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ATTORNEYS AT LAW

*The Increasing Significance of  
Aggregation in Complex Claims Litigation:  
The U.S. Perspective*

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**I. INTRODUCTION.**

Perhaps one of the most complex aspects of claims management involves determining if two or more claims should be considered separate or multiple occurrences or separate or a single aggregated claim under the policy wording. The range of claim types in which this issue arises spans from employee thefts in which several thefts span over more than one policy period to mass tort cases with exposure periods spanning decades and latent injuries not appearing until years later. The circumstances of such claims can be as mundane as whether a series of embezzlements spanning several years constitute a single claim to the tragic 911 attacks on the World Trade Center in which insureds argued that two separate hijacked planes hitting each of the two towers 16 minutes apart constituted separate occurrences.

The consequences of the number of occurrences or aggregation of claims determination can be significant for both the insured and the insurer. If the policy provides for substantial self-insured retentions or deductibles, the aggregation of a large number of small value claims may be the only way to reach a policy's coverage. On the other hand, if each claim sought to be aggregated has a large value, a finding that each claim is a separate occurrence or claim could result in multiples of policy limits being at stake. The implications of the number of occurrences or claims determination on the amount of available coverage to the insureds is not lost on U.S. courts addressing the issue. Seemingly inconsistent decisions by the same court can frequently be explained by the court's attempt to maximize available coverage.

Most claim handlers are familiar with these issues arising in mass tort claims like asbestos, silicosis, noise induced hearing loss and repetitive stress injuries. Questions involving whether coverage is implicated by date of exposure, date of manifestation, a triple trigger or by injury-in-fact have been the basis of significant litigation both in the United States and Europe.

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Today, we face similar aggregation issues, but in the context of new claim types. The issue of claim aggregation is at the forefront of claims involving the marketing of abusive tax shelters, stock option back-dating, pension mis-selling, and other claims of corporate malfeasance.

Pharmaceutical and progressive injury claims are on the rise. Current significant claim types implicating aggregation issues include welding fume exposures, clergy sexual abuse cases, employment class action claims and renewed tobacco class action litigation based on “light” or “low tar” advertising by manufacturers.

In this paper, we address the state of U.S. law on aggregation for claims spanning more than one policy period and involving more than one potentially triggering event. Particular emphasis will be on the “series of loss” clauses, aggregation clauses, and “occurrence-first-reported” forms as they have been interpreted under U.S. law. We address the aggregation issue in the context of current claims in the forefront of the news and which may become significant to the insurance industry in the near future.

### **II. HISTORY OF POLICY WORDING AFFECTING AGGREGATION OF CLAIMS.**

The most significant factor and starting point in addressing aggregation of claims is the policy wording. When dealing with a coverage dispute pending in the United States or addressing claims against a U.S. insured, the particular laws of the relevant state or states within the United States must also be considered. The approaches and interpretation of identical policy wordings can vary greatly from state to state; this is particularly true in the area of aggregation of claims. Hence, consideration of the law in potential forums can be of critical importance.

Policy wordings have emerged over the years in response to the adverse and or inconsistent rulings by different U.S. courts. The asbestos crisis beginning in the 1970’s and the

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rash of environmental claims in the 1980's were sustained by the insurance industry in the 1980's and 1990's. These claims contributed to the insolvencies of a number of insurers and contributed to the reconfiguration of entire markets, the London market specifically. In response, more pro-active companies sought ways to remain viable while still providing marketable products to multinational corporations such as chemical and pharmaceutical manufacturers.

### **A. The Occurrence Form.**

Prior to World War II, policies in the United States were issued by U.S. insurers on an "accident" basis. The umbrella policy was introduced shortly after the War and was provided at a low excess level with coverage on an "occurrence" basis.<sup>1</sup> The U.S. Insurance Services Organization (ISO) changed the standard primary general liability policy to occurrence-based in 1966. Under the occurrence form, coverage is triggered by liability from property damage or bodily injury that was caused by an "occurrence" and that takes place during the policy period.

### **B. The "Claims Made" Form.**

During the 1980's as corporations, and consequently their insurers, began to be found liable under theories of strict liability for U.S. products claims, insurers found they were paying claims under occurrence based policies written and priced decades earlier. The long tail nature of claims such as asbestos, silicosis, Agent Orange and DES caused occurrence based policies to respond well beyond the expectations of the insurers when the coverage was written. Insurers became unwilling to write new business on the same terms. In the mid-1980's U.S. insurers began writing coverage on a new ISO "claims-made" form instead of the traditional "occurrence based" forms although both remained available. The claims-made form was triggered when a claim was made against the insured (and on some forms also reported to the insurer) during the

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<sup>1</sup> Richards, Masters & Stanley, Liability Insurance in International Arbitration, Hart Publishing, 2004, p. 2.

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policy period. In both England and the U.S., the claims-made form continues to be the standard for professional liability policies which figure prominently in the rash of corporate malfeasance claims.

Along with the advent of the claims-made form, various provisions affecting trigger and allocation were introduced to make the form more marketable to corporate insureds. One such form was the “aggregation of claims” clause. Such an aggregation clause may state:

The inclusion herein of more than one Insured or the making of claims or the bringing of suits by more than one person or organization shall not operate to increase the Company's limit of liability. Two or more claims arising out of a single act, error or omission or a series of related acts, errors or omissions shall be treated as a single claim.

[See, e.g., Bay Cities Paving & Grading, Inc. v. Lawyers’ Mutual Ins. Co., 855 P.2d 1263 (Calif. 1993)]

Variants of this clause in U.S., English and European-generated policies can significantly affect a U.S. court’s analysis such that particular attention needs to be paid to the wording before a coverage determination can be made.

Aggregation provisions are also included in policies written on an occurrence basis. The term “occurrence” is typically defined as an “accident, including continuous or repeated exposure to substantially the same general conditions.” For a pharmaceutical manufacturer, a “batch clause endorsement” might specifically provide that “all ‘bodily injury’ and ‘property damage’ arising out of one manufactured, prepared or acquired lot of goods or products will be considered as arising out of one ‘occurrence.’” A variant of the aggregation clause is found in policies providing personal injury coverage for claims such as false arrest, malicious prosecution, wrongful eviction, slander or violation of privacy rights. Even if these policies are written on an occurrence basis, the policy may limit to a single occurrence all damage to any one person or organization regardless of the number of allegations against the insured. [ISO form BP 00 06 06

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89] Under such clauses, an insured would not be able to argue that the various claims by one claimant constituted more than one occurrence.

In addition to the aggregation clauses, the “series of loss clause” in claims-made policies can significantly influence the allocation of claims. Such a clause typically states:

The Limit of Liability stated in Item 3.(B) of the Declarations is the Company’s maximum liability for all Damages and Claims Expenses because of all Claims for which this Policy applies regardless of the number of Insured, Claims made or persons or entities making Claims.

All Related Claims shall be deemed a single Claim, and such Claim shall be deemed to be first made on the date the earliest such Related Claims is first made against the Insured, regardless of whether such date is before or during the Policy Period.

There are of course wide variations of this language in use. Some policies define the term “related claims.” For example, the above-cited related claims provision contained in an errors and omissions policy defines “Related Claims” and “Related Wrongful Acts” as follow:

Related claims mean all claims arising out of a single Wrongful Act or a series of Related Wrongful Acts in the performance of or failure to perform Professional Services.

Related Wrongful Acts mean all Wrongful Acts that are temporally, logically, or causally connected by any common fact, circumstance, situation, transaction, event, advice or decision.

The definition of “Related Wrongful Acts” relating to services “temporally, logically or causally connected by any common fact, circumstances, transaction, event, advice or decision” attempts to provide an unambiguous broad definition of “related” that will withstand judicial scrutiny. Other wordings may deem claims arising from “Interrelated Wrongful Acts” to be one claim “first made” on the date of the earliest claim. In this example, the policy defines “Interrelated Wrongful Acts” as “any and all Wrongful Acts that have as a common nexus any fact,

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circumstance, situation, event, transaction, cause or series of causally or logically connected facts, circumstances, situations, events, transactions, or causes.” See, e.g., Seneca Ins. Co. v. Kemper Ins. Co., 133 Fed.Appx. 770 (2nd Cir. 2005) As discussed below, cases interpreting these clauses have more readily found all claims to be “related” than “interrelated” which requires a stronger logical nexus between the acts or omissions.

As an example of the variety in policy language that can be used in claims-made policies, the following provisions are from a claims-made and reported accountants’ liability policy:

a claim is defined as “a demand received by any *Insured* for money or services, and includes the service of suit(s) or a demand for arbitration. A *Claim* also includes a *Multiple Claim*, which is formed by two or more *Claims* arising out of or resulting from a single act, error or omission in the rendering of *Professional Services*, or from related or identical acts, errors or omissions in the rendering of *Professional Services*, whether such demands are made: (1) against one or more *Insureds*, (2) by one or more *Persons*, or (3) during one or more *Policy Periods*.” The policy provided coverage for sums “that an *Insured* becomes legally obligated to pay as *Damages* because of a *Claim* arising out of an *Insured’s* negligent act, error or omission in rendering or failing to render *Professional Services* performed after the *Retroactive Date* and before the end of the *Policy Period*. ... Related or identical acts, errors or omissions shall be deemed to have occurred on the date that the earliest of those acts, errors or omissions began. A *Multiple Claim* is deemed made and reported to the Company on the date the first of the *Claims* forming the *Multiple Claim* is reported to the Company.” The policy’s limits of liability were \$3,000,000 per claim and \$6,000,000 policy aggregate for all claims made and reported during the policy period.

[Camico Mutual Ins. Co. v. Rooney, Ida, Nolt and Ahern Accountancy Corp., 2006 WL 866321 (Cal. App. April 5, 2006)]

Another accountant’s liability policy contains the following aggregation clause:

- (d) All claims arising out of the same act, error, omission, breach of contract or duty or libel or slander or any allegation thereof or related act, error, omission, breach of contract or duty or libel or slander or any allegation thereof of the Assured Firm shall be considered a single claim and only one sum insured is applicable to the total amount of such claim.

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A current sample D&O policy contains the following Insuring Agreement:

With respect to Coverage A, B and C, solely with respect to Claims first made against an Insured during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy, and subject to the other terms, conditions and limitations of this policy, this policy affords the following coverage:

Excluded from this sample D&O policy is coverage for any Claim made against an Insured:

Alleging, arising out of, based upon or attributable to the facts alleged, or to the same or related Wrongful Acts alleged or contained in any Claim which has been reported, or in any circumstances of which notice has been given, under any policy of which this policy is a renewal or replacement or which it may succeed in time.

Under this policy any claims relating to the same wrongful acts first reported in a prior policy period would be excluded from coverage. This D&O policy does not provide limits on a per claim basis, but contains a retention clause providing that “[a] single Retention amount shall apply to Loss arising from all Claims alleging the same Wrongful Act or related Wrongful Acts.”

The 2003 ISO CGL form providing for claims-made coverage continues to require an “occurrence” along with the first reporting of the claim during the policy period. The definition of “occurrence” encompasses a “continuous or repeated exposure to substantially the same general conditions.” There is no separate aggregation clause in this form and we would expect courts to look to precedent interpreting occurrence-based policies to determine aggregation under this ISO form.

The above can be considered a sampling of the various permutations of clauses and definitions used in both occurrence-based and claims-made policies. Consequently, in each case,

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the language of the particular policy at issue will be pivotal to the aggregation of claims determination and in the allocation of claims where the policy contains the “first reported” aggregation clause. A review of the case law for any potentially applicable jurisdiction must always take into consideration any differences between the policy language at issue in the decision and the language at issue in the case in dispute. That said, these clauses can be significant depending on how they are interpreted. Under the appropriate circumstances they can serve as a complete defense to coverage (if all related claims should be allocated to a prior year) or as a way to significantly reduce the amount allocated to your policy. We mention the possibility, however, that a U.S. court could refuse to enforce an aggregation or series of loss clause as ambiguous. This is a distinct possibility where a clause can operate to significantly reduce or extinguish the available coverage to an insured and/or the underlying plaintiffs.

### **C. The Bermuda Form.**

While ISO issued the claims made forms in response to the insurance implications of the occurrence forms, two Bermuda based insurers were formed in the 1980’s to issue a new hybrid form that was neither a claims-made nor an occurrence based form, but rather a mix of the two. This product was first marketed by ACE Insurance and later XL Insurance; and is currently used by a number of European insurers. The form is commonly referred to as the “Bermuda form” or the “occurrence-first-reported” form. In the 1980’s, it was marketed to U.S. products and pharmaceutical manufacturers potentially facing large numbers of claims that were unable to obtain excess coverage in the U.S. The form was designed to avoid litigation in U.S. courts and specifically provides for London arbitration. But as companies other than XL and ACE use the form and contribution actions by other insurers cause its provisions to be at issue, more cases may arise.

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The Bermuda form provides for New York law to apply with one notable exception. The policy provides coverage for punitive damages which are uninsurable as a matter of public policy under New York law.<sup>2</sup> Additionally, the most recent version of the form (XL 004) contains no right to appeal the arbitration award.<sup>3</sup>

The Bermuda form has several provisions that implicate trigger and allocation. For coverage to be triggered, the injury must have taken place after the specified retroactive date of the policy and the occurrence must have been notified to the insurer within the policy period or a specified extended notification period. The policies typically have large self insured retentions such as \$25 million on limits of \$100 million. To ensure policy response to a large number of small claims (none of which would individually exceed the self insured retention if considered separately) the policy allows the insured to integrate related occurrences.<sup>4</sup> The policyholder is allowed, but not required, to provide notice of an “integrated occurrence” that results in all claims under the defined integrated occurrence to be deemed one occurrence under the policy regardless of when subsequent claims are received. The policy does, however, contain an expected or intended exclusion which excludes the normal “noise level” of product claims typically expected by a manufacturer. For example, a pharmaceutical manufacturer may expect 1 in 100,000 patients to suffer an adverse reaction to a particular drug. The exclusion would preclude coverage for this one expected patient, but to the extent an unexpected number or type of claims is received (“fundamentally different in nature” or “at a level or rate vastly greater in

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<sup>2</sup> *Home Ins. Co. v. American Home Products*, 75 N.Y.2d 196 (1990).

<sup>3</sup> See generally, Richards, Masters & Stanley, *Liability Insurance in International Arbitration*, Hart Publishing, 2004; “Bermuda Solves Excess Liability Problem” The Finance Director website [www.the-financedirector.com/features/feature114](http://www.the-financedirector.com/features/feature114)

<sup>4</sup> Richards, Masters & Stanley, *Liability Insurance in International Arbitration*, Hart Publishing, 2004, p. 13.

order of magnitude” than the normal level of claims expected for a particular product), the policy would respond.<sup>5</sup>

**III. CASES ADDRESSING AGGREGATION CLAUSES IN OCCURRENCE BASED POLICIES.**

The ISO CGL forms define “occurrence” as an “accident, including continuous or repeated exposure to substantially the same general conditions.” Most claims professionals are familiar with the cases addressing the number of occurrences in the context of asbestos or environmental suits under such policy wording and are well aware that the states’ interpretation of the above definition of occurrence in the context of multiple claims against an insured varies significantly.

Perhaps the greatest divergence among the states on the number of occurrences issue appears in the asbestos context. For example, in the context of asbestos property damage, the Second Circuit applying New York law in Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F.3d 1178, 1213 (2nd Cir. 1995) stated that to determine the number of occurrences for deductible purposes under New York law, the court determines whether multiple claims result from “an event of an unfortunate character that takes place without one’s foresight or expectation.” (internal quote omitted) In Stonewall, the primary policies contained the following deductible provision: “[t]he deductible amount applies to all damages and claim expenses for all coverages combined as the result of any one occurrence.” Id. at 1212. Consistent with its decision that each building installation would constitute a separate occurrence, the Second Circuit also held that a separate deductible would apply to each asbestos-in-building claim. Id. at 1214. Although not expressly stated, the court implicitly acknowledged

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<sup>5</sup> Matthew Smith & John Sylvester, Coming to Grips With The Bermuda Form, Strategic Risk, Feb. 2006, p. 38, 39.

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that for each claimant that constitutes a separate occurrence a deductible from each triggered policy will apply. *Id.* at 1214, n. 22 (“Even if the relevant event were each delivery of NGC’s asbestos-containing products to intermediaries or directly to consumers, the number of such deliveries over the years-and thus *the number of deductibles under each policy*-would likely be substantial and result in significantly diminished coverage for NGC.”)

In the context of asbestos bodily injury claims, New York law is less clear. One Second Circuit decision applying New York law has held that for asbestos bodily injury claims, each claimant’s exposure is a separate occurrence. The Second Circuit decision in In Re Prudential Lines, 158 F.3d 65 (2nd Cir. 1998) held that the claimants’ exposure was the last link in the chain to the insured’s liability. Under this effects test the court reasoned that since each claimant was exposed to asbestos separately and at a different point in time, each claim constituted a separate occurrence. The court noted, however, that the policies at issue did not contain the same provision contained in most CGL policies specifying that all injuries arising out of continuous or repeated exposure to the same general condition would be considered as arising out of a single occurrence. The court therefore cautioned that its decision may have limited application to asbestos claims under more standard CGL wordings. On the other hand, the court also noted that the Stonewall decision discussed above characterized the Owens Illinois decision in New Jersey (which found all asbestos claims to arise out of a single occurrence) as an attempt to maximize coverage. *Id.* at 82, n. 9. This comment suggests that the Second Circuit would find each claimant to be a separate occurrence under a standard CGL policy as well.

In stark contrast to the law in New York, and highlighting the differences a mere few hundred miles can make, Pennsylvania and New Jersey consistently hold that the manufacture of asbestos-containing products is the occurrence and that all asbestos claims arising out of

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exposure to such products will be deemed to be a single occurrence. An example of the language of the liability policies supporting these rulings is a “Limits of Liability” section of a CGL policy providing:

For the purpose of determining the limit of the company's liability, all bodily injury and property damage arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence.

In Colt Industries, Inc. v. Aetna Casualty and Surety Co., 1989 WL 147615, \*6 (3d Cir. 1989), reconsideration granted in part on other grounds, 1991 WL 97702 (3d Cir. 1991), the United States Court of Appeals for the Third Circuit considered this language in the context of the policy as a whole, as supporting a finding that all asbestos claims constituted one occurrence for purposes of determining the number of applicable deductibles to be applied. Each of the claims arose out of “substantially the same general conditions.”

Considering this same policy language, the Third Circuit also held in the Liberty Mutual Ins. Co. v. Treesdale, Inc., 418 F.3d 330 (3d Cir. 2005) that all asbestos claims arose from the manufacture and sale of asbestos-containing products, a common cause of loss supporting a finding of one occurrence. Id. at 339. The New Jersey Supreme Court also applied a “cause of loss” test and found all asbestos claims to be a single occurrence. Owens-Illinois, Inc. v. United States Ins. Co., 138 N.J. 437 (1994).

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### A. Batch Clauses.

Commercial General Liability policies issued to pharmaceutical or chemical manufacturers may contain the following “Batch Clause Endorsement:”

All “bodily injury” and “property damage” arising out of one manufactured, prepared or acquired lot of goods or products will be considered as arising out of one occurrence.

Few reported decision interpret this batch clause. Of the few courts that have addressed it, one found it ambiguous and two interpreted it narrowly.

The one court that found an occurrence-based batch clause to be ambiguous considered conflicting arguments as to whether the clause telescoped claims into one policy period regardless of the date of injury or whether the insured was still required to prove that each claimant suffered a bodily injury within the policy period. Stryker Corp. v. XL Insurance America, Inc., 2006 WL 1997142 (slip op.)(W.D. Mich. July 14, 2006). The claims at issue in Stryker were injuries caused by defective knee replacement implants. The implants were being used by doctors after their expiration date and had started to deteriorate; 79 claims resulted. An endorsement to the insured’s liability policy provided that “all Bodily Injury . . . which arises out of one batch of the Named Insured’s Products shall be considered one occurrence.” The endorsement further provided that the date of the advisory memorandum [notice of claim] will be considered the date of occurrence for *all claims* resulting from or relating to the batch.” Id. at \*4. (emphasis in original).

The Stryker court confirmed its prior holding that the batch clause endorsement was ambiguous as it could not determine which interpretation of the endorsement was correct and under Michigan law, this ambiguity was a question of fact to be determined by the jury. The jury would be charged with determining whether the parties intended the clause to telescope all

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claims into one policy year. Id. at \*2. There would be no charge to the jury, however, that the clause must be interpreted against the insurer unless the jury continued to find it ambiguous after hearing the parties' evidence of intent. Id. at \* 8.

A similar clause was not deemed ambiguous under New York law, but was strictly interpreted. A New York court held batch clauses could not be read to render each of 133 lots of Agent Orange delivered to the military during the Vietnam War to be separate occurrences triggering separate deductible requirements. Diamond Shamrock Chemicals Co. v. Aetna Casualty & Surety Co., 258 N.J.Super. 167 (App. Div. 1992). The underlying claims against Diamond Shamrock all arose from the military's use of Agent Orange as an herbicide during the Vietnam War. Military personnel exposed to Agent Orange were injured and brought a class action. Diamond Shamrock participated in the settlement of this class action and brought a coverage action against its insurers. The New Jersey Appellate Division applied New York law as it was the place of contracting for the relevant policies.

Aetna unsuccessfully argued that separate lots of Agent Orange should each constitute a separate accident or occurrence. Aetna's policies in effect from 1955 to 1966 provided that "all such damages arising out of one lot of goods or products prepared or acquired by the named insured or by another trading under his name shall be considered as arising out of one accident." Starting in 1967, Aetna's policies were written on an occurrence basis and provided "[a]ll such damage arising out of one lot of goods or products prepared or acquired by the named insured or by another trading under his name shall be considered as arising out of one occurrence." The court rejected Aetna's argument on the basis of the parties' intent that the batch clause minimize the number of occurrences and maximize coverage. Id. at 247. It would similarly not interpret the clause to increase the number of applicable deductibles; the lower court's determination that

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the clause was meant to apply to manufacturing defects and not to design defects was upheld as consistent with the parties' intent. Ibid.

A Maryland District Court similarly rejected insurers' arguments that the batch clause required each lot of defective cement used in railroad ties to constitute a separate occurrence. Lafarge v. National Union Fire Ins. Co. of Pittsburgh, Pa., 935 F.Supp. 675 (D.Md 1996). The batch clause at issue provided that "all property damage arising out of one batch or lot was to be considered a single occurrence." The court rejected the insurers' arguments that each batch of defective cement sold was a separate occurrence requiring a separate deductible; the batch clause only required that a batch be one occurrence rather than more than one occurrence triggering multiple deductibles. Id. at 689. The court did not strain to interpret the clause as providing that where claims arose from more than one batch each batch would constitute a separate occurrence. Lafarge v. National Union Fire Ins. Co. of Pittsburgh, Pa., 935 F.Supp. 675 (D.Md 1996).

Courts following the above cases will likely interpret a batch clause in favor of the insured on both the number of occurrences and applicable deductible provisions. This is particularly so where the policies contain significant deductibles or retentions that could eviscerate coverage.

Although the recent Styker decision discussed above addresses a batch clause in an occurrence based policy, the trend in pharmaceutical underwriting is to write policies on a claims made basis. While we have not encountered specific batch clauses in such claims made policies; the aggregation of claims and series of loss clauses in such policies could effect the same result and warrant similar consideration.

**IV. CLAIMS MADE POLICIES: AGGREGATION FOR A “SERIES OF RELATED ACTS.”**

**A. The Majority View Broadly Interprets the Phrase.**

The majority of states broadly interpret a “related acts” provision to find underlying suits arising from similar facts or conduct to be related regardless of the number of plaintiffs or differences in the exact facts surrounding the claims. Where there is proof of a plan or scheme or a firm policy or course of conduct, the chance of finding the underlying claims to be related increases substantially. Even where there is no such evidence, courts may find separate underlying claims to be related if there is a significant similarity in facts among the claims at issue.

There are essentially three landmark cases cited by the majority of courts to support their position or holding on the aggregation of claims issue. Of the states with state or federal decisions addressing the aggregation issue, the majority of courts cite to the Seventh Circuit’s decision in Gregory v. Home Ins. Co., 876 F.2d 602 (7th Cir. 1989), the California Supreme Court decision in Bay Cities Paving & Grading, Inc. v. Lawyers’ Mutual Ins. Co., 5 Cal.4th 854 (1993), and/or the Eleventh Circuit decision in Continental Casualty Co. v. Wendt, 205 F.3d 1258 (11th Cir. 2000). While the results under the various fact patterns in cases applying these decisions come out both in favor of and against aggregation, courts applying these decisions adopt a broad interpretation of the term “related acts” which can include both a logical and a causal connection. As they form the basis of the decisions in most other jurisdictions, we address the facts and holding of these major cases below.

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The Gregory decision, applying Indiana law, addressed the applicable limits under a lawyers' professional liability policy which contained the following provision under "Limits of Liability":

IV. Multiple Insureds, Claims and Claimants: The inclusion herein of more than one insured or the making of claims or the bringing of suits by more than one person or organization shall not operate to increase the Company's limit of liability. *Two or more claims arising out of a single act, error, omission or personal injury or a series of related acts, errors, omissions or personal injuries shall be treated as a single claim.* All such claims, whenever made, shall be considered first made during the policy period or Optional Extension period in which the earliest claim arising out of such act, error, omission or personal injury, was first made, and all such claims shall be subject to the same limits of liability.

[Gregory, *supra*, 876 F.2d at 604.]

The insured attorney, Gilbert, was hired by Producer's Brokerage Company (PBC) to provide legal services in connection with a videotape investment program. Gilbert drafted the production service agreement and promissory note to be signed by each buyer at the time of purchase. He also drafted a tax and security opinion letter for PBC stating that the videotapes were not securities that needed to be registered with the Securities and Exchange Commission and that purchase of the videotapes would provide the purchasers with tax benefits. PBC reprinted the opinion letter in the sales brochure distributed to potential buyers. *Id.* at 603.

The IRS disagreed with the Gilbert opinion letter and disallowed the investors' claimed deductions, assessing interest and penalties against them. The investors brought suit against PBC and Gilbert's law firm alleging violations of securities laws, the Racketeer Influenced Corrupt Organization Act (RICO) and common law fraud. PBC crossclaimed against the law firm. The underlying case settled following the district court's finding that the videotape sales were investment contracts requiring registration with the SEC and that the law firm had violated

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securities laws and regulations. The lead underlying plaintiff brought the subject declaratory judgment to determine applicable limits to be paid under the settlement agreement.

The court found that Gilbert's actions in drafting the tax and security opinion letter, the promissory note and the production service agreement were all interdependent components of a single plan. It also held that the additional action of advising PBC of the tax and security law consequences of its offering was also a related act "by any plain and ordinary meaning of 'related'." Id. at 605. In support of its holding the court cited the dictionary definitions of "related" and the Arizona Supreme Court decision in Arizona Property & Casualty Ins. Guar. Fund v. Helme, 153 Ariz. 129, 134-135 (1987) which held that the word "related" covers a broad range of connections, both causal and logical. Id. at 606.

In Bay Cities, the California Supreme Court addressed policy wording that "two or more related claims arising out of a single act, error or omission or a series of related acts, errors or omissions shall be treated as a single claim." Id. at 857. The term "related" was not defined and the court considered the term in its "ordinary and popular sense." The underlying suit involved a claim by construction company client against its attorney for losses incurred as a result of the attorney's failure to file a stop notice to creditors on a construction project and failure to timely file a complaint to enforce a mechanics lien. The attorney claimed entitlement to separate limits of liability under his attorney malpractice policy for each of the two alleged errors, asserting that each was a separate claim under the policy.

Applying the policy language and the Gregory decision discussed above, the California Supreme Court found the term "related" was not ambiguous and as applied to the facts before it, dictated that the two errors were one claim because they caused only one harm to one plaintiff. Id. at 873. The Court specifically rejected the argument that the claims must be causally related,

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reasoning that the term “related” is commonly understood to encompass both logical and causal connections. The Court went on to hold that with this understanding, the claims at issue clearly were logically connected and would constitute a single claim.

The Wendt decision, applying Florida law, follows the reasoning of the Gregory decision to find that the term “related” as used in a “first made” provision of a lawyer’s professional liability policy is not ambiguous and that it encompasses both causal and logical connections between claims. Id. at 1262. In Wendt, the insured attorney, Hall, promoted securities in a Canadian corporation, K.D. Trinh, through seminars and to individual clients, representing himself as an expert in securities laws. Hall issued opinions to clients and agents that the sale of the securities did not violate securities laws, took loans of money from his clients, drafted brochures for use by the agents in selling the securities, and committed “various other illegal and unethical activities all performed with the aim of supporting investment in K.D. Trinh loans.” Id. at 1263.

Hall argued that these various alleged actions were a series of disconnected acts that caused different harms to the individual investors in the first filed suit and to the agent in his later third party suit. He further argued that he owed distinct and different duties to the individuals in these suits. The court rejected these arguments, finding the acts to constitute a “course of conduct” to encourage investment in the K.D. Trinh notes.

Though clearly this course of conduct involved different types of acts, these acts were tied together because all were aimed at a single particular goal. The fact that these acts resulted in a number of different harms to different persons, who may have different types of causes of action against Hall does not render the “wrongful acts” themselves to be “unrelated” for purposes of the insurance contract.

[Id. at 1264.]

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The Wendt court found the individual and the agents' suits to be related and entitling the insured to only the per claim limits under the terms of the first policy which stated that the limits for "each claim" would be the maximum paid for "all claims and claim expenses arising out of, or in connection with, the same or related wrongful acts."

In a corporate malfeasance case, proof of "related" acts supporting a one claim position is of course easier if the insured can be shown to have engaged in a scheme or plan to commit the acts complained of or if the acts were in furtherance of such a scheme or plan. For example in Gateway Group v. McCarthy, 300 F.Supp.2d 236 (D.Mass. 2003), the court found that claims from the insured's promotion and sale of franchises resulting in separate actions by investors in different states were related claims. The court noted:

Similarly, in the instant case, [the insureds] engaged in a "single course of conduct designed to promote investment" in the franchise program. *Id.* The fact that the sales pitch was made to different people over time, and that the franchises were located in different states, does not render the wrongful acts unrelated. Rather, like in *Wendt*, the conduct at issue in both the Illinois and Missouri claims "was arguably the 'same' and at the very least 'related' in any common sense understanding of the word." *Id.*

[Id. at 245.]

These cases highlight that the determination of the number of claims or occurrences will be very fact specific. The facts supporting the determination may be unavailable absent discovery of the insured's internal documents and to depose key employees and involved individuals.

**B. The Minority View Narrowly Construes the "Related" Clause Where More Than One Claimant is Involved to Reject Aggregation of Claims.**

Not all jurisdictions apply the "causal or logical connection" test espoused in Gregory, Bay Cities and Wendt to determine if claims are "related."

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Some cases addressing the “related” language have distinguished the Gregory and Wendt decisions on the grounds that the professional services at issue in those cases were provided to one client or to a group of investors or to a client who disseminated it to third parties, whereas the case before the court involved separate duties owed to each client. See, e.g., Beale v. American National Lawyers Ins. Reciprocal, 379 Md. 643 (2004) (legal malpractice claims brought by six children represented by insured attorney in lead paint cases each deemed a separate claim where insured owed each a separate duty, facts were not identical and claims did not arise out of same or “related professional services”); City of Idaho Falls v. Home Indemnity Co., 126 Idaho 604 (without citation to any precedent, court held insured city’s issuance of opinions, negligent management of nuclear plant construction, entering into a Participants’ Agreement without authority, failure to file declaratory judgment action to determine enforceability of agreement prior to sale of bonds, negligent misrepresentations in connection with bond issuance and other acts were not “related acts” under the prior acts endorsement).

Even in states that narrowly construes the “related claims” language in aggregation clauses, a one claim position can be supported by showing the insured had a practice or procedure in place which dictated the malfeasance complained of. For example, the Eastern District of Wisconsin held in American Medical Security, Inc. v. Executive Risk Specialty Ins. Co., 393 F.Supp.2d 693, 707 (E.D.Wis. 2005) that it would narrowly construe the subject policy’s prior/pending proceeding exclusion that contained the phrase “in any way involving any fact, circumstance, transaction, event, Wrongful Act or series of facts, circumstances, situations, transactions, events or Wrongful Acts” alleged in a prior litigation or proceeding. Notwithstanding each of 39 asserted claims by health insurance policyholders would be deemed one claim because they were all based on the insured’s practice of underwriting renewals of

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purported “group” health insurance policies based on its assessment of the individual group participant’s or beneficiary’s health risk.

Some courts have also found the “related acts” wording of aggregation clauses to be ambiguous and have refused to enforce the clauses as written. In St. Paul v. Chong, 787 F.Supp. 183 (D.Kans. 1992), the court found the “series of related wrongful acts” language in a legal malpractice policy to be ambiguous; it interpreted the clause as “multiple causally connected negligent acts or omissions.” Id. at 187-88. Because the insured attorney owed separate duties to each client, the claims of the various clients did not arise out of a series of related wrongful acts. Id. at 188. See also Lyon v. Lumbermens Mutual Casualty Co., 566 N.E.2d 388, 392 (Ill. App. Ct. 1990) (Court finds “series of related acts” language of aggregation clause to be ambiguous and therefore to be interpreted in favor of the insured; each of 11 envelopes of cash stolen from restaurant on two occasions deemed to be a separate occurrence maximizing available coverage).

### **V. CASES ADDRESSING “SERIES OF INTERRELATED ACTS” LANGUAGE.**

In addition to the language discussed above regarding loss arising from a series of related acts constituting a single claim or occurrence, a number of policies alternatively contain provisions relating to an “interrelated” series of acts or events. An example of such a provision would be as follows:

[f]or the purpose of this policy, all Loss arising out of all interrelated Wrongful Acts of any Insured Person(s) shall be deemed one Loss, and such Loss shall be deemed to have originated in the earliest Policy year in which any of such Wrongful Acts is first reported to the Company.

In the above clause, “Wrongful Acts” and “interrelated Wrongful Acts” were defined as

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follows:

Wrongful Act means any error, misstatement or misleading statement, act or omission, or neglect or breach of duty committed, attempted or allegedly committed or attempted by any Insured Person, individually or otherwise, in the discharge of his duties to the Insured Organization in his Insured Capacity, or any matter claimed against him solely by reason of his serving in such Insured Capacity. All such *causally connected* errors, statements, acts, omissions, neglects or breaches of duty or other such matters committed or attempted by, allegedly committed or attempted by or claimed against one or more of the Insured Persons shall be deemed interrelated Wrongful Acts.

[*Stauth v. National Union Fire Ins. Co. of Pittsburgh*, 185 F.3d 875 (Table)(10th Cir. 1999).]

While individual courts may find underlying claims or suits to be “interrelated” acts under policy wording such as that cited above, the vast majority of courts in the U.S. find the above language to be ambiguous or find the alleged facts forming the basis of the underlying claims not to be “interrelated.” Certainly, a stronger nexus between the acts alleged to have caused the loss will be required to show the acts to be “interrelated” than to be merely “related.” For example, in the Eastern District of Michigan, the “interrelated acts” language was strictly interpreted to find the insured investment firm’s actions in sale of failed company’s investment products (debentures, mortgage pools, and real estate pass-through certificates) to investors did not constitute “interrelated” acts entitled to only one per-claim limit. *Sigma Financial v. American International Specialties Lines Ins. Co.*, 200 F.Supp.2d 697 (E.D.Mich. 2001). The *Sigma* court found the inclusion of the term “interrelated wrongful acts” to be more restrictive than the “related” language at issue in *Gregory*. While the sale of the various investment products may be “related” they were not “interrelated” as they did not have mutuality or interrelatedness where they were different products sold by different brokers to different customers. *Id.* at 720-21.

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Where a policy contains an aggregation clause referring to “interrelated acts, errors or omissions,” the possibility also exists that a court may find it ambiguous or that as applied it does not aggregate claims as expected. See, e.g., Home Ins. Co. of Illinois v. Spectrum Information Technologies, Inc., 930 F.Supp. 825 (E.D.N.Y. 1996). (“Spectrum”)

In Spectrum, the court considered the following “first made” provision contained in section IV(C) of the policy at issue:

*All claims arising from the same wrongful act or interrelated, repeated or continuous wrongful acts of one or more assureds shall constitute a single claim and shall be deemed to be a claim first made and reported to the Insurer in the policy period in which the first such wrongful act is reported to the Insurer in accordance with Clause VI(A).*

[Id. at 848.]

The claims at issue in Spectrum were (1) two claims/inquiries made during a policy period prior to that of the policies issued by the insurer plaintiffs in the declaratory judgment action and (2) a number of suits brought within the plaintiffs’ policy period. The two claims that pre-dated the subject policies were an informal SEC investigation into misstatements Spectrum made in connection with a joint venture with AT&T and an AT&T transaction-related class action suit brought by Spectrum stockholders. Claims brought and noticed within the subject policy years were a number of lawsuits relating to insider trading, misstatement of earnings and misstatements by the CEO. The insurers asserted that because all the suits had been consolidated into one action, the above aggregation clause would operate such that all subsequent claims related back to the AT&T suit and the SEC investigation and therefore were excluded from coverage under their claims-made policies.

The court rejected the insurers’ argument on this issue, noting:

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At best, Section IV(C)'s language is ambiguous, which requires a construction in favor of the insured. *See, e.g., McCuen v. American Casualty Co. of Reading, Pa.*, 946 F.2d 1401, 1407-08 (8th Cir.1991) (commenting that the terms “similar” and “interrelated” in the phrase “same act, interrelated acts, or one or more series of similar acts ... shall be considered a single [l]oss[,]” were “so elastic, so lacking in concrete content, that they import into the contract, in our opinion, substantial ambiguities”). Expansive phrases such as “continuous wrongful acts” must have some practical boundary. Thus, the Court concludes that these subsequently alleged wrongful acts are not the same as, interrelated to, a continuation of, or repetitious of those contained in the AT & T Lawsuits.

[ibid.]

The Spectrum decision should not be read to mean that an aggregation clause referring to “interrelated” acts will always be struck down as ambiguous. A recent New York decision upheld the clause’s validity (untroubled by the lack of practical boundaries) and found claims to be “interrelated” even where the plaintiffs allege separate transactions as the cause of their losses. In Seneca Ins. Co. v. Kemper Ins. Co., 2004 WL 1145830 (S.D.N.Y.), aff’d, 133 Fed. Appx. 770 (2nd Cir. 2005), the court addressed the insured’s claim for coverage of two separate antitrust suits. Underlying plaintiffs, applicants to USA Equestrian for permission to hold and promote horse shows on various dates, claimed violation of antitrust laws by USA Equestrian’s alleged restraint of competition in refusing the applications on the grounds of mileage conflicts (i.e. that a particular show would be located too close to another approved show).

The first claim was brought within plaintiff, Seneca Insurance’s policy period. The second claim, in the form of a complaint jointly filed with the first claimant, was brought and noticed within the subsequent Kemper policy period. Seneca agreed to defend the first claim and brought a declaratory judgment action against Kemper to compel Kemper to defend the second claim.

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Kemper denied coverage for the second claim under its policy's "first made" provision that provided that all claims arising "from the same Wrongful Act and all Interrelated Wrongful Acts shall be deemed one Claim" and that the claim shall be deemed made on the date of the earlier of the claims. Since the first claim was made prior to the Kemper policy period, a finding that both suits constituted one claim would effectively exclude coverage under the Kemper policy. "Interrelated Wrongful Acts" was defined under the policy as "any and all Wrongful Acts that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of causally or logically connected facts, circumstances, situations, events transactions or causes." Id. at \*5.

The Seneca court found the "first made" provision in the Kemper policy to be unambiguous. Looking to the facts of each claim, the Seneca Court found the two claims to be interrelated. Included among the common facts were that both plaintiffs intended to promote the same class of horse show on certain dates and in certain locations, but not on the same dates or in the same location. Both applied to USA Equestrian for these dates. USA Equestrian denied both plaintiffs' applications on the basis of a mileage rule. The mileage rule gave USA Equestrian a monopoly over such horse shows, prohibited new promoters, such as the plaintiffs, from entering the market and both plaintiffs were the target against which the antitrust activity was directed. Both plaintiffs' businesses were damaged as a result of USA Equestrian's conduct. Additionally, the attorney was also the same for both plaintiffs and filed both complaints on their behalf. Id. at \*9. Based on these facts, the court determined that the second claim arose from common facts and was neither factually nor legally distinct from the prior claim. Ibid. The Seneca Court cited with approval an earlier District Court opinion wherein the court noted "nothing in the Policy requires that a claim involve precisely the same parties, legal theories, 'Wrongful Act[s]', or

requests for relief for the ... [prior or pending suit] exclusions to apply” Id. at \*4 (citing, Zunenshine v. Executive Risk Indemnity, Inc., 1998 WL 483475, \*5 (S.D.N.Y. 1998)).

**VI. ENGLISH CASES ANALYZING AGGREGATION CLAUSES.**

In 2003, the highest court in England addressed the interpretation of an aggregation clause in a corporate malfeasance case. In Lloyds TSB General Ins. Holdings et al. v. Lloyds Bank Group Ins. Co., Ltd., [2003] UKHL 48, the House of Lords addressed claims for coverage for pension mis-sellings in the UK. These claims essentially involved advice by investment consultants employed by the insured TSB companies as to whether individual investors should move their retirement investments from their employer-controlled funds to private investment funds. The consultants advised thousands of employees to move their retirement savings without conducting a proper analysis and advising the employees of the risks of such a move. This analysis and recommendation was known as the “best advice” requirement under the applicable regulatory scheme. TSB employees failed to comply with this best advice requirement and upon notice to the affected employees of the existence of a possible claim, approximately 22,000 claims were received.

The policy at issue contained a £1 million self insured retention. If each claim were determined to be a separate occurrence, there would be no coverage under the policy as none of the claims at issue exceeded £35,000. The insuring clause of the policy provided:

[...] the underwriters shall be liable only for that part of each and every third party claim during the policy period...which exceeds the deductible stated in item 7 of the Schedule.

The deductible shall apply to each and every third party claim and shall be subject to no aggregate limitation.

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The policy also contained the following aggregation clause:

If a series of third party claims shall result from any single act or omission (or related series of acts or omissions) then, irrespective of the total number of claims, all such third party claims shall be considered to be a single third party claim for the purposes of the application of the deductible.

The trial court ordered trial on the issue of whether the mis-selling claims all constituted a single third party claim under the above language. The trial judge determined that the insured's breach of its duties to train and monitor employees as required under the regulations constituted a series of acts or omissions within the meaning of the clause such that the claims should be aggregated. *Id.* at ¶19.

The appellate court overturned the ruling and found that an "act or omission" must be something that constitutes the investor's cause of action. It cannot mean an act or omission which is causally more remote. *Id.* at ¶20. The appellate court did not accept that the lack of a training program or monitoring was relevant to the insured's liability to the investors. Instead it found that the actions of the consultants caused the liability, vicariously, to the employer. Consequently, the failure to ensure compliance with the regulations could not be the "unifying factor" which created a single act or omission. Notwithstanding, the appellate court found that acts or omissions could be a "related series of acts or omissions" if they had a "single underlying cause" or "common origin." The court found the lack of training or monitoring to be this single underlying cause or common origin of the investors' claims, and therefore found in favor of aggregation.

Two Lords of the High Court issued opinions which disagreed with the appellate court's decision to aggregate the claims. Lord Hoffman opined that separate losses caused to a number of people by the combination of more than one act or omission did not constitute a "series" of

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acts or omissions as the policy language required. This was true even where the losses could not be caused by any of the acts considered individually. Consequently, Lord Hoffman found that the claims at issue did not arise from a “related series of acts or omissions.” Each claim arose from a separate violation of the regulations. *Id.* at ¶29.

Lord Hobhouse’s opinion also stresses that the investors’ claims cannot be either a “single act or omission” or a “related series of acts or omissions” because the investors’ claims were proximately caused by the actions of the consultants, not the insured’s failure to ensure that the consultants followed the regulations requirements to provide “best advise.” *Id.* at ¶¶ 45, 46. Lord Hobhouse relied heavily on the language of the aggregation clause and cautioned that the result could be different if the parties had employed different language. He noted that the following wordings would support an aggregation of the claims at issue in Lloyds TSB:

- “each and every loss and/or occurrence ..... and/or series of losses and/or occurrences ..... arising out of one event.” ¶ 48 (AXA Re v Field [1996] 1 WLR 1026]
- “any claim or claims arising from one originating cause or series of events or occurrences attributable to one originating cause (or related causes)” ¶ 48 (AXA Re v Field [1996] 1 WLR 1026]
- “or arising out of all occurrences of a series consequent on or attributable to one source or original cause.” ¶ 50 (Municipal Mutual Ins. Ltd v. Sea Ins Co [1998] Lloyd’s Rep IR 421)

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Lord Hobhouse found the “attributable to,” a “single source” and “originating cause” to be the operative broad wording that would have allowed the court to look beyond the immediate cause of loss to determine if series of losses should be deemed one claim. *Id.* at ¶ 51.

The remaining three Lords agreed with the opinions of Lords Hoffman and Hobhouse that the claims should not be aggregated. The Lloyds TSB decision suggests that like their US counterparts, English courts will closely scrutinize and interpret the language of an aggregation clause.

More recently, in October 2005, the United Kingdom prescribed the permissible aggregation clauses for any professional liability policy issued to solicitors registered in England and Wales. The precise wording of the permissible aggregation clause provides:

- (a) all Claims against any one or more insured arising from:
  - (i) one act or omission;
  - (ii) one series of related acts or omissions;
  - (iii) similar acts or omissions in a series of related matters or transactions

and

- (b) all Claims against one or more Insured arising from one matter or transaction

will be regarded as one Claim.

[Minimum Terms and Conditions of Professional Indemnity Insurance for Solicitors Registered in England and Wales, 2005]<sup>6</sup>

This language contains the series of related acts or omissions language from the Lloyds TSB decision, but adds specific additional situations which will be deemed a single Claim under the policy. These additional situations were likely included to avoid the

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<sup>6</sup> Available at [www.lawsociety.org.uk/documents](http://www.lawsociety.org.uk/documents).

outcome of Lloyds TSB where there was no coverage for thousands of underlying claims because of the wording of the aggregation clause.

**VII. IMPLICATIONS OF U.S. COURT DECISIONS ON CURRENT CLAIM TYPES.**

**A. Terrorism/911 Attacks Cases.**

Perhaps the most noteworthy of U.S. cases addressing the aggregation of claims under an “occurrence” definition is the insurance dispute that followed the World Trade Center attacks of September 11.

In S.R. Intl Business Ins. Co. v. World Trade Center Properties LLC, 222 F.Supp.2d 385 (S.D.N.Y. 2002), the Second Circuit addressed several insurers’ motions for partial summary judgment in the coverage action brought by the recent purchasers of the World Trade Center Towers. Because the purchase of the Towers occurred just months before the attacks, the first party property policies had not yet been issued; only binders were in effect. The insured argued that certain of the binders included the definition of the term “occurrence” to mean “all losses or damages that are attributable directly or indirectly to one cause or to one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one occurrence irrespective of the period of time or area over which such losses occur.” Id. at 398. This form was referred to as the “Wilprop form” and was found to constitute the operative language for a number of the defendant insurers who had issued binders but had not yet issued policies.

The insurers argued that under the wording of the “Wilprop form” where one hijacked plane struck one tower followed by a second hijacked plane striking the second tower sixteen minutes later, the insureds’ losses were the result of “one series of similar causes” and

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constituted a single occurrence. The insureds, seeking to maximize available coverage by claiming entitlement to two occurrence limits, argued that the language should be construed such that the attacks were not from a series of similar causes. The District Court held that based on “common speech” and the “reasonable expectations and purpose of the ordinary businessman,” the two plane hits to the two towers in a sixteen minute period causing the “total destruction of the World Trade Center resulted from one series of similar causes.” *Id.* at 399. The Second Circuit affirmed this holding on appeal. World Trade Center Properties, L.L.C. v. Hartford Fire Ins. Co., 345 F.3d 154, 180 (2nd Cir. 2003)

The binder issued by defendant Travelers Insurance was not subject to the Wilprop form, but instead was governed by a separate binder. This binder referred to the term “occurrence” but did not define it. The binder provided:

[t]he Company will pay for direct physical loss or damage to Covered Property at premises ..., caused by or resulting from a Covered Cause of Loss. Covered Cause of Loss means risks of direct physical loss unless the loss is excluded in Section D., Exclusions; limited in Section E., Limitations; or excluded or limited in the Supplemental Coverage Declarations or by endorsements.

The court found the term “occurrence” to be ambiguous as used in a first party property context. According to the court, a jury could find “direct physical loss or damage” does not refer to the “event” that triggers coverage, but could refer to the scope of damage resulting from the “event.” *Id.* at 189. Consequently, the jury would need to consider extrinsic evidence to determine the meaning of the term occurrence and to determine whether the two tower attacks constituted one or more occurrences. In so holding, the Second Circuit Court recognized that:

To be sure, a jury could find two occurrences in this case, as it did in *Newmont Mines*, or it could find that the terrorist attack, although manifested in two separate airplane crashes, was a single, continuous, planned event causing a continuum of damage that resulted in the total destruction of the WTC, and, thus, was a single occurrence.

[Id. at 190.]

The jury ultimately found two occurrences under the Travelers policy binder form. This verdict has been appealed to the Second Circuit. No decision has yet been rendered.

**B. Abusive Tax Shelter Claims.**

Over the past few years, U.S. Internal Revenue Service and Senate investigations have documented a significant number of companies involved in the design, marketing and sale of at least fourteen abusive tax shelters in the U.S. Companies involved range from small one-man operations promoting transfer of assets off-shore, to multi-national law firms; global investment banks and large global accounting firms. Criminal charges and Deferred Prosecution Agreements have resulted. The insurance implications may reach hundreds of millions of U.S. dollars.

Many of the policies at issue for the affected companies contain forms of the aggregation or series of loss clauses discussed above. Where applicable policy language requires aggregation of related claims into a first reported policy, an argument can be made that all claims against an insured are “related” where most of the approximately fourteen known tax shelter products were each developed seriatim from a prior product. The different tax shelter products frequently differ only in minor respects and the possibility exists that they will be considered “related.”

An even stronger argument for aggregation may exist where it can be shown that an accounting firm had a common scheme, devised at the highest management levels, to sell off-the-shelf “prepackaged” tax shelter products with only questionable IRS code compliance. Similarly, a financial institution’s decision to facilitate a series of

transactions under different tax shelter schemes may also constitute related acts supporting aggregation of claims.

The financial implications to the insurance industry are significant and we expect the issues of aggregation and allocation to be at the forefront of the dispute.

**C. Stock Option Backdating.**

Stock option backdating claims feature prominently in recent headlines and will likely be a notable insurance concern as claims begin to escalate. To date there are no cases directly addressing trigger and aggregation issues in the context of stock option backdating, although the decisions discussed above in other contexts may help predict the outcome or at least outline a court's likely analysis of the issues. The D&O policies at issue for these claims are usually written on a claims-made basis and may contain the aggregation clauses discussed above.

In cases in which the insured company backdates options issued to its executives on more than one occasion, evidence may reveal or support an argument that the company had a policy in place to backdate. Such a policy or even the number of backdating transactions themselves could constitute a "series of related acts" supporting aggregation of claims. Proof of a corporate policy could be pivotal to aggregation of claims if the aggregation clause incorporates the more exacting "series of interrelated acts" language. On the other hand, where significant deductibles or retentions exist, insurers may argue that each decision to issue/backdate options as a component of incentive compensation constitutes a separate occurrence.

**D. Welding Rod Exposure Cases.**

On June 27, 2006 a jury rendered a defense verdict in the first of approximately 3,800 consolidated cases pending in federal court against welding rod manufacturers. It is estimated that in addition to these 3,800 consolidated claims, there are an additional 10,000 welding rod

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claims pending in federal and state courts. The plaintiffs, comprised of welders and other workers, allege that long-term exposure to manganese from welding rods has caused injuries including manganese-induced Parkinson's disease. The U.S. Bureau of Labor and Statistics estimates that approximately 360,000 Americans work as welders and as many as 500,000 American workers may be exposed to welding fumes as welding is used in other trades. One neurologist has found evidence of 12% of a sample population of welders experience Parkinson's-like symptoms. Applying this percentage to the 500,000 exposed workers suggests that as many as 40,000 welders may be able to allege manganese-induced Parkinson's disease.

It is uncertain whether the progression of manganese-induced illnesses or conditions follow the same progressive nature as in asbestos related diseases; there is at least some evidence to support a finding that the same continuous progression exists for these claims. There has been very little case law addressing the insurance issues relating to welding rod claims and the majority of reported decisions address whether the pollution exclusion applies as a coverage defense. One Pennsylvania decision does address the number of occurrences issue for a welding fumes case. In Air Products and Chemicals, Inc. v. Hartford Accident and Indemnity Co., 707 F.Supp.762 (E.D.Pa. 1989), rev'd in part on other grounds, 25 F.3d 177 (3d Cir. 1994), the court applied the "cause of loss" test applicable under Pennsylvania law. It found all welding claims, regardless of injuries caused and method of exposure, to arise out of a common cause; the insured's continuing sale of welding rods. Id. at 773.

We anticipate that other courts addressing the number of occurrence issue in welding rod coverage cases will apply the same test they employ in the asbestos context. Accordingly, states such as Pennsylvania and New Jersey will deem all claims to be one occurrence while states such as New York will likely view each welding rod claim as a separate occurrence.

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We continue to closely monitor these claims which will certainly be a source of interest to products liability carriers in the coming months and years.

### **E. Clergy Sexual Molestation Claims.**

The aggregation issue has been addressed over the past years in connection with the numerous sexual molestation claims brought against priests and a number of Catholic Archdiocese in Massachusetts and across the country. A number of reported decisions address the aggregation of claims under occurrence based policies.

While some early decisions adopted a “first encounter” doctrine holding that only the policy in effect at the time of the first encounter would be triggered, later cases adopted a type of “exposure” trigger in which all policies in effect when a particular child was molested would be triggered. These decisions held there would be one occurrence during each year in which a child was abused regardless of the number of incidents within a year. For example, a claim that a child was abused once during each of four years would be deemed four occurrences. See e.g., Roman Catholic Diocese of Joliet, Inc. v. Interstate Fire Ins. Co., 685 N.E.2d 932, 939 (Ill. App. 1st Dist. 1997) (rejects first encounter rule where parties do not agree that all damage occurred at time of first encounter and finds one occurrence in each policy period in which abuse occurred); Interstate Fire & Cas. Co. v. Archdiocese of Portland, OR, 35 F.3d 1325, 1331 (9th Cir. 1994)(“because each policy covers only damages stemming from [child’s] exposure to [priest]occurring during the policy period, and because the parties do not contest that [child] was exposed to the negligently supervised priest in each of the four policy periods, we conclude that [child’s] claim implicates four occurrences.”)

A number of aggregation-related issues arise in connection with these molestation cases. In fact, despite the number of reported cases addressing aggregation, the cases raise more

questions than they answer. For example, how will the existence of more than one perpetrator within one insured diocese affect the number of occurrences? Will all children abused by a single perpetrator be treated as one occurrence? At least one court has held that damage to each child is a separate occurrence. Roman Catholic Church of Diocese of Lafayette and Lake Charles, Inc. v. Interstate Fire & Cas. Co., 26 F.3d 1359, 1364 (5th Cir. 1994) Should the focus of the analysis be on the number of priests involved or on the diocese's policy or practice of negligent supervision? The answer to these questions may be state-dependent. In a state in which the courts look to the cause of the loss, the negligent supervision may render all claims a separate occurrence. It has been suggested however, that even a claim of negligent supervision does not dictate a single occurrence. Where developed facts could reveal that the diocese had several warnings regarding a particular perpetrator and did nothing after each warning, multiple occurrences may be found. On the other hand, if the diocese had no warnings, the continued negligent supervision over the years could be deemed a single occurrence. Lee v. Interstate Fire & Cas. Co., 86 F.3d 101, 104-5 (7th Cir. 1996).

As these claims are now addressed in the reinsurance context through arbitration, the number of reported decisions is unlikely to increase to answer these questions. Claims handlers who are armed with a background of how courts analyze aggregation issues in other contexts will therefore be well prepared to analyze, arbitrate and resolve these claims.

**F. Employment Class Action Suits.**

Recent certification of class actions against Smith Barney, IBM, and Walmart highlight the importance of the aggregation issues. Similar to other claims, the class action suits involve a

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number of different claims and claimants against insureds, but the added consideration is the effect of class certification on the aggregation issue.

Employment class action suits would be noticed under Employment Practices Liability Insurance (EPLI) policies which cover retaliation, misrepresentation, and failure to comply with employment statutory requirements such as the Americans with Disabilities Act and the like. EPLI was created in response to significant changes in the law in the early 1990s. The *Civil Rights Act of 1991*, the Americans with Disabilities Act (ADA) of 1992, and the *Family Medical Leave Act (FMLA) of 1993* provided employees with significantly more rights than they had before. Many employers have seen an increase in the number of lawsuits based on harassment, discrimination, and wrongful termination.<sup>7</sup> For example, Walmart was sued by female employees claiming sexual discrimination based on failure to promote women to management positions, disparate pay rates and related claims. Walmart's most recent "10-Q" filing with the SEC indicates that if the largest class action suit is successful by adverse judgment or negotiated settlement, "the resulting liability could be material to the Company."

More recently, there has been a significant increase in the number of suits alleging misdesignation of "exempt" status to white collar employees. Such employees, including computer programmers, brokers and other office workers, are typically paid an annual salary rather than on an hourly basis. Their suits against their employers allege they should have been designated as hourly employees and should be paid back overtime and other compensation. Examples of corporations defending these suits are IBM (class certified), Smith Barney, and UBS (financial company paid \$89 million to settle four suits). Given the high salaries of some of

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<sup>7</sup> Business & Legal Reports, "Employment Practices Liability Insurance" [www.hr.blr.com/topic.cfm/topic/56/state/155/tab2/106/](http://www.hr.blr.com/topic.cfm/topic/56/state/155/tab2/106/)

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the employee-plaintiffs, a successful class action suit for back overtime pay could have a substantial impact on defendant companies.

Similar to professional liability policies, EPLI policies are written on a claims made basis and would usually contain the same aggregation of claims and first reported telescoping provisions. Claims arising out of a “series of related Wrongful Employment Acts” would be deemed a single claim under these policies.

A court addressing coverage claims arising from class action suits may more easily find claims should be aggregated. In order for a class to be certified the court in the primary case requires:

- The class must be so large as to make individual suits impractical
- There must be legal or factual claims in common
- The claims or defenses must be typical of the plaintiffs or defendants
- The representative parties must adequately protect the interests of the class

The second requirement that there be legal or factual claims in common is very close to the “related” claims analysis under claim aggregation clauses. Consequently, if there is a class certification in the primary case, the facts supporting aggregation may already be a matter of judicial record. As discussed above, aggregation can work both for or against the insured, depending on whether they have low per claim deductibles or SIRs or they have low per claim limits.

**VIII. CONCLUSION**

It is certain that the issues of aggregation and policy response will feature prominently in today's complex claim landscape. With the increasing dollar values of corporate malfeasance, mass tort and pharmaceutical claims on the rise, the interpretation and application of these clauses will be critical to successful resolution of claims.