A Policyholder’s Settlement with Some Insurers Does Not Cut Off Its Access to Others

SCOTT P. DEVRIES, CARL L. BLUMENSTEIN, AND DEBORAH E. BECK

I. INTRODUCTION

It is becoming increasingly common for policyholders to enter into policy “buyback” settlements with some of their insurers while preserving their rights to proceed against other insurers. When these settlements are made with the uppermost excess insurers, they do not affect the availability of coverage from other excess insurers.

But when a buyback settlement involves primary or lower level excess insurers, issues about the policyholder’s access to the remaining excess coverage arise. In that situation, the non-settling excess insurers argue that the policyholder can never trigger their coverage, no matter when the harm may be found to have occurred and no matter how much in damages may eventually be assessed against the policyholder in the underlying cases. If this were the law, the excess insurers would not have to pay a

Scott P. DeVries is the Managing Partner of Nossaman Guthner Knox & Elliott LLP. Scott works out of the firm’s San Francisco office, where his practice focuses on the representation of corporations in the trial and appeal of complex civil cases, including insurance coverage, environmental insurance coverage, and mass and class action toxic torts. Scott may be reached at (415) 398-3600 or sdevries@nossaman.com.

Carl L. Blumenstein, a partner in the San Francisco office, specializes in complex business litigation. He assists policyholders in enforcing their rights to insurance coverage for environmental, employment and intellectual property claims. Carl may be reached at (415) 398-3600 or cblumenstein@nossaman.com.

Deborah E. Beck, a senior associate in the San Francisco office, has significant experience in environmental litigation matters. She represents policyholders at the trial and appellate court levels in complex insurance cost recovery and bad faith litigation and defends clients against Proposition 65, CERCLA and toxic tort actions. Deborah may be reached at (415) 398-3600 or dbeck@nossaman.com.
single penny on their policies, no matter how the underlying cases were resolved.

The excess insurers’ position is contrary to the law in most jurisdictions. Parties’ rights and obligations under an insurance contract are defined by the terms of the policy and policies rarely, if ever, dictate what language a settlement agreement must contain. The typical excess policy provides that excess coverage is triggered when the primary insurer (1) “has admitted liability” or (2) “has paid” its policy limits or (3) “has been held liable to pay” them. Significantly, courts have held that actual payment of the full policy limits is not required, as courts can deem a payment made in settlement an admission of liability or a payment of policy limits.

II. GUIDING PRINCIPLES

In this section, we identify the principles that guide our analysis. In Part A, we review what should be an uncontested principle: an insurer’s obligation to provide coverage is defined by the terms of its own policies and is not affected by language in other insurers’ policies.

In Part B, we review what also should be uncontested: that a primary insurer’s tender of its policy limits on a pending underlying matter, with the policyholder’s consent, will terminate the insurer’s obligations.

In Part C, we explain why the terms of the excess policy determine when that policy is triggered.

A. Because Each Insurer Enters into a Separate Contract with Its Policyholder, Each Must Provide Coverage According to the Terms of Its Own Policy

It is a fundamental principle of insurance law that the nature and scope of an insurer’s coverage obligations, and of the policyholder’s rights and duties, are governed by the terms of the insurance policy. “Contractual terms of insurance coverage are honored whenever possible.” (Olympic Ins. Co. v. Employers Surplus Lines Ins. Co., 126 Cal. App. 3d 593, 599 (1981)) As the California Supreme Court has stated, “We may not rewrite what they themselves wrote.” (Aerojet-General Corp. v. Transport Indem. Co., 17 Cal. 4th 38, 75 (1997))

It follows that each insurer’s rights and obligations are governed by the policy of insurance that that particular insurer issued. Unless the policy
explicitly states otherwise, the contractual relationship between the policyholder and a particular insurer is not affected by language in policies issued by other insurers. “[E]ach insurer’s defense and indemnification liabilities, if any, are several and depend on the terms and conditions of the policy of each, neither being liable for the policy obligations owed by the other.” (Hartford Acc. & Indem. Co. v. Superior Court, 29 Cal. App. 4th 435, 441 (1994))

The bedrock principle is clear—each liability policy is a contract between the policyholder and the issuing insurer only. The terms and conditions of one insurer’s policy do not control the contractual relationships between the policyholder and its other insurers. Where an excess insurer argues that a policyholder’s settlement with a primary insurer precludes excess coverage, this principle applies in at least two ways:

1. Since each insurance policy is a contract between the policyholder and the issuing insurer only, those parties are fully within their rights to modify or terminate their contractual relationship as they see fit. A policyholder can consent to a primary insurer’s termination of its coverage obligations and is fully within its rights when it agrees to a buyback settlement with one or more of its insurers. Buyback settlements neither increase nor decrease the remaining excess insurers’ indemnity obligations to the policyholder, which are governed by the terms of their excess policies.

2. Because an insurer’s obligations are governed by the language of that insurer’s policy, the court should focus on the language of each policy—not on the underlying primary policies or on other excess policies—to determine each insurer’s rights and obligations.

B. A Primary Insurer’s Tender of Its Policy Limits on a Pending Underlying Matter, with the Policyholder’s Consent, will Terminate the Insurer’s Obligations

No one disputes that once a primary insurer’s liability policy has been “exhausted,” that insurer no longer has a duty to defend under that policy. (Community Redevelopment Agency v. Aetna Cas. & Sur. Co., 50 Cal. App. 4th 329, 340 (1996)) The issue is whether a primary insurer can terminate
its obligation on a pending claim by tendering its policy limits. The answer depends on whether the policyholder has agreed.

As California law makes clear, when a primary insurer pays its policy limits, with the consent of the policyholder, toward settlement of an underlying claim, the payment exhausts the primary policy. (Johnson v. Continental Ins. Cos., 202 Cal. App. 3d 477 (1988)) In Johnson, individuals injured in an accident made claims against the policyholder, the policyholder demanded that the insurer tender its policy limits to settle them, and the insurer did so. In a later products liability action arising from the same accident, the policyholder was sued on two cross-complaints, which she tendered to the same insurer. The appellate court held that the insurer had no obligation to defend because its policy limits had been exhausted, at the policyholder’s request, by the earlier settlement payment. Id. at 486. The court contrasted the case before it with one where a primary insurer seeks to tender its policy limits without the consent of the insured in order to “walk away from its duty to defend its insured.” (Id.)

Johnson is consistent with decisions in other jurisdictions. “[T]he opinions have uniformly recognized the avoidance of the duty [to defend] is dependent upon whether a judgment or settlement has been reached with the injured party or the permission of the insured has been obtained to forego the duty to defend.”¹ (Viking Ins. Co. v. Hill, 787 P. 2d 1385, 1389–1390 (Wash. Ct. App. 1990) (citing cases); see also M.H. Detrick Co. v. Century Ind. Co., 701 N. E. 2d 156 (Ill. App. 1998))

The rule that emerges from these authorities is clear: When the policyholder consents to a primary insurer’s tender of its policy limits on a pending underlying claim, the insurer’s duties under that primary policy are extinguished. That rule is fully consistent with the principle that since an insurance policy creates a contract between the policyholder and the issuing insurer only, the policyholder can agree to terminate the insurer’s obligations.

C. The Terms of the Excess Policies Determine When and How Those Policies are Triggered

Excess insurers contend that a primary policy can be exhausted by settlement only if the settlement agreement allocates the settlement proceeds

¹ Unless otherwise noted, all emphasis in quotations has been added.
to specific policy periods and between defense and indemnity. But the duty of each excess insurer is controlled by the terms of its own policy and the typical excess policy says no such thing.

What the excess policies generally provide is indemnity for “all sums” the insured becomes “legally obligated to pay”—but not until that sum exceeds the attachment point of the excess policy, and only after the underlying insurers “have paid” or “have been held liable to pay” or “have admitted liability” for the full amount of the underlying limits. As we will explain in the next section, exhaustion can be established by a judicial declaration that any one of these three conditions has been satisfied.

The quoted policy language makes plain that an excess insurer’s obligation to provide indemnity coverage is not affected by the policyholder’s settlements with one or more of its primary insurers. For that reason, it should be of no concern to the excess insurer whether the policyholder settles with its primary insurers for the entire underlying limits, for some portion of the limits, or only for one dollar because the excess policy does not attach until after covered losses exceed the underlying limits. If the policyholder chooses to settle with its primary insurers for one dollar, the unpaid primary limits would come out of the policyholder’s coffers, not from the excess insurers.

### III. THE COURT HAS THE AUTHORITY TO DECLARE THAT PRIMARY INSURERS “HAVE ADMITTED LIABILITY” OR “HAVE PAID” OR “HAVE BEEN HELD LIABLE TO PAY” THE UNDERLYING LIMITS, THUS TRIGGERING THE EXCESS POLICIES

Insurers argue that the court lacks authority to make the factual determinations needed to trigger a policyholder’s excess coverage—specifically, that a court would never be able to determine whether the settling primary insurers “have admitted liability for” or “have paid” or “have been held liable to pay” their policy limits, particularly where the settlement agreements are silent on the point and the settled insurers are out of the case. In no published decision has a court so narrowly circumscribed its ability to determine whether underlying coverage has been exhausted.
This argument ignores the difference between interpreting a settlement agreement to resolve a dispute between the parties to it and simply determining, as a factual matter, how an agreement affects third parties. The court can make factual determinations about the effect of a settlement agreement on the continuing dispute between the policyholder and its excess insurers. It has the authority to determine whether the settlements exhausted the settled policies, triggering the excess policies by their express terms. It can make those factual determinations notwithstanding the dismissals of the settled insurers because they are not indispensable or even necessary parties.

A. There Are Two Ways of Construing an Excess Policy’s “Attachment of Liability” Provision and the Policyholder Can Show Exhaustion of Primary Limits Under Both Interpretations

Many excess policies contain an “Attachment of Liability” provision that describes how and when the policies are triggered. While the wording can vary from policy to policy, the following language is representative:

[L]iability to pay under this insurance shall not attach unless and until the Primary and Underlying Excess Insurers shall have admitted liability for the Primary and Underlying Excess Limits or unless and until the policyholder has by final judgment been adjudged to pay an amount which exceeds such Primary and Underlying Excess Limits and then only after the Primary and Underlying Excess Insurers have paid or have been held liable to pay the full amount of the Primary and Underlying Excess Limits.

The intertwined disjunctive and conjunctive clauses of this sentence make it reasonably susceptible of two interpretations. We set out both interpretations below, with spacing and paragraph numbers inserted to illustrate the disjunctive and conjunctive prongs. As we will explain below, under the first construction the policyholder needs to show two things to trigger its excess coverage: first, that its liability exceeds the primary limits or that its primary insurers have admitted liability to pay them and second, that the primary insurers have paid or have been held liable to pay those limits. By contrast, to trigger excess coverage under the second construction the policyholder needs to show either that its primary insurers...
have admitted liability to pay their policy limits or that they have paid or have been held liable to pay them.

1. First Construction of the “Attachment of Liability” Provision

[A] Liability to pay under this insurance shall not attach

[1] unless and until the Primary and Underlying Excess Insurers shall have admitted liability for the Primary and Underlying Excess Limits

or

[2] unless and until [the policyholder] has by final judgment been adjudged to pay an amount which exceeds such Primary and Underlying Excess Limits

and then only after

[B] the Primary and Underlying Excess Insurers

[1] have paid

or

[2] have been held liable to pay

the full amount of the Primary and Underlying Excess Limits.

This construction requires the satisfaction of either [A1] or [A2] and either [B1] or [B2]. Because insurers rarely dispute that the requirement of [A2] will one day be met, the only issue is whether either [B1] or [B2] has been or can ever be satisfied.

2. Second Construction of the “Attachment of Liability” Provision

Liability to pay under this insurance shall not attach

[A] unless and until the Primary and Underlying Excess Insurers shall have admitted liability for the Primary and Underlying Excess Limits

or

[B] unless and until [the policyholder] has by final judgment been adjudged to pay an amount which exceeds such Primary and
Underlying Excess Limits and then only after the Primary and Underlying Excess Insurers have paid

or

[2] have been held liable to pay the full amount of the Primary and Underlying Excess Limits.

This construction can be satisfied by [A] alone or by either disjunctive in [B].

Either of the two constructions is a reasonable interpretation of this convoluted policy provision. Where a policy term is reasonably susceptible to two interpretations, a court must construe the policy provision against the insurer that drafted it and as a reasonable policyholder would understand it. (*AIU Ins. Co. v. Superior Court*, 51 Cal. 3d 807, 822 (1990)) If the policyholder satisfies either one, its excess coverage will be triggered.

**B. The Trial Court Has Authority to Issue the Declarations That the Policyholder Needs to Trigger Its Excess Policies**

Implicit in any coverage complaint are requests for judicial declarations that settled insurers “have paid” or “have been held liable to pay” or “have admitted liability” to pay their respective policy limits. These are factual determinations that the court has the authority to make whether or not the settled insurers are parties.

It is settled that a court is not precluded from acting simply because every person with some interest in the matter is not present. (C.C.P. § 389; *McKeon v. Hastings College*, 185 Cal. App. 3d 877, 889–890 (1986)) As the California Supreme Court explained nearly a century ago, a court can proceed if a decision can be made without prejudicing an absent person:

According to the general rule, all persons interested in a suit ought to be parties to it, but one of the exceptions to this rule is that where a decree with reference to the subject matter of the litigation may be made without concluding in any way the rights of a person having an interest, such person is not a necessary party to the action. (*Reed v. Wing*, 168 Cal. 706, 708 (1914))
Numerous cases arising in a variety of contexts illustrate this basic legal principle.

The McKeon court explained that unless prejudice will result, the failure to join a party will not disable a trial court from acting. Thus, the failure to join all persons displaced by a law school’s acquisition of residential property was not in error where, among other things, “Hastings’ professed willingness to give all benefits ... to the former tenants” ensured that their “rights to such would not be impaired. ...” (McKeon, 185 Cal. App. 3d at 889) “[T]he absent tenants may be deemed proper or even necessary parties, but they are not indispensable. Their absence did not disable the trial court from acting.” (Id. at 889–890) Indeed, the McKeon court went even further, explaining that “the failure to join an ‘indispensable party’ is not a jurisdictional defect in the fundamental sense; even in the absence of an ‘indispensable party, the court still has the power to render a decision as to the parties before it which will stand.’” (Id. (citations omitted))

The court reached the same conclusion in Lushing v. Riviera Estates Ass’n, 196 Cal. App. 2d 687 (1961), where a landowner wanting to construct a building on his property sought a declaration that a deed restriction was invalid. The court held it was valid, rejecting the defendant’s contention that other lot owners—none of whom had been joined as defendants—were indispensable or conditionally necessary parties. Explaining that “[t]he judgment protects, rather than impairs, the rights of all the owners,” the court held that other owners “would not be necessary parties unless their rights would be prejudiced.” (Id. at 691) “If the court can determine a controversy between parties before it without prejudice to the rights of others or by saving their rights, it may do so.” (Id. at 690; see also Jones v. Feichmeir, 95 Cal. App. 2d 341, 344–345 (1949) (applying rule in context of sublease agreement); Wollenberg v. Tonningsen, 8 Cal. App. 2d 722 (1935) (trust agreement))

The rule is no different when the contract at issue involves insurance. In Home Indem. Co. v. Mission Ins. Co., 251 Cal. App. 2d 942 (1967), a second-level excess insurer disputed its obligation to contribute to the settlement of an accident claim, arguing that the primary insurer, which had paid only $9,000 of its $10,000 policy limits, had not exhausted its policy and could not be “held liable” to pay its limits because it had been
dismissed from the case. Emphasizing the absence of prejudice, (id. at 966), the court soundly rejected that contention:

Mission suggests that the dismissal of this action as to . . . [the primary] . . . precluded any binding adjudication against [it]. This confuses the issue. Plaintiffs originally sought a binding adjudication against all persons concerned. For reasons best known to themselves, some of the parties compromised rather than await the final adjudication of this court. The compromise does not preclude a determination of the rights and obligations of the dismissed parties insofar as those rights and obligations are material to the matters remaining at issue. (Id. at 966)

Reversing the trial court and finding that the primary insurer would have been liable to pay the full amounts of its policy limits had it remained in the case, the court held that Mission had to contribute to the settlement once the attachment point of its policy was reached:

The approach adopted by the trial court and now advocated by Mission fails to consider that the respective rights and obligations of the parties became fixed at the time of the accident. The present case was commenced to determine those rights. The court in this action has the power to determine whether Tower should be “held liable” to pay the full amount of its liability. The fact that Tower elected to compromise that issue with Home does not change the fact that it either was or was not so liable at the time of the accident. Nor does it preclude plaintiffs from adjudicating that issue with Mission, unless Mission has been prejudiced because of the subsequent settlement. (Id. at 965–966)

Policyholders seek the same thing—a factual determination that the settled insurers were liable to pay or paid or admitted liability to pay their policy limits. Courts have the authority to act because the determinations these policyholders seek will in no way compromise the rights of any absent insurers.

Nor will the relief sought prejudice any excess insurer because (1) they presumably were long aware of the policyholder’s position and (2) their policies will not be triggered any sooner or at lower levels than they contracted for.

Nor will the rights of the settled insurers be compromised since, as in the cases described above, the court’s declarations will not affect them. Their settlement agreements typically contain hold harmless clauses vis-à-vis the policyholder that ensure they will not have to pay additional amounts.
1. **Policyholders Should be Able to Trigger Their Excess Coverage Under the First Construction of the Attachment of Liability Provision**

   a) Policyholders will eventually be able to show that they have been adjudged to pay an amount exceeding the primary and underlying excess limits.

   There is generally no dispute that a policyholder will be able to satisfy the disjunctive clause requiring a showing that it “has by final judgment been adjudged to pay an amount which exceeds such Primary and Underlying Excess Limits” ([A2] under the first construction and [B] under the alternative construction) because that depends entirely on the outcome of the underlying cases.

   That being so, all the policyholder must do to trigger its excess coverage under the first construction is to satisfy either ([B1] that the underlying insurers “have paid” their policy limits) or [B2] (that they “have been held liable to pay” those limits).

   b) The court or the jury can declare that the settled insurers “have paid” their policy limits—a declaration that will satisfy the [B1] conjunctive.

   The court has the authority to declare that the settled insurers “have paid” their policy limits for two reasons: first, because an underlying policy can be “exhausted” without actual collection of the full policy limits, and secondly, because even if an allocation among various policies and policy periods were necessary, that is a question of fact to be determined from all of the evidence.

   (1) “Payment” of policy limits is broader than payment in cash.

   A long line of authority supports the view that a primary insurer that settles has, by the fact of its settlement, constructively “paid” its policy limits. In the seminal case of Zeig v. Massachusetts Bonding Ins. Co., 23 F.2d 665 (2nd Cir. 1928), the court held that because “payment” of policy limits
is broader than payment in cash, an underlying policy can be “exhausted” without actual collection of the full policy 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. (Zeig, 23 F.2d at 666)

To hold otherwise would, as the Zeig court explained, frustrate the policy of encouraging settlements:

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.)

Reasoning that an excess insurer has “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,” id., the Zeig court held that the policyholder “should have been allowed to prove the amount of his loss, and, if that loss was greater than the amount of the expressed limits of the primary insurance, he was entitled to recover the excess to the extent of the policy in suit.” (Id.; see also Grace v. Ins. Co. of North Am., 944 P. 2d 460 (Alaska 1997); Stargatt v. Fidelity & Cas. Co., 67 F.R.D. 689, 691 (D. Del. 1975), aff’d, 578 F.2d 1375 (3d Cir. 1978) (Stargatt)

California follows the rule articulated by Zeig. In Phoenix Ins. Co. v. United States Fire Ins. Co., 189 Cal. App. 3d 1511, 1529 (1987) (Phoenix), an excess carrier argued that it could not be held liable for a share of the settlement of the underlying malpractice case because the primary insurers—who had been dismissed after paying what the trial court determined to be their respective shares—had paid less than the full amounts of their policy limits. The Court of Appeal rejected that argument:

In effect, the primary coverage was “exhausted” when [the absent primary insurers] paid their share of the settlement and were dismissed from the declaratory
A POLICYHOLDER’S SETTLEMENT WITH SOME INSURERS

relief action. (Id. at 1529; see also Home Ins. Co. v. Mission Ins. Co., 251 Cal. App. 2d 942, 965-967 (1967) (Home))

In the situation addressed by this article, the policyholder seeks a declaration that the settled insurers have paid their policy limits. Here, as in Zeig, the excess insurers would have “no rational interest” in whether the policyholder actually collected the full amount of the primary policies, because the excess policies will not be triggered any sooner or at a lower level than the excess insurers contracted for.

(2) At a minimum, the trier of fact should look to all of the evidence, as Phoenix requires.

At a minimum, the allocation of settlement monies among various policies and policy periods is a question of fact to be determined not only from the settlement agreement but from all of the evidence.

In Phoenix, an insurer that funded most of a malpractice settlement brought a declaratory relief action to determine other insurers’ contributions. Since the settlement agreement in that case was silent about allocation, id. at 1520, the trial court, acting as a trier of fact, apportioned the payment among the various insurers based on documentary evidence adduced in the underlying cases. Rejecting the excess insurer’s argument that the allocation to various policy periods was “arbitrary, speculative and founded on conjecture” (Id. at 1529), the appellate court affirmed:

While the testimony of [the divorce lawyers] and the client, of course, would have cast a clearer light on the representation provided by the attorneys, the trial court still had evidence of substantial weight and credibility upon which to allocate the indemnification between the carriers. Furthermore, the trial judge clearly had the expertise to study the evidence and apportion the settlement. (Id.)

Phoenix teaches that the trial court is not limited to the terms of the settlement agreements, because the trier of fact can allocate the settling insurers’ payments based on all of the evidence.2 Thus, to the extent that the court could not conclude as a matter of law that the settled insurers

2 The determination would, under EOTT Energy Corp. v. Storebrand Int’l Ins. Co., 45 Cal. App. 4th 565 (1996) have to await the jury’s findings about how
“had paid” their policy limits, it certainly should hold that a question of fact remained—one to be addressed at a later stage in the proceeding.

c) **Trial courts also have authority to declare the settled insurers “liable to pay” their policy limits—a declaration that will satisfy the [B2] conjunctive.**

The trial court has authority to declare the settled insurers liable to pay their policy limits—a finding that would permit the policyholder to satisfy the [B2] conjunctive of the Attachment of Liability provision. This provision does not require that they “pay” their limits—only that they be “held liable to pay.” And where they are neither indispensable nor necessary parties, their absence does not preclude the policyholder from obtaining a determination to this effect to trigger its excess coverage, as the court squarely held in *Home.* (*Home*, 251 Cal. App. 2d at 965–966)

California courts have held that this excess policy language does not require actual payment by the primaries as a precondition to coverage by the excess. (Id.) As the Court of Appeal has stated:

> The language of the policies limiting the liability of [the excess insurers] . . . states that those excess insurers are liable only when the underlying insurer has paid the policy limit or has been held liable to pay the policy limit (whether or not the underlying insurer has actually paid) and that their liability is limited to amounts in excess of the underlying policy limit (whether or not actually paid) up to the limits of the [excess insurers’] policies. (*Denny’s Inc. v. Chicago Ins. Co.*, 234 Cal. App. 3d 1786, 1794 (1991); see also *Vons Cos., Inc. v. U.S. Fire Ins. Co.*, 78 Cal. App. 4th 52 (2000); *Reserve Ins. Co. v. Pisciotta*, 30 Cal. 3d 800, 813 (1982))

Other jurisdictions have applied similar excess policy language to hold underlying coverage exhausted where less than the full underlying limits were paid. The Alaska Supreme Court, for example, has explained:

> INA’s policy required it to pay “all sums . . . for which the insured shall become obligated to pay by reason of liability,” as provided in the [underlying] policy.

> many occurrences caused the alleged damage and which policies those occurrences “triggered.”
These terms do not require that such funds actually be paid before coverage is triggered. Moreover, several cases have held that payment or non-payment of funds owed by a primary insurer is irrelevant to an excess carrier’s duty. . . . INA has cited no authority to the contrary, nor do its policy terms unambiguously indicate that its duty to pay was contingent on actual payment of the underlying limits. (Grace, 944 P. 2d at 467 (citations omitted))

In Stargatt, where an excess insurer settled by paying $135,000 of its $250,000 policy limits, the court likewise rejected the argument that payment less than policy limits precludes exhaustion of a policy. (Stargatt, 67 F.R.D. at 690–691)

When excess insurers want to require actual payment of underlying policy limits as a precondition to coverage, they know how to draft policy language to accomplish that result. The excess policy at issue in U.S. Fire Ins. Co. v. Lay, 577 F.2d 421, 423 (7th Cir. 1978), for example, expressly stated that “[l]iability of the company . . . shall not attach unless and until the insured, the company in behalf of the insured, or the insured’s underlying insurer, has paid the amount of the retained limit.” The court enforced the provision, holding that the excess insurer had no indemnity obligation where the retained limit had not been paid. (Id. at 423)

The message is plain: If excess insurers want to require actual payment before their coverage attaches, they must draft language to make that explicit. But as a general rule, insurers have not included such a provision in their policies. And in the absence of such language, courts have uniformly concluded that actual payment of the underlying limits is not required. Insurers have no basis for insisting on full payment of the underlying policy limits as a precondition to their duty to indemnify.

The following scenario illustrates the point: Assume that the jury in a coverage action renders a $50 million verdict in the policyholder’s favor. Assume further that the entire amount is allocated to the 1967 policy period. In that scenario, the primary insurer for that period would be “held liable” to pay its property damage per occurrence/aggregate limit. Where the insurer had settled out, it wouldn’t actually pay. But it would nonetheless “have been held liable to pay.” A declaration to that effect would be a predicate to obtaining a declaration that the excess insurers must indemnify the policyholder if and when the attachment levels of their policies are reached.
Courts routinely make factual determinations about persons who, because they have settled, are no longer parties to ongoing cases. The court effectively declared two settling insurers “liable” in *Phoenix*, for example, when it allocated $480,000 of a $1.8 million settlement to them after they had paid that amount and were dismissed from the case. (*Phoenix*, 189 Cal. App. 3d at 1522; see also *Home*, 251 Cal. App. 2d 942 (1967)).

Moreover, the excess insurer that was held liable for the difference could not be heard to complain:

Had USFIC wanted to raise this issue, it could simply have named Olympic and Central as defendants in its cross-complaint, thereby assuring that all the parties were before the court when the reapportionment was determined. (*Phoenix*, 189 Cal. App. 3d at 1529–1530)

Similar determinations are made when courts apportion liability to joint tortfeasors who settled before trial. In *Roslan v. Permea, Inc.*, 17 Cal. App. 4th 110, 113 (1993), an action for personal injuries caused by a defective shipping carton, the court reduced the damages awarded by the plaintiff’s 30% comparative fault but made no adjustment for the comparative fault of two codefendants who had settled before trial. The appellate court reversed, holding that the trial court erred in failing to apportion liability for non-economic damages among the entire universe of tortfeasors—including those who had settled—and the case was remanded for the jury to make the necessary factual determinations.

Settled insurers are not indispensable or even necessary parties. As a result, the trial court has the authority to declare them “liable to pay” their policy limits.

### 2. A Policyholder Can Also Trigger Its Excess Coverage Under the Second Construction of the Attachment of Liability Provision

The policyholder can trigger its excess coverage under the second construction by establishing either of the predicates addressed above or by establishing that the primary insurers “have admitted liability” to pay their limits. If it establishes the latter, it need do *nothing more* to trigger its excess coverage.

A policyholder’s experts will testify that it is the custom and practice of the insurance industry to regard settlement by a primary or underlying
Excess insurer as an admission of liability that triggers the next layer of coverage. The fact that the settlement agreement contains a boilerplate disclaimer provision stating that the agreement compromises disputed claims and does not admit liability does not change this result. Insurers typically will not deny the accuracy of this expert testimony, nor will they offer contrary evidence or controverting authority. Instead, they argue that the court should exclude the testimony because it lacks foundation or violates the parol evidence rule.

**a) A proper foundation for expert testimony about insurance industry custom and practice can be laid.**

The law is well-settled that “[t]he opinion of an expert is admissible when based upon his special knowledge and upon matter perceived by him or made known to him at the hearing that is of a type that reasonably may be relied upon by an expert in forming an opinion.” (People v. Sundlee, 70 Cal. App. 3d 477, 484 (1977) (citation omitted); Evid. C. § 801) Special knowledge about industry custom and practice can be established by detailing years of experience managing claims, testifying as an expert witness on insurance-related issues, reviewing the relevant policy language and the language of the settlement agreements, and providing opinions about industry practices and procedures. Such opinions are not based “on assumed and/or conjectural data,” as insurers contend, but rather upon facts specific to the case, viewed in the light of the expert’s specialized knowledge and expertise in the insurance industry.

**b) Expert testimony about insurance industry custom and practice does not violate the parol evidence rule because evidence of custom and usage is always admissible—even where the contract language appears unambiguous on its face.**

As Witkin explains, “[a]ble critics have attacked the ‘plain meaning’ rule as unsound, for (a) words have no such absolute meaning, but must always derive their sense from the objects to which they refer, and (b) words which have a ‘plain’ ordinary meaning are sometimes used by
the parties in a special, technical or local sense.” (2 B.E. Witkin, *California Evidence*, Documentary Evidence § 79 (4th ed. 2000))

In *Ermolieff v. RKO Radio Pictures, Inc.*, 19 Cal. 2d 543 (1942), the California Supreme Court held that extrinsic evidence should have been admitted to show that the apparently unambiguous term “United Kingdom” in a motion picture distribution contract included Ireland notwithstanding a judicially-noticed stipulation of the parties “that Eire is independent of the United Kingdom and not a part thereof.” (Id. at 549–552) As *Ermolieff* explains, “[p]arol evidence is admissible to establish the trade usage, and that is true even though the words are in their ordinary or legal meaning entirely unambiguous, inasmuch as by reason of the usage the words are used by the parties in a different sense.” (Id at 550)

The basis of this rule is that to accomplish a purpose of paramount importance in interpretation of documents, namely, to ascertain the true intent of the parties, it may well be said that the usage evidence does not alter the contract of the parties, but on the contrary gives the effect to the words there used as intended by the parties. The usage becomes part of the contract in aid of its correct interpretation. (Id.)

As *Body-Steffner Co. v. Flotill Products, Inc.*, 63 Cal. App. 2d 555, 558 (1944), explains, “It is a rule of practically universal acceptation... that however clear and unambiguous the words of a particular contract may appear on its face, it is always open to the parties to the contract to prove that by the general and accepted usage of the trade or business in which both parties are engaged and to which the contract applies the words have acquired a meaning different from their ordinary and popular sense.”3 Thus, “such an apparently clear expression as ‘one thousand’ may be shown by a trade usage to mean more than the number one thousand... or less than that number... or to be estimated in an arbitrary manner without regard to actual number... , and the word ‘white’ may, by similar usage, be shown to include its antithesis black.” (Id. ((citations omitted))

The rule is no different in the insurance context. See, e.g., *Beneficial Fire & Cas. Ins. Co. v. Hitke & Co.*, 46 Cal. 2d 517 (1956) (parol evidence

3 The rule is not limited to situations where both parties are in the same business. While a special usage cannot bind one ignorant of it, *Latta v. Da Roza*, 100 Cal. App. 606, 608 (1929), “[it] is presumed to be known by and binding upon those who are engaged in that particular trade or calling.” (Id.)
should have been admitted to show custom and practice in insurance industry that “earned commissions” are never returnable).

Policyholders can proffer expert testimony along the lines of the following to establish insurance industry custom and practice:

[A]s a practical matter, excess insurers and the industry generally treat a primary insurer’s buyback as an “admission of liability,” notwithstanding the fact that settlement documentation may contain boilerplate language of the kind found in virtually all settlements in virtually all contexts, stating that the insurer does not admit liability. Such settlement language is not deemed to be material by the industry for purposes of determining whether an excess insurer must provide coverage. . . .

Expert testimony regarding general custom and practice is properly admitted. (Campbell v. Fong Wan, 60 Cal. App. 2d 553, 557 (1943)) In the situation presented here, expert evidence will establish that a policyholder’s buyback of an insurance policy is treated by the industry as an “admission of liability” notwithstanding boilerplate language of the kind found in virtually all settlements that the insurer does not admit liability. Where insurers offer no contrary evidence of industry custom and do not claim their own practices differ from the general industry practice, it must be presumed that they follow the general practice. (Watson Land Co. v. Rio Grande Oil Co., 61 Cal. App. 2d 269, 272 (1943)) At a minimum, this presents a question of fact precluding summary adjudication.

c) Thomas Drayage provides an independent basis for the admission of expert testimony about industry custom and practice.

As Witkin explains, “the modern tendency is to hold that evidence is admissible to show the meaning of words used even though no ambiguity is asserted. (2 B. E. Witkin, California Evidence, Documentary Evidence § 79 (Fourth ed. 2000)) Insurers ignore the “modern tendency,” arguing that the expert declaration should be ignored because the settlement agreements contain “unambiguous” boilerplate language of the kind found in virtually all settlement agreements in virtually all contexts, stating that the settling party does not admit liability.
But as the California Supreme Court squarely held in *Pacific Gas & Elec. v. G.W. Thomas Drayage & Rigging Co.*, 69 Cal. 2d 33 (1968), extrinsic evidence must always be considered by a court that is faced with conflicting contentions about what contract language means, so that the court may fairly determine whether that language is ambiguous. Explaining that “[a]lthough extrinsic evidence is not admissible to add to, detract from, or vary the terms of a written contract, these terms must first be determined before it can be decided whether or not extrinsic evidence is being offered for a prohibited purpose” (Id. at 39), the *Thomas Drayage* court emphasized that “the fact that the terms of an instrument appear clear to a judge does not preclude the possibility that the parties chose the language of the instrument to express different terms.” (Id.) “That possibility is not limited to contracts whose terms have acquired a particular meaning by trade usage, but exists whenever the parties’ understanding of the words used may have differed from the judge’s understanding.” (Id.)

**IV. CONCLUSION**

As “buyback” settlements become more common, it becomes increasingly important for policyholders to understand how to preserve their rights to coverage from the non-settling insurers. The arguments that excess insurers typically advance are contrary to the law in most jurisdictions. As an initial matter, the parties’ rights and obligations are defined by the terms of their policies, which rarely, if ever, dictate what language a settlement agreement must contain. Actual payment of full policy limits is not required, and courts can issue factual declarations that will bolster the policyholder’s ability to trigger its excess policies.

In this way, the policyholder obtains the coverage it contracted for and the insurer is held to the obligations it agreed to undertake. No prejudice results. The court’s declarations will not affect the settled insurers, whose settlement agreements typically contain hold harmless clauses *vis-à-vis* the policyholder, and the excess policies will not be triggered any sooner or at lower levels than the levels that the excess insurers contracted for.