.2d at 666 ("It is doubtless true that the parties could impose such a condition precedent to liability upon the policy if they chose to do so."). *See Reliance Ins. Co. v. Transamerica Ins. Co.*, 826 So. 2d 998, 999 (Fla. Dist. Ct. App. 2001) (recognizing that "the parties could impose such a condition precedent to liability upon the policy, if they chose to do so").

Although states have different rules determining when courts will deem language ambiguous or interpret language to accord with the principle of *contra proferentum*, they quite clearly appear to require that the underlying insurers "have paid or have been held liable to pay the full amount" of their limits.

Clearly, there is nothing ambiguous about the first option. The plain and ordinary meaning of "have paid" is just that: the underlying insurers must have paid the full amount of their policy limits.

At least one court has claimed to find ambiguous meaning in "has been held liable to pay the full amount of their respective ultimate net loss." In *Rummel v. Lexington Ins. Co.*, 123 N.M. 752, 945 P.2d 970 (1997), the New Mexico Supreme Court held that this language must have a meaning independent of actual payment and could be construed as extending to situations in which "an insurer was in the past bound legally to pay, but has up to the present made no payment, and whose nonpayment may continue into the future." Elaborating, the court wrote,

> It would be senselessly redundant for this phrase to also connote the idea of payment in full, in cash. The rules of contract construction prohibit such an absurd interpretation. *See* 2 Couch 3d, (*supra*), §22:10. "Has been held" is the present perfect progressive form of the verb "to hold," which, in this context, means "to bind legally." Webster's Third New International Dictionary 1078 (1961) ("hold" definition 2(e)). The act that legally binds someone to pay—such as a judgment or a bona fide payment demand by the insured—precedes the actual act of paying. Being held liable to pay is a completely different cir-

Underlying, continued on page 73

Policyholders have argued that even if these requirements are unambiguous, courts should declare them void because they disregard the strong public policy that favors settlement.

Underlying, from page 33

> cumstance than actually handing over a cash payment.

Despite such linguistic leaps, the plain and ordinary meaning of "held liable to pay" is that an insurer has a legal obligation to issue a payment, as happens if an insurer has yet to satisfy a court order directing the insurer to pay a loss. A voluntary compromise of a disputed coverage claim would not satisfy this requirement.

Nor have courts found ambiguity based on a claimed conflict between the exhaustion clause in an excess policy and the separate requirement that the insured maintain the promised underlying insurance. As the U.S. Court of Appeals for the Eleventh Circuit noted in *Hercules Bumpers, Inc. v. First State Ins. Co.*, 863 F.2d 839 (11th Cir. 1989):

> Neither of the clauses are [sic] ambiguous when considered separately; each has a distinct purpose and the language utilized within each clause clearly describes that purpose. Moreover, the clauses are unambiguous when construed together. Condition O [maintenance of underlying insurance] is a warranty given by Hercules Bumpers; it operates as a condition precedent to First State's liability. Provision III [exhaustion requirement], on the other hand, sets forth certain limits on First State's liability.

Enforcing These Exhaustion Requirements Disregards Public Policy

Policyholders have argued that even if these requirements are unambiguous, courts should declare them void because they disregard the strong public policy that favors settlement. However, apart from cases involving state-mandated auto insurance requirements, courts generally have treaded carefully in voiding otherwise clear wording on the basis of some claimed public policy interest.

The California Court of Appeal in *Qualcomm* rejected arguments that the public policy that favors settlement should trump unambiguous "Exhaustion Clauses": "Whatever merit there may be to conflicting social and economic considerations, they have nothing whatsoever to do with our interpretation of the unambiguous contractual terms. If contractual language in an insurance contract is clear and unambiguous, it governs and we do not rewrite it for any purpose." *Qualcomm, Inc. v. Certain Underwriters at Lloyd's*, 161 Cal. App. 4th 184, 204, 73 Cal. Rptr. 3d 770, 786 (2008). Likewise, in *Comerica v. Zurich American Ins. Co.*, 498 F. Supp. 2d 1019 (E.D. Mich. 2007), the district court observed that

> Comerica seeks the certainty that its settlement bought and the benefit of coverage from its excess carrier as if it had won its dispute with the primary insurer, despite language in the excess policy to the contrary. No public policy argument says that Comerica may have its cake and eat it too.

Id. at 1197.

Conclusion

Attorneys should take care when analyzing this issue, as the requirements for exhaustion of excess policies differ dramatically. For the most part, courts have only followed *Qualcomm* in situations in which policies explicitly required actual payment of limits. When policies don't mention exhaustion requirements or the insuring language reads ambiguously, courts generally become far more likely to adopt policyholder contentions that they may "exhaust" those limits by filling in the difference through funds from other sources.