

## PLRB/LIRB 2009 Claims Conference

### Umbrella Policies: The Duty to Drop Down

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As a general rule, an excess insurer has a duty to indemnify an insured for any losses beyond the policy limits of the primary insurance. Taking a straightforward example, an insured has two policies: a primary CGL policy with a \$1 million limit and an excess policy with a \$2 million limit. If the policyholder injured a third party and a judgment was entered against the insured in the amount of \$1.5 million, the primary policy would exhaust its \$1 million limit and then the excess insurer would pay indemnity for another \$500,000.

If only it were that simple all the time.

#### **I. Overview of Umbrella/Excess Liability Policies**

Umbrella excess liability insurance policies are intended to “ ‘pick[ ] up, above the limits of all other contracts, such as automobile and homeowners coverages, to give the security and peace of mind so necessary today where jury verdicts, or court awards, may be very substantial, to discharge the unexpected, but potentially bankrupting, judgment.’ ” *Illinois Emasco Ins. Co. v. Continental Cas. Co.*, 487 N.E.2d 110 (Ill.App. 1985) quoting 8A Appleman, *Insurance Law and Practice*, § 4906, at 348, § 4909.85, at 452 (1981). Umbrella excess liability policies are more than excess coverage because they are intended to provide comprehensive coverage to the insured. *See Travelers Indem. Co. v. American Cas. Co. of Reading, PA*, 786 N.E.2d 582 (Ill.App. 2003).

#### **A. Different purpose and risks**

Both excess and umbrella liability policies are purchased by insureds for coverage in addition to any primary policy. Excess policies typically insure for the same risks as an underlying primary policy and provide coverage if and when the limits of the primary policy are exhausted. An excess policy is a policy “designed to protect against catastrophic loss and intended to ‘kick-in’ only at large dollar-amounts of liability.” *Archunde v. International Surplus Lines Ins. Co.*, 905 P.2d 1128, 1129 (N.M.App. 1995) quoting, Lisa K. Gregory, *Annotation, Excess or Umbrella Insurance Policy as Providing Coverage for Accidents With Uninsured or Underinsured Motorists.*, 2 A.L.R.5<sup>th</sup> 922, 932 n. 1 (1992).

In contrast, an umbrella policy may insure for different or additional risks than the primary policy, in addition to being triggered upon the exhaustion of the underlying primary policy. An umbrella policy acts as both an excess policy and as a primary policy for specified gaps in coverage in the insured's primary coverage. "Umbrella policies are different from simple excess policies because they are intended to fill gaps in coverage, both vertically (by providing excess coverage) and horizontally (by providing additional primary coverage)." *Dolly v. Old Republic Ins. Co.*, 200 F.Supp.2d 823, 840 (N.D. Ohio 2002). In other words, "[t]he vertical coverage provides additional coverage above the limits of the insured's underlying primary insurance, whereas the horizontal coverage is said to 'drop down' to provide primary coverage for situations where the underlying insurance provides no coverage at all." *American Special Risk Ins. Co. v. A-Best Products, Inc.*, 975 F.Supp. 1019, 1022 (N.D. Ohio 1997).

## **B. Types of Umbrella Liability Policies**

An example of an umbrella policy with features of excess and primary coverage can be found in *Sainsbury v. Hartford Acc. & Indem. Co.*, 469 F.2d 392 (6<sup>th</sup> Cir. 1972), in which the policy read as follows:

"III. UNDERLYING LIMIT - RETAINED LIMIT: The Company shall be liable only for ultimate net loss resulting from any one occurrence in excess of either

(A) The amounts of the applicable limits of liability of the underlying insurance as stated in Item 5 of the Declarations [\$300,000] . . . , or

(B) If the insurance afforded by underlying insurance is inapplicable to the occurrence, the amount stated in the Declarations as the retained limit [\$10,000] . . .

The court held that an exclusion in the underlying insurance made such insurance "inapplicable" under the above Insurance Agreement III(B), and since it was "inapplicable," the language of the umbrella policy required that the umbrella coverage be excess of the retained limit of \$10,000. *Id.* at 396.

## **C. Types of Excess Liability Policies**

### **1. Follow form**

Requiring an excess insurer's coverage to "drop down" would effectively make it a party to the prior layer's contract. This is not what an excess insurer agrees to, even when it uses a "follow form" policy. When an excess policy is known as a "follow form" policy, it means that "its terms, conditions, and exclusions were the same as those in the primary policy." *Allmerica Financial Corp. v. Certain Underwriters at Lloyd's, London*, 871 N.E.2d 418, 420 (Mass. 2007). In *Allmerica*, the follow form policy stated that it "is

subject to the same conditions, limitations and other terms ... as are contained in or may be added to the Policy(ies) of the Primary Insurer(s).” *Id.* The court noted that “[u]se of a follow form clause is advantageous in crafting . . . an insurance program (involving a primary policy and one or more excess policies) because it makes an excess policy a carbon copy of the primary policy, with the only differences being the names of the parties and the coverage limitations. Follow form language thus allows an insured to have coverage for the same set of potential losses (and with the same set of exceptions) in each layer of the insurance program.” *Id.*

The excess insurer is usually careful about making clear that the “follow form” wording carves out key excess terms such as limits of liability, additional conditions, premium, etc. *See e.g. Playtex, Inc. v. Columbia Cas. Co.*, 622 A.2d 1074 (Del.Super. 1992), where the policy of second layer excess insurer stated:

IT IS AGREED THAT THE TERMS AND CONDITIONS OF THIS [EXCESS] POLICY, **EXCEPT WITH REGARD TO LIMITS AND PREMIUM ARE CANCELLED AND SUPERCEDED BY THE TERMS AND CONDITIONS OF UNDERLYING MISSION [EXCESS] INSURANCE COMPANY POLICY NO. MN037126,**

*Id.* (emphasis added), and where the policy of third layer excess insurer stated:

POLICY FOLLOWS THE EXACT TERMS AND CONDITIONS AS THE IMMEDIATE UNDERLYING POLICY AS ON FILE WITH INTERNATIONAL INSURANCE COMPANY (**EXCEPT FOR THE LIMIT OF LIABILITY, THE ADDITIONAL CONDITIONS STATED IN THIS ENDORSEMENT, AND THE PREMIUM**) . . . .

*Id.* (emphasis added). In the *Playtex* case, the first layer excess insurer became insolvent and the insured demanded that the subsequent layers of excess coverage drop down into the layer of the insolvent excess insurer.

## 2. Pure or true excess insurance

One court listed the reasons why a policy constituted a true excess or umbrella policy, as opposed to a primary policy: (1) the policy is denominated on its face to be an “Umbrella Liability Policy”; (2) the policy lists a “Schedule of Underlying Insurance”; (3) the policy provides for liability for “the ultimate net loss in excess of the applicable limits of underlying insurance as stated in Item 5 of the Declarations, and any other insurance collectible by the insured”; (4) the Other Insurance clause states that “[t]he insurance afforded under this policy shall apply as excess insurance, not contributory, to other collectible insurance ... available to the insured and covering loss against which insurance is afforded hereunder”; and (5) the policy requires that the insured “maintain the underlying policies (and renewals or replacements thereof) with limits of liability as stated in Schedule A in full effect during this policy period, .... [and] [f]ailure of the Named Insured to comply with the foregoing shall not invalidate this policy but in the

event of such failure, GNIC shall be liable only to the extent that it would have been liable had the Named Insured complied therewith.” *Washington Ins. Guar. Association v. Guar. National Ins. Co.*, 685 F.Supp. 1160, 1162-1163 (W.D.Wash. 1988). Such a policy is not a policy having an Other Insurance clause that declares conditions under which the stated coverage will be excess rather than primary, and the entire policy is one in which the coverage is described as being in excess of other coverage. *Id.*

#### **D. In Relation to Primary Liability Policies**

Excess insurance policies are separate and distinct contracts from the primary liability policy. *Allmerica Financial Corp. v. Certain Underwriters at Lloyd’s, London*, 871 N.E.2d 418, 426 (Mass. 2007). An insurance program involving a primary policy and one or more excess policies divides risk into distinct units and insures each unit individually. *Id.* “The individual insurers do not (absent a specific provision) act as coinsurers of the entirety of the risk.” *Id.* Rather, each insurer contracts with the insured individually to cover a particular portion of the risk, and the layer of risk each insurer covers is defined and distinct. *Id.*

Premium for an excess policy is comparatively smaller than the premium for a primary policy. By way of example, in *Travelers Indem. Co.*, 786 N.E.2d at 587, the premium for the first \$300,000 of coverage under the Travelers Primary Policy was \$78,820, and the premium for the Travelers Excess Policy, which provided \$10,000,000 of coverage, was \$59,977. “[T]his disparity in premiums is indicative of the reduced risk assumed by the [excess] policy.” *Illinois Emasco Ins. Co.*, 487 N.E.2d at 112.

##### **1. Primary insurance versus self-insurance**

In some instances, the excess policy sits above a self-insured retention, instead of an underlying primary policy. *See Travelers Indem. Co. v. American Cas. Co. of Reading, PA*, 786 N.E.2d 582 (Ill.App. 2003). A self-insured retention (“SIR”) is generally a specific amount of loss that is not covered by any policy but instead must be borne by the insured. *See H. Walter Croskey et al., California Practice Guide: Insurance Litigation at 7:384* (1996). “A SIR endorsement effectively transforms what is labeled a primary policy into an excess policy covering only amounts in excess of the amount of the SIR.” *General Star National Ins. Corp. v. World Oil Co.*, 973 F.Supp. 943, 949 (C.D.Cal. 1997); *see also Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co.*, 275 Kan. 698, 71 P.3d 1097, 1132 (2003) (self-insured retention is the equivalent of underlying or primary insurance).

##### **2. Primary insurance with Other Insurance clause**

An Other Insurance clause in a primary policy attempts to make the insurer excess in coverage if another primary policy provides coverage concurrently. A typical Other Insurance clause states: “If there is other applicable similar insurance we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide with respect to a vehicle

you do not own shall be excess over any other collectible insurance.”

## II. What is the “Drop Down” Issue?

The drop down issue typically arises when there is no insurance coverage at a certain level, whether the level is primary or excess, and an insurer at the next level higher is being asked to drop down into the lower level and fill the gap in coverage. Or the primary limits may be exhausted and the excess insurer is expected to drop down and provide a defense because the primary insurer for whatever reason has withdrawn its defense. Or two insurers are fighting over who is primary and who is excess on a particular claim. The players in the game can be the insured, the insurer being asked to drop down, the insurer who created the gap, an insurer on the periphery impacted by the issue, an additional insured, the claimant and possibly others.

Generally, there is no duty to drop down and defend and indemnify. But it is the exceptions that can worry you.

Excess coverage is not triggered until the primary insurer has paid out its limits. See J. Stephen Barry and Jerry McNally, *Allocation of Insurance Coverage: Prevailing Theories and Practical Applications*, 42 Tort Trial & Ins. Prac. L.J. 999 (2007). However, depending on the insurance language used, excess insurers are often called upon to “drop down” and provide coverage at levels that were supposedly covered by a lower level of insurance. Drop down coverage occurs “when an insurance carrier of a higher level of coverage is obligated to provide the coverage that the carrier of the immediately underlying level of coverage has agreed to provide.” *Fred Weber, Inc. v. Granite State Ins. Co.*, 829 S.W.2d 589, 590 n. 2 (Mo.App.1992).

**Duty to Defend.** Drop down is usually just an indemnity issue but sometimes it comes into play on the duty to defend issue where the umbrella policy language contemplates a defense under certain situations. When the allegations of the claim “leave it in doubt” whether the case alleged is covered by the policy, the refusal of the excess insurer to defend is at its own risk. *United States Fire Ins. Co. v. Aspen Building Corp.*, 367 S.E.2d 478, 480 (Va. 1988). The insurer is liable for breach of its covenant to defend “if it turns out on development of the facts that the case is covered by the policy”; likewise, if the development of the facts fails to prove the case alleged, the excess insurer is not liable for its refusal to defend. *Id.*

**Ambiguity.** Part and parcel of nearly all cases involving drop down is the ambiguity argument. Is the policy language ambiguous such that the court will construe the policy in favor of the insured and require the insurer to drop down. For example, a Louisiana court found that the policy language was ambiguous “insofar as it define[d the excess insurer's] liability for loss in excess of the limits of ‘the underlying insurance listed in Schedule A ..., plus the applicable limits of any other underlying insurance collectible by the insured,’ ” and that such ambiguity was evidenced by the panel's disagreement as to the appropriate interpretation of the policy language. The court consequently employed the rule of construction that ambiguities are to be construed against the insurer to impose

liability on the secondary insurer. *Poirrier v. Cajun Insulation, Inc.*, 501 So.2d 800, 808 (La.Ct.App.1986), writ denied, 502 So.2d 579 (La.1987).

### **III. Different Types of “Drop Down” Scenarios and Resulting Obligations**

#### **A. Insured fails to maintain primary insurance, thereby breaching umbrella/excess policy**

The excess insurer usually wins the drop down battle when the insured fails to maintain the primary insurance in breach of the excess policy. Typically, excess insurance policies will contain a clause requiring an insured to maintain a certain level of primary insurance coverage. In *Benton v. Long Mfg. N.C., Inc.*, 550 So.2d 859, 861 (La.App. 2 Cir. 1989), a maintenance clause stated:

MAINTENANCE OF UNDERLYING INSURANCES. It is a condition of this policy that the underlying insurances as set out in Item 7 of the Declarations shall be maintained in full effect during the currency of this policy except for any reduction of the aggregate limit or limits applicable thereto solely by payment of claims in respect of occurrences occurring during the period of this policy. Failure of the Insured to comply with the foregoing shall not invalidate this policy but in the event of such failure the Company shall only be liable to the same extent as it would have been had the Insured complied.

The *Benton* court held that if an insured allows the primary coverage to lapse, then the excess insurer will not be required to drop down in coverage. *Id.* at 863. Instead, the insured will not have the right to indemnification until the expected underlying policy limits would have been reached. *Id.*

An insured may also find itself in breach of the maintenance clause by failing to renew its primary insurance at adequate insurance levels. See *Reserve Insurance Co. v. Pisciotto*, 30 Cal.3d 800, 640 P.2d 764 (Cal. 1982). If an insured unilaterally causes a gap in its coverage, an excess insurer usually is not required to fill that gap. Rather, the excess insurer’s obligation begins at the contracted-for level and the insured will be uninsured for the so-called gap. *Id.* at 813.

#### **B. Limits of primary insurance have been exhausted**

Drop down should not be at issue because under the general rule excess coverage is triggered “only after a predetermined amount of primary coverage has been exhausted.” *Dolly v. Old Republic Ins. Co.*, 200 F.Supp. 2d 823 (N.D. Ohio 2002) quoting *Continental Marble & Granite v. Canal Ins. Co.*, 785 F.2d 1258 (5<sup>th</sup> Cir. 1986); see also Barry R. Ostrager & Thomas R. Newman, *Handbook on Insurance Coverage Disputes* 188 (5th ed. 1992), where it is stated: “The traditional view is that an excess insurer is not required to contribute to the defense of the insured so long as the primary insurer is required to defend.”

**”Exhaustion”**. However, an excess carrier may encounter situations where it is called upon by the court to drop down and provide indemnity and a defense to the insured when the meaning of “exhaustion” comes into question. The issue often boils down to whether the primary carrier’s limits have been exhausted. For instance, if the primary insurer refuses to defend the claim or the primary insurer reaches a settlement with the insured to tender the limits of the policy to the claimant, then the excess carrier may be required to drop down and provide a defense. *See 1 Insurance Claims and Disputes 5th § 4:11.*

A Hawaii court considered this scenario in a case involving environmental contamination. In *Pacific Employers Ins. Co. v. Servco Pacific, Inc.*, 273 F.Supp.2d 1149 (D.HI. 2003), the primary insurer argued that when it paid the insured \$1.5 million, the primary insurer had exhausted its stated \$500,000 limits. The primary carrier and the insured agreed that the payment settled all questions of coverage. But they did not specify how the payment would be allocated between indemnification and defense costs. Payments for defense costs did not erode the policy limits. Further, the insured still faced regulatory actions in relation to the environmental claims that had not been fully adjudicated or settled at the time of the \$1.5 million payment. The excess carrier argued that the primary insurer’s payment was not made as a result of a settlement or claim in litigation but was mostly for defense costs, so the limits of the primary coverage were not exhausted.

The court sided with the primary carrier, finding the primary limits were exhausted, and ordered the excess carrier to drop down and provide the insured a defense from the time of the settlement between the primary carrier and insured. While the court acknowledged that a primary carrier cannot shirk its duty to defend by prematurely tendering its limits, the court did not see this as a case of premature tender. *Id.* at 1155. Additionally, the court made the policy argument that the excess carrier’s viewpoint would create only an “illusory” duty to defend at the excess level. The court noted: “Requiring the primary carrier first to litigate the underlying claim to judgment, or make the payments in settling the claim, would mean the excess carrier would then have nothing left to defend (save perhaps litigating an appeal or defending an entirely different ‘suit’ arising from the same occurrence).” *Id.* at 1154. Further, the court stated that the plain terms of the excess policy “provide that its duty to defend arises when ‘the limits of liability of the underlying insurance are exhausted *because of... property damage* ‘ - not when the limits are exhausted by payments of judgments or settlements of the underlying claim.” *Id.*; *See also Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 142 Wash.2d 654, 15 P.3d 115, 135 (2000) (holding that payment of environmental remediation company costs are the “equivalent of settlement” for exhaustion purposes).

**Within the Primary Limits.** Many courts have held that where the damages are within the limits of primary coverage or no possibility exists of payment by the excess carrier, no obligation to drop down and defend of the excess carrier is created. *See Belmer v. Nationwide Mut. Ins. Co.*, 599 N.Y.S.2d 427, 429-30 (App.Div. 1993). Other courts have similarly held that where the recovery was not yet determined or was within the primary limit, the excess insurer was not required to contribute to the cost of defense. *Id.* In refusing to order reimbursement to the primary insurer, the court in *Financial Indemnity Co. v. Colonial Ins. Co.*, 132 Cal.App.2d 207, 281 P.2d 883 (1955) reasoned

that there was no right of contribution from one insurer to another because the duty to defend is between the insured and each insurer, and thus the excess carrier did not have a duty to the primary insurer.

An Oklahoma court stated this principle further. In *United States Fidelity & Guaranty Co. v. Federated Rural Electric Ins. Corp.*, 37 P.3d 828 (Okla. 2001), the court held that an excess insurer is not liable to the primary insurer under the doctrine of equitable subrogation for defense costs incurred prior to exhaustion, even though the claim against the insured is for an amount in excess of the primary policy. The Oklahoma court explained:

*Primary insurance* provides immediate coverage for the insured upon the occurrence of a loss or the happening of an event which, under the terms of the policy, gives rise to immediate liability, . . . a primary insurer generally has the primary duty to defend and indemnify the insured unless specific language in the policy provides otherwise. An *excess insurance* policy is one which by its terms provides coverage that is secondary to the primary coverage; there is usually no obligation to the insured until after the primary coverage limits have been exhausted.

*Id.* at 831 (emphasis in original). Courts generally reject the argument that if a claim against the insured is for a sum greater than the primary coverage the excess insurer should be required to participate in the defense even though the primary policy is not exhausted. “Since the duty of an excess insurer to participate in the insured’s defense is triggered only by exhaustion of the primary policy, a holding that the excess carrier must pay because the claim is greater than the primary coverage would be contrary to the policy’s provisions, and the court would be reallocating risks that the parties had freely agreed to and had been compensated to assume.” *Id.* at 833.

**Filling the Gap to Force Drop Down.** Where “exhaustion” of the primary policy limits is interpreted to mean an insured’s personal payment on the claim to fill the gap between the primary insurer’s payment and the start of the excess insurer’s liability, courts have relied on an ambiguity in the definition of “exhaustion” or lack of specificity in the excess contract as to how the primary insurance is to be discharged and have required the excess carrier to make payments even though the primary limits are not exhausted. *See, e.g., Stargatt v. Fid. and Cas. Co. of New York*, 67 F.R.D. 689, 690 (D.Del.1975) (where excess policy took effect “only when the Primary Policy in the amount of \$250,000 ... has been exhausted”, court observed that the “plain meaning of ‘exhausted’ is ‘entirely used up,’ and the coverage of the primary policy has been entirely used up by the settlement”; primary insurer paid \$130,000 in settlement and dismissed its \$650,000 counterclaim, and thus it was not clear that the settlement had a value of less than \$250,000); *Gasquet v. Commercial Union Ins. Co.*, 391 So.2d 466, 472 (La.Ct.App.1980) (holding that an excess policy that did not become effective “unless and until the insured, or the insured’s underlying insurer, shall have paid the amount of the underlying limits on account of such occurrence” was triggered by a settlement that gave the excess carrier “a ‘credit’ for the policy limits of the primary insurer”).

Other cases reaching similar drop down results generally deal with overlapping coverage of automobile insurance and priority disputes over which policy shall be deemed “excess.” For example, in *Smit v. State Farm Mut. Auto. Ins. Co.*, 207 Mich.App. 674, 525 N.W.2d 528, 533 (1994), the Michigan court stated that “[w]e agree with the trial court that it is not necessary to exhaust the limits of the primary policy insuring the owner in order to proceed with a claim for excess coverage available under a second policy insuring the driver.” Another Michigan court held that “while recovery under the primary policy is a prerequisite to pursuit of the excess coverage, it is not necessary to exhaust the first policy in order to proceed with a claim under the second policy so long as actual damages in the amount of the primary policy are shown.” *Allstate Ins. Co. v. Riverside Ins. Co. of Am.*, 509 F.Supp. 43, 46 (E.D.Mich.1981).

**Filling the Gap Makes No Difference.** But a different result occurs (*i.e.* no drop down) when the policy language is more specific about what constitutes “exhaustion of policy limits.” One example can be found in *Danbeck v. Am. Family Mut. Ins. Co.*, 245 Wis.2d 186, 194, 629 N.W.2d 150, 154 (2001), where the court held that “[w]hile the ‘settlement plus credit’ approach to exhaustion has the same practical effect as payment of full policy limits, it is not consistent with the plain language of the policy, which unambiguously requires exhaustion ‘by payment of judgements or settlements,’ not ‘settlement plus credit.’” In a Missouri case, the primary insurer paid its limits and then plaintiff obtained judgment well into the limits of the first and second layer excess insurers. *Wright v. Newman*, 598 F.Supp. 1178, 1196 (D.C.Mo.1984). Plaintiff sought coverage only from the second layer insurer without exhaustion of first layer. The second layer excess policy stated: “[l]iability ... shall not attach ... unless and until ... and only after the Primary and Underlying Excess Insurers have paid or been held liable to pay the full amount of ... [their] Limits”; court rejected insured’s argument that second layer excess insurer had “no rational interest in requiring actual payment,” and instead ruled that no drop down was required because “an insurance policy must generally be enforced as written, ... the policy contains an express provision requiring resort to underlying insurance.” *Id.*

A recent Michigan case demonstrates the kind of policy language necessary to trigger exhaustion of the primary insurer’s policy limits – the actual payment of losses by the primary insurer. In *Comerica, Inc. v. Zurich American Ins. Co.*, 498 F.Supp.2d 1019 (E.D.Mich. 2007), such language read as follows:

In the event of the depletion of the limit(s) of liability of the ‘Underlying Insurance’ solely as a result of *actual payment of loss thereunder by the applicable insurers*, this Policy shall ... continue to apply to loss as excess over the amount of insurance remaining.... In the event of the exhaustion of the limit(s) of liability of such ‘Underlying Insurance’ solely as a result of payment of loss thereunder, the remaining limits available under this Policy shall ... continue for subsequent loss as primary insurance ....

*Id.* (Emphasis added). The insured insisted that its own payment of \$6 million toward the settlement filled the gap between the primary insurer’s payment and the balance of the

primary policy limit, and that should serve as the functional equivalent of exhausting the primary policy limit because it exposed the excess insurer to no greater liability than if the primary insurer had made the payment. But the court rejected this argument, stating “[p]ayments by the insured to fill the gap, settlements that extinguish liability up to the primary insurer's limits, and agreements to give the excess insurer ‘credit’ against a judgment or settlement up to the primary insurer's liability limit are not the same as actual payment.” *Id.* at 1032. In other words, excess insurer drop down was not required because the primary insurer did not pay its entire limits.

The lesson learned in *Comerica* is this: for an excess insurer to indemnify (a) when the underlying insurer did not actually pay its limits, (b) when the insured filled the gap, (c) when a settlement extinguished liability up to the primary insurer's limits, or (d) when there was an agreement to give the excess insurer “credit” up to the amount of the underlying insurance, the excess policy needs to explicitly say so.

### C. Insolvency of primary insurer

Umbrella liability policies were not intended to provide for insolvency drop down. The purpose of a liability insurance program is to protect the insured against third party liability claims, not to insure the solvency of underlying insurers. *Playtex, Inc. v. Columbia Cas. Co.*, 622 A.2d 1074 (Del.Super. 1992).

An insured often looks to its excess insurer if he finds himself without coverage at the primary level. Insolvencies of either the self-insured or the primary carrier commonly lead to this scenario. *See e.g.* Daniel A. Austin, *Drop Down? Drop Dead!*, 24 Am. Bank. Inst. J. 24 (2005); Jane M. Draper, B.C.L., *Primary insurer's insolvency as affecting excess insurer's liability*, 85 A.L.R.4<sup>th</sup> 729 (1991) § 2b. The prevailing view in most courts is that an excess liability insurer does not owe coverage in the case of insolvency of the primary insurer. *Austin, supra*. Despite the odds against them, insureds continue to seek drop down coverage from excess or umbrella carriers in the face of insolvency.

As a starting premise, courts look to the contract language of the applicable insurance policies to determine if an excess carrier should drop down in the case of insolvency. Insureds argue that either the contract language specifically calls for drop down or, alternatively, that the contract language on insolvency is ambiguous.

**No Drop Down.** In most instances, the drop down argument is unavailing and the insured will be exposed for that loss or will have to seek state assistance from an insurance security fund. *See Highlands Ins. Co. v. Gerber Products Co.*, 702 F.Supp. 109 (D.Md.1988) (second level excess carriers not required to drop down into place of insolvent first level excess carrier); *Ambassador Associates v. Corcoran*, 143 Misc.2d 706, 541 N.Y.S.2d 715 (N.Y.Sup. 1989) (court denied insured's argument for excess insurer's drop down coverage and noted that the insured would need to look to the New York Security Fund for coverage lost through the primary insurer's insolvency).

In *U.S. Fire Ins. Co. v. Coleman*, 754 S.W.2d 941 (Mo.App. 1988), the excess policy provided as follows: “[T]he company's liability shall be only for the ultimate net loss in

excess of the insured's retained limit defined as the greater of: (a) the total of the applicable limits of the underlying policies listed in Schedule A hereof, and the applicable limits of any other insurance collectible by the insured; or (b) an amount as stated in item 4(C) of the declarations as the result of any one occurrence not covered by the said policies or insurance.” The court concluded that the insuring agreement was clear and unambiguous and the insolvency of the primary insurer did not require the excess insurer to drop down and provide primary coverage. *Id.* at 944-45.

**Yes Drop Down.** However, insureds that successfully demonstrate an ambiguity in the contract language of the excess policy have been able to gain insolvency drop down coverage, *See e.g. Coca Cola Bottling Co. v. Columbia Casualty Ins. Co.*, 11 Cal.App.4th 1176, 1186-1188, 14 Cal.Rptr.2d 643 (Cal.App.4.Dist) (third tier excess insurer must drop down into insolvent second tier excess insurer’s coverage because third tier policy used “follow form” contract language under which the third tier insurer agreed to be liable for amounts in excess of the “amount recoverable” under underlying policies, and term “amount recoverable” was deemed ambiguous).

**Other Insurance Clause.** Insureds facing an insolvent primary carrier have also successfully argued for an excess carrier to drop down under other circumstances. Several courts have ordered drop down coverage based on the wording in the Other Insurance clause in the excess policy. For instance, in a case regarding injuries suffered by a bus passenger, the court awarded the injured party \$14.6 million. *See e.g. Bernard v. Royal Ins. Co.*, 586 So.2d 607 (La.App.1991). The insured claimed that the excess carrier had an obligation to drop down in the case of the primary insurer’s insolvency. The excess insurer claimed that its coverage did not apply because it was not triggered until \$20 million in claims was reached. The excess policy contained the following clauses:

[Insured shall] indemnify the Insured for the Limits of Liability in excess of the Underlying Limits of Liability, both as shown in the Declarations, for all sums which the Insured shall become legally obligated to pay by reason of the liability imposed upon the Insured by law, or assumed by the Insured under contract or agreement....

If other valid and *collectible* insurance with any other Insurer is available to the Insured covering a loss also covered by this policy, other than insurance that is in excess of the insurance afforded by this policy, the insurance afforded by this policy shall be in excess of and shall not contribute with such other insurance.

(emphasis added). The court interpreted the second clause – the “Other Insurance” clause -- as requiring the excess insurer to drop down in the case of an insolvent primary. The court said that the excess policy is “an example of an excess policy that would drop down because its underlying limit of excess coverage is dependent on collectibility of primary limits” and here the primary limits were not collectible due to insolvency. *Id.* at 621.

More typically, however, courts presented with an insured’s argument based on the

“Other Insurance” clause do not order the excess/umbrella insurer to provide drop down coverage. See Austin, *supra*, at 24; See Draper, *supra* at § 5(b). For instance, in a case out of Alaska, the court held that the “Other Insurance” clause did not create any ambiguity in the insurance contract in context of the primary insurer. See *Alaska Rural Elec. Co-op. Ass’n, Inc. v. INSCO Ltd.*, 785 P.2d 1193 (Alaska 1990). The court pointed to the basic contract premise that an insurance contract should be read to give meaning to the intentions of the party -- “we do not believe that insolvency of the primary carrier is one of the risks considered in determining an excess carrier's premium.” *Id.* at 1194. To this point, courts take notice of the generally lower premiums for excess coverage and the fact that the insured, not the excess carriers, retain the right to choose a primary insurer.

For discussion of the Other Insurance clause outside the context of insolvency, see page \_\_\_\_\_ below.

“Companies which write excess or umbrella insurance ought not be required to analyze the financial stability of primary insurers and that requiring the excess carriers to assume the burdens of insolvent primary coverage adds a risk not considered or assumed in the insurance marketplace.” *Northmeadow Tennis Club, Inc. v. Northeastern Fire Ins. Co.*, 526 N.E.2d 1333, 1335 (Mass.App. 1988).

**Northmeadow v. Northeastern.** The case of *Northmeadow* is an interesting case in contrasts. The first layer excess policy stated it attached only after the primary insurers “have paid or have been held liable to pay the full amount of their respective ultimate net loss.” The court concluded that this “posits an eventuality in which the insured, and hence the primary insurer, are liable but the insurer for some reason has not paid. The case of insolvency [of primary insurer] would be such an eventuality.” *Id.* at 1336. Thus, drop down was required. On the other hand, the second layer excess policy in *Northmeadow* required a different analysis and result. The policy provided that the company shall be liable for the excess over primary insurance or, as to “any claim ... to which no primary policy applies,” shall be liable for the excess over the greater of (a) “any other insurance available to the insured” or (b) the “retained limits.” *Id.* at 1336. To the *Northmeadow* court, this language meant that the second layer excess insurer intends “to insure over the underlying insurance and, if for some reason that underlying insurance is not there, that is to be the responsibility of the policyholder, not the insurance company.” *Id.* In other words, no drop down was required. Other language in the policy supported this reading. First, the policy contemplated the possibility of “reduction or exhaustion of the applicable aggregate limit or limits of liability under said primary policy or policies solely by reason of losses paid thereunder on account of occurrences during this policy period....” *Id.* In that event, the court stated that the company agrees to pay the excess over the reduced limit, as if it were the primary insurer, and the “occurrences” which may give rise to reduction or exhaustion of the underlying policies are defined in the policy as an “accident ... which results in personal injury or property damage.” Second, a condition of the policy required the insured to maintain the primary policies in amounts not less than those stated at the inception of the excess policy, and if there is a change in the scope of the underlying policies, the condition provided that the excess policy shall apply “in the same manner as though such primary policies and limits of liability ... had been in effect, so maintained and unchanged.” *Id.*

**“Inapplicable”**. Some cases focus on the term “inapplicable”. In *Continental Marble & Granite v. Canal Ins. Co.*, 785 F.2d 1258 (5<sup>th</sup> Cir. 1986), the excess policy provided that the insurer “shall be liable only for ultimate net loss resulting from any one occurrence in excess of [blank] ... if the insurance afforded by such underlying insurance is *inapplicable* to the occurrence, the amount stated in the declarations as the retained limit.” *Id.* at 1259 (emphasis added). The issue was whether the word “inapplicable” contemplated a situation where the underlying insurer was insolvent. The insured argued that the primary insurer's insolvency rendered the underlying insurance “inapplicable” and that, therefore, the excess liability policy dropped down to become the primary policy. The Fifth Circuit Court of Appeals rejected the insured's contention. The court held that term “inapplicable” did not require excess liability insurer to defend and indemnify the insured for any liability resulting from the lawsuits after the primary insurer became insolvent. *Id.*

Other courts sided with the insured and required drop down. *See e.g. Macalco, Inc. v. Gulf Insurance Co.*, 550 S.W.2d 883, 896 (Mo.Ct.App.1977) (“inapplicable” did require drop down).

Other cases where the courts have required drop down of the excess insurer involve policies where the excess insurer used the terms “collectible” or “recoverable.”

**“Collectible”**. The use of the word “collectible” in the insuring agreement of the umbrella policy has generated much litigation. The excess policy often reads:

[Insurer] shall be liable only for the ultimate net loss in excess of the Insured's retained limits defined as the greater of: (a) an amount equal to the limits of liability indicated beside the underlying insurance listed in the Schedule of Underlying Insurance hereof, plus applicable limits of any other underlying insurance *collectible* by the insured; or (b) the amount specified in Item 5 of the Declarations as the result of any one occurrence not covered by the said insurance.

The argument by the insured is that the adjective “collectible” modifies both the insurance listed in the schedule and any other underlying insurance and if the primary insurer is insolvent, its insurance is not collectible.

Many courts have held that such language does not impose an obligation on the secondary insurer to provide coverage in the event that the primary insurer becomes insolvent. *See e.g. Zurich Ins. Co. v. Heil Co.*, 815 F.2d 1122, 1124-26 (7th Cir.1987). As stated in *Transco Exploration Co. v. Pacific Employers Ins. Co.*, 869 F.2d 862, 864 (5th Cir.1989), “the quoted language . . . plainly contemplates two types of underlying insurance, scheduled and non-scheduled. Each appears in a distinct phrase, as is evidenced by the use of a comma between the words ‘hereof’ and ‘plus’ and by the use of the word ‘plus’ itself. The most natural reading of the language is therefore to read the two phrases separately, with the collectibility requirement being confined to the second

phrase. With the policy so construed, only nonscheduled underlying insurance need be collectible to be included in the calculation of the insured's retained limit; the limits of scheduled underlying insurance ... is included regardless of whether the insured can actually collect on the policy.”

Other courts go the other way and require the excess insurer to drop down because of the “collectible” wording. A Louisiana court found that the policy language was ambiguous as evidenced by the panel's disagreement as to the appropriate interpretation of the policy language. *Poirrier v. Cajun Insulation, Inc.*, 501 So.2d 800, 808 (La.Ct.App.1986), writ denied, 502 So.2d 579 (La.1987); see also *Gros v. Houston Fire & Casualty Insurance Co.*, 195 So.2d 674, 676 (La.Ct.App.1967) (drop down required where term “collectible” at issue).

One court was able to sidestep the “collectible” issue because the primary insurer became insolvent after the accident occurred. In *Shapiro v. Associated International Ins. Co.*, 899 F.2d 1116 (11<sup>th</sup> Cir. 1990), the excess insurer was not required to drop down because under Florida law collectibility of primary insurance is to be determined as of date of occurrence fixing liability and at that time the primary insurer was not insolvent.

**“Amount Recoverable”.** Courts have struggled with whether an excess insurer must drop down to the layer below it when its coverage is excess of the “amount recoverable” under the underlying insurance. The argument is that since the first layer excess insurer is insolvent, the insurance under such insurer is not an “amount recoverable,” and therefore the second layer excess carrier must drop down and pay the claims in the layer of the insolvent excess insurer. See *Playtex, Inc. v. Columbia Cas. Co.*, 622 A.2d 1074 (Del.Super. 1992).

A typical “amount recoverable” language can be found in *Playtex, Inc.*, where the policy stated: “THE COMPANY SHALL BE LIABLE FOR \$5,000,000 ULTIMATE NET LOSS EACH OCCURRENCE, EVENT, OFFENSE OR ACT, ERROR OR OMISSION NOT TO EXCEED \$5,000,000 ULTIMATE NET LOSS IN THE AGGREGATE FOR EACH ANNUAL PERIOD DURING THE CURRENCY OF THIS POLICY IN EXCESS OF: (1) THE AMOUNT RECOVERABLE UNDER THE UNDERLYING INSURANCE SET FORTH UNDER SCHEDULE A . . . .”

The majority of the courts have ruled that the policies with this language, when read as a whole, were unambiguous and they precluded insolvency drop down. *Hoffman Construction Co. v. Fred S. James & Co.*, 106 Or.App. 329, 807 P.2d 808 (1991) (the court ruled that if it were to accept the plaintiffs' contention that “amount recoverable” means “collectible,” the Loss Payable provision would be rendered meaningless); *Morbark Industries, Inc. v. Western Employers Ins. Co.*, 170 Mich.App. 603, 429 N.W.2d 213 (1988) (“amount recoverable” wording on declarations page clarified by insuring agreement); *Radiator Specialty Co. v. First State Ins. Co.*, W.D.N.C., 651 F.Supp. 439 (1987) (“amount recoverable” language in Limits of Liability provision is unambiguous when read in conjunction with the insuring agreements, definitions, and conditions of the policy); *Southeast Atlantic Cargo Operators, Inc. v. First State Ins. Co.*, 197 Ga.App.

371, 398 S.E.2d 264 (1990) (“amount recoverable” language on the declarations page Limits of Liability section does not negate more specific provisions in the body of the policy); *Werner Industries v. First State Ins. Co.*, 112 N.J. 30, 548 A.2d 188 (1988) (taken in its entirety, the policy, which covered commercial risks, was procured through a sophisticated broker, and used “amounts recoverable” language on its declarations page, was found to be unambiguous); *McNeal v. First State Ins. Co.*, E.D.Penn., Civ. A. Nos. 85-3927, 85-4087, 1986 WL 4477 (April 10, 1986) (although it would be necessary to decide whether it would be reasonable to believe that the parties intended drop down if Limits of Liability provision using “amount recoverable” language stood alone, when read in conjunction with other policy provisions, however, the policy clearly precludes drop down).

A minority of jurisdictions have ruled that the phrase “amount recoverable” unambiguously means collectible or actually recoverable and, absent an express exclusion, requires an insurance policy to drop down when the underlying insurer becomes insolvent. *See e.g. Sifers v. General Marine Catering Co.*, 892 F.2d 386 (5th Cir.1990). The California case of *Reserve Ins. v. Pisciotto*, 30 Cal.3d 800, 180 Cal.Rptr. 628, 640 P.2d 764 (1982), has been widely cited in cases of insolvency drop down. The policy at issue was boat liability coverage under a standard policy. In *Pisciotto*, the Supreme Court of California ruled that the term “amount recoverable” was amenable to two reasonable interpretations: first, that the excess insurer is liable for amounts over the dollar limits of the underlying policy; and second, that the excess insurer is liable for anything above the amount actually collectible from the underlying insurer. Based on this interpretation, the court ruled that the policy was ambiguous. *Id.* A number of other jurisdictions have based their decisions in favor of insolvency drop down on the application of construe-policy-against-insurer doctrine after finding that the policies were ambiguous. *See e.g. Donald B. MacNeal, Inc. v. Interstate Fire & Casualty Co.*, 1st Dist., 132 Ill.App.3d 564, 87 Ill.Dec. 794, 477 N.E.2d 1322 (1985) (the term ‘amount recoverable’ can be interpreted as a variable amount which depends on the actual amount recoverable from the primary insurer, not the fixed policy limits.”) *McGuire v. Davis Truck Services, Inc.*, 518 So.2d 1171 (1988) (since the term “amount recoverable” in the Limits of Liability provision means collectible, and that interpretation conflicts with the loss payable condition, the policy is ambiguous and should be interpreted in favor of the insured).

**1. If state guaranty fund takes over, does umbrella/excess insurer’s liability drop down to statutory limits?**

In the context of state guaranty funds, some general observations are first worth noting. “The intention of the legislature in establishing a State Insurance Guaranty Fund was to protect the public from losses arising from insolvency of insurers doing business in the state. Thus, such a statute may limit insolvent insurers to those authorized to do business in the state. But in creating a property and liability insurance security fund, the intent of the legislature was to extend protection against the insolvency loss to all holders of property risk policies regardless of the type of company that wrote the insurance. It has been said that a State Insurance Guaranty Fund is not a collateral or independent source

of recovery; rather, it is a substitution when expected coverage ceases to exist. One purpose of the Insurance Guaranty Fund Act was to place the claimants in the same position that they have been in if the liability insurer had not become insolvent. The dominant purpose of an Insurance Guaranty Association Act is to avoid delay and to settle as soon as possible claims of insolvent insurers which are ripe for payment.” Appelman, *Insurance Law and Practice* § 10801, p. 367.

When a state guaranty fund steps in to defend and indemnify an insured due to the insolvency of the primary insurer, the question often becomes whether the state fund may require the excess insurer to drop down and take over the defense and indemnity and/or reimburse the state fund. The case of *Washington Ins. Guar. Association v. Guar. National Ins. Co.*, 685 F.Supp. 1160 (W.D.Wash. 1988) is an example of such a dispute where drop down was not required.

The facts were that the primary insurer, Guaranty National Insurance Company (“GNIC”), had gone bankrupt, Washington Insurance Guaranty Association (“WIGA”) stepped in and defended and settled a claim, and WIGA sued the excess insurer for reimbursement of all sums expended in defense and settlement of the claim. The court noted that WIGA is a statutory creation composed of member insurers whose purpose is “to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, ....” *Id.* The court also focused on the meaning of the excess policy language in the Limits of Liability clause, which stated that “GNIC shall only be liable for the ultimate net loss in excess of the (a) applicable limits of underlying insurance as stated in Item 5 of the Declarations, and any other underlying insurance collectible by the insured.” *Id.* at 1164. Given the insolvency of the primary insurer, the meaning of the word “collectible” was in dispute. The court reasoned that “the phrase ‘collectible by the insured’ must modify both scheduled insurance and insurance that does not appear on the schedule.” *Id.* The analysis did not end there though. Does “collectible” mean that funds must actually be paid or does it serve as a reference point for establishing a threshold above which the umbrella coverage begins? The court held that “when GNIC's policy is considered in its entirety as in Part I of the analysis herein, the theme of the policy as excess, over and above other insurance, mandates that ‘collectible’ refers merely to the existence of other applicable insurance forming a threshold for the beginning of GNIC's coverage.” *Id.* “‘Collectible’ does not refer to the actual payment of a sum of money, but instead refers to the existence of other applicable insurance coverage based on the particular occurrence in question.” *Id.* quoting *Wurth v. Ideal Mutual Ins. Co.*, 34 Ohio App.3d 325, 518 N.E.2d 607, 612 (1987). “Both the language of the GNIC contract and its entire theme as well as the statutory mission of WIGA mandate the conclusion that GNIC is not required to ‘drop down’ and take up the burden of being the primary insurer in the place of the insolvent insurer.” *Washington*, 685 F.Supp. at 1164. Thus, the State Guaranty Fund could not require the excess insurer to defend or indemnify so long as the damages or judgment did not exceed the limits of the primary policy of the insolvent carrier. *Id.*

If the liability of the state guaranty fund is unlimited, the excess insurer is unlikely

required to drop down ever. For example, in *Commissioners of State Insurance Fund v. Aetna Cas. & Sur. Co.*, 728 N.Y.S.2d 6, 7 (App.Div. 2001), the State Insurance Fund's coverage was unlimited. The umbrella policy stated that it provides coverage for a loss of the insured in excess of the “applicable underlying limit,” defined as, among other things, “the amount of insurance stated in the policies of ‘underlying insurance’ in the Declarations or any other available insurance less the amount by which any aggregate limit so stated has been reduced solely due to payment of claims.” Though the State Insurance Fund was not listed in the umbrella policy's schedule of underlying insurance, the fund fit within the policy's definition of “underlying insurance,” because this term is defined in the policy to encompass both the policies listed in the schedule of underlying insurance and “[a]ny other insurance available to the insured.” *Id.* Because the State Insurance Fund's coverage was unlimited, the court concluded that the umbrella policy was not triggered – “unambiguous terms of this contract require that the State Insurance Fund be exhausted before the Aetna umbrella policy is triggered.” *Id.*

**D. Primary policy limits are less than those required by umbrella/excess insurer**

A gap in coverage may be a result of a primary policy with liability limits less than those required by the excess policy. Some courts have not required the umbrella to drop down into this gap. For instance, in *Fried v. North River Ins. Co.*, 710 F.2d 1022 (4<sup>th</sup> Cir. 1983), a father obtained an umbrella policy that insured his entire family for catastrophic loss and liability up to \$1 million. The umbrella policy defined “retained limit” as “the total of the applicable limits of the underlying policies listed in Schedule A hereof, and the applicable limits of any other underlying insurance available to the insured.” Son #1 caused a car accident while driving the car of Son #2. Son #1 was not an insured on any of the primary policies listed on Schedule A. Instead, the injured parties from the accident were paid on the policy issued to Son #2. The limits on that policy were \$15,000 per person/\$30,000 per occurrence, but the limits on the underlying policies from Schedule A were \$115,000/\$330,000. The umbrella insurer was successful in arguing that it did not have a duty to step into the gap. The court acknowledged that the likely result was that the injured parties would never be fully compensated, but held that the clear intent of the parties to the umbrella policy was to establish excess coverage starting at \$115,000/\$330,000.

Not all courts follow this reasoning and an umbrella policy may have language requiring it to fill any gaps left by inadequate primary insurance.

**UM/UIM.** Along these lines, a drop down dispute sometimes occurs in the context of uninsured-underinsured motorist coverage when a court reads UM/UIM coverage into an excess policy because of a financial responsibility statute. In *Dolly v. Old Republic Ins. Co.*, 200 F.Supp. 2d 823 (N.D. Ohio 2002), an employee was severely injured by an underinsured motorist, his damages were stipulated to be \$2.35 mil. and he sought UM/UIM coverage from the employer’s primary and excess liability policies. The excess policy had policy limits of \$5 million. In the policy, the insurer agreed “to pay on behalf of the Insured the Ultimate Net Loss in excess of the Retained Limit hereinafter stated ...[.]” The Retained Limit for liability purposes was \$3 million per occurrence. The

argument of the excess insurer was that the excess layer is not triggered until plaintiff's damages exceed \$3 million, and since the parties stipulated plaintiff's damages to be \$2.35 million, the excess layer did not "drop down" to cover the difference between \$500,000 (already recovered by the plaintiff under the primary policy and the tortfeasor's policy) and \$2.35 million. Rejecting this argument of no drop down, the court held that the UM/UIM coverage is implied by law with respect to the excess layer of insurance, and the \$3 million retained limit in the liability portion does not apply to the UM/UIM coverage. *Id.* at 842. The rationale was that under Ohio law since the parties to the excess policy never intended UM/UIM coverage to be part of the policy, none of the provisions in the liability portion of the policy, including the Retained Limit requirement, could be impressed upon the underinsured coverage implied by law. Therefore, the court required the umbrella/excess layer to drop down to cover what the primary policy had not covered. Since there was \$500,000 of UM/UIM coverage from the primary layer, the excess layer must pick up where that coverage left off. *Id.*

**Unilateral Reduction of Limits.** What happens if the insured unilaterally reduces the limits of its primary coverage after obtaining excess coverage – may the insured expect the excess insurer to fill the gap when a claim exceeds these reduced primary limits? A Louisiana court answered the question in the negative and refused to require drop down. In *Benton v. Long Mfg. N.C., Inc.*, 550 So.2d 859, 861 (La.App. 1989), the insured was obligated to maintain \$1 million worth of primary coverage pursuant to a policy with its excess insurer. However, the insured unilaterally reduced the limits of the primary policy to \$100,000. The excess policy specified the underlying limits of its liability with the following language: "LIMIT OF LIABILITY - The company shall only be liable for the ultimate net loss the excess of either (a) the amount recoverable under the underlying insurances as set out in Item 7 of the Declarations, or ..." The court stated it did not see any indication that the excess insurer intended to drop down and cover any claims against Long Manufacturing for over \$100,000 simply because Long Manufacturing unilaterally decided to renew its underlying policy at the lower limit of \$100,000. *Id.* at 861. The intent of the parties to the excess policy appeared to be that the insured would maintain underlying insurance for bodily injury claims up to \$1 million, with any claims over that amount and up to \$5 million being covered by the excess insurer. *Id.* Thus, the court held that the excess insurer need not drop down to the reduced primary limits of \$100,000. In support of its holding, the court relied on policy provisions that reduction or exhaustion of the underlying limits can only occur by payment of claims by the underlying insurer. *Id.* There was no policy provision, according to the court, that allowed the insured to unilaterally reduce its underlying policy limits, have the underlying insurer pay the reduced amount, and claim that the reduction occurred *solely* by reason of payment of claims. The unilateral reduction of the underlying policy limits did not constitute a reduction by payment of claims. *Id.*

**Inadequate Limits.** Another excess insurer had no duty to drop down and defend when the primary limits were less than those required and the claimant's judgment came within the gap in coverage. In *United States Fire Ins. Co. v. Aspen Building Corp.*, 367 S.E.2d 478 (Va. 1988), the insured in an excess policy warranted that the underlying policies listed in Schedule A shall be maintained in force during the term of the policy and that

the limit of underlying insurance would be \$100,000. Contrary to its warranty, the insured acquired a primary policy providing underlying insurance of only \$50,000. In the claim against the insured, the *quantum* of the loss arising from the occurrence was determined to be less than \$100,000. The court held that the “occurrence, therefore, did not satisfy the terms and conditions of the coverage USFIC had contracted to provide.” *Id.* at 479.

#### E. Primary insurer denies coverage

A drop down issue can arise when the primary policy excludes coverage for whatever reason and the insured demands the excess insurer to drop down and cover those damages. *See e.g. Sainsbury v. Hartford Acc. & Indem. Co.*, 469 F.2d 392 (6<sup>th</sup> Cir. 1972) (exclusionary provision of primary policy applied and thus primary policy was “inapplicable” and excess policy was required to drop down).

A decision in favor of the excess insurer occurred in *Haggard Hauling & Rigging Co., Inc. v. Stonewall Ins. Co.*, 852 S.W.2d 396 (Mo. App. 1993). There, the insured filed suit against its excess insurer to recover the amount it was forced to expend in the defense and settlement of an underlying action for property damage when the primary insurer declined coverage. An endorsement of the umbrella policy stated: “In consideration of the premium charged, it is agreed that unless coverage is provided by the underlying insurance at the full limits of liability as shown on the schedule of underlying insurance and not otherwise specifically excluded by endorsement hereon, this policy shall not apply to: . . . 2. Property damage, as defined in insuring agreement II. C. [and] 3. Liability assumed by the insured under any contract or agreement.” In other words, the excess policy would cover property damage if the primary policy covered it, also. The court held that the insured is not entitled to coverage under the umbrella policy because the underlying insurance policies which it chose to maintain did not provide property damage coverage as required by the condition precedent under the umbrella policy. *Id.*

If the underlying insurer has refused to defend, asserting that there is no coverage under the substantive provisions of the underlying policy, the excess insurer may have a duty to defend so long as there is coverage under the excess policy and the claim falls within the policy limits of the excess insurer. In determining whether the proper conditions are present to invoke the excess insurer's duty, the standard is the same as that for a primary insurer: the excess insurer's duty is to be determined by the pleadings and readily ascertainable facts, with any doubt resolved in favor of the insured. *See e.g. American Motorists Ins. Co. v. Trane Co.*, 544 F.Supp. 669, 692 (W.D.Wis.1982), *aff'd*, 718 F.2d 842 (7th Cir.1983). The *American Motorist* court dealt with the issue of whether the excess insurer has a duty to defend when the primary insurer refuses and the amount of the claim approaches or exceeds the primary limits. The court noted that plaintiff's complaint alleged damages well in excess of the limits of the primary policy. The court held that this fact alone was sufficient to trigger the excess carrier's duty to defend. *Id.*

**Wrongful Refusal to Defend.** What about when the primary insurer wrongfully refuses to defend – is there drop down then? Courts tend to treat the refusal to defend cases like

insolvency drop down cases - they look to the specific language of the excess policy to ascertain the existence of a duty to defend, and whether the excess insurer must drop down to assume the obligation to defend of a primary insurer. In *Ticor Ins. Title Co. v. Employers Ins. Of Wassau*, 48 Cal.Rptr.2d 368, 373 (Ct.App. 1995), the court did not require drop down. The excess policy stated that the duty to defend arises when there is a claim for damages for an occurrence under the policy *and* “no defense coverage is provided by underlying insurance.” The insured argued that the primary insurer’s wrongful refusal to defend was an example of “no defense coverage is provided by underlying insurance,” and thus the excess insurer must drop down and defend. Rejecting this argument, the court noted the dictionary definition of “coverage” as “something that covers: as a: inclusion within the scope of an insurance policy or protective plan: INSURANCE.” *Id.* at 374. In the context of an insurance policy, the California court stated that coverage means “inclusion within the scope of an insurance policy,” not “the act or fact of covering,” and thus “coverage” has nothing to do with how, in reality, the excess insurer acts with respect to its insurance obligations. The court agreed then with the excess insurer that if there was a duty to defend at all, that duty was the primary insurer’s until its limits of liability were spent. *Id.* at 374.

But some courts rule the other way and conclude that if the primary insurer wrongfully refused to defend, the excess insurer is required to drop down and defend the insured. For example, in *Hocker v. New Hampshire Ins. Co.*, 992 F.2d 1476 (10<sup>th</sup> Cir. 1992), the circuit court held that under Wyoming law and the terms of the excess policy, the excess insurer’s defense obligations were activated even though the primary insurer wrongfully refused to defend. The excess policy language covered occurrences “not covered, as warranted” by the underlying policy. The court said that this language spoke to the possibility that the primary insurer would wrongfully deny coverage for an occurrence that it had warranted would be covered; in that case, the excess insurer had to drop down and provide a defense. *Id.* at 1481-1482.

**Paying Insured’s Costs?** What happens when the primary carrier provides a defense and the action is settled within the limits of the primary-level policy but the plaintiffs’ claims originally exceeded the limits of the primary-level policy and the insured hired additional defense counsel to assist – would the excess insurer be obligated to pay defense costs and settlement amounts incurred by the insured and not paid for by the primary insurer? A Wisconsin court answered with a no. In *Azco Hennes Sanco, Ltd v. Wisconsin Ins. Security Fund*, 502 N.W.2d 887 (Wis.App. 1993), the excess carrier provided coverage to the insured against “all sums which [it] shall become legally obligated to pay as damages on account of ... Personal Injuries” arising out of “occurrences covered under the policy....” The policy further stated that the excess insurer, “[a]s respects occurrences covered under this policy, *but not covered under the underlying insurance* [ ],” will defend the insured against any suit “alleging liability insured under the provisions of this policy....” The court rejected the insured’s two arguments: first, that because the primary policy had a limit of \$500,000 and the plaintiffs’ suits sought damages in the millions of dollars, “[t]he complaints obviously alleged claims ... which were unquestionably ‘not covered by the underlying insurances,’” and second, that as a result the excess insurer had a duty to defend and pay

attorney's fees and other costs incurred in defending and settling the actions. Declining to follow the insured's arguments, the court ruled that excess liability insurer owed no duty to defend under terms of its policy and was not responsible for attorney fees and other costs. *Id.* at 887.

#### **F. Insured has large self-insured retention on primary policy**

As a general rule, self-insured retentions “constitute primary coverage and thus [an insured] must exhaust the SIRs before looking to the insurers for coverage.” *Missouri Pacific Railroad v. International Ins. Co.*, 288 Ill.App.3d 69, 82, 223 Ill.Dec. 350, 679 N.E.2d 801 (1997); *see also Illinois Emcasco Insurance Co. v. Continental Casualty Co.*, 139 Ill.App.3d 130, 133, 93 Ill.Dec. 666, 487 N.E.2d 110 (1985). If a policy is written to be excess over a substantial self-insured retention, the policy should be treated as an excess policy. As a result, no payment should be owing under such a policy until the SIR and all applicable primary policies are exhausted. *See 1 Insurance Claims and Disputes 6:45*, citing *Pacific Employers Ins. Co. v. Domino's Pizza, Inc.*, 144 F.3d 1270, 1276–77 (9th Cir. 1998) (California law) (“It is well recognized that self-insurance retentions are the equivalent to primary liability insurance, and that policies which are subject to self-insured retentions are 'excess policies' which have no duty to indemnify until the self-insured retention is exhausted.... This means that an excess insurer has no duty to contribute to a settlement on its behalf until all underlying insurance, including any self-insurance, is exhausted”). As aptly stated by one commentator:

A self-insured retention (like a deductible) represents the amount of the loss that the insured is responsible for before the coverage is triggered. The position of a primary insurer over a retention or deductible can be analogized to the position of an excess insurer over a primary policy. The primary insurer's obligations are triggered once the deductible is exceeded, just like an excess insurer's obligations are triggered once the primary limits are exceeded. And an excess insurer's obligations are triggered once both the primary limits and the self-insured retention are exceeded. By its very nature, excess insurance is not reached until the underlying primary insurance is exhausted, and the primary insurance is not even triggered until the self-insured retention is exhausted.

*1 Insurance Claims and Disputes 5<sup>th</sup> at 6:45 (March 2008).*

**Bankrupt Insured.** The rules are different when the insured is a bankrupt debtor and has failed to satisfy the self-insurance retention of a liability policy, and the “drop down” issue is usually decided against the excess insurer. The excess insurer may try to argue that the bankruptcy dissolves its obligation to pay any excess coverage because the self-insurance of the insured is never going to be exhausted. This was the excess insurer's argument in the case of *In re Vanderveer Estates Holding, LLC*, 328 B.R. 18 (Bankr. E.D.N.Y. 2005). But the argument was rejected by the bankruptcy court as being contrary to statute and the policy itself. *Id.* at 23. By Illinois statute, a liability policy must state that the “insolvency or bankruptcy of the insured shall not release the company from the

payment of damages for ... loss occasioned during the term of such policy....” The policy in *Vanderveer* contained just such a provision: “[the] bankruptcy or insolvency of the [insured] or of the [insured’s] estate will not relieve [insurer] of [its] obligations under this [insurance policy].” The court concluded that “this provision of Illinois law prevents insurers from avoiding indemnity obligations where self-insured retentions have not been paid by a bankrupt insured....[and therefore] injured parties shall be compensated whether or not a bankrupt debtor pays its self-insured retention.”*Id.* at 24-25. As a result, the excess carrier was required to pay the claims above the retention limit and pay essentially the full cost to defend the insured. *Id.* at 27. See also *Home Insurance Co. v. Hooper*, 294 Ill.App.3d 626, 633, 229 Ill.Dec. 129, 691 N.E.2d 65 (1998), *cert. denied* 178 Ill.2d 576, 232 Ill.Dec. 846, 699 N.E.2d 1031 (Ill.1998) (even though the self-insured retention provision required the insured to make payment of the first \$250,000 of any settlement or judgment against it before the excess policy would pay damages in excess of the SIR amount, court held that the insurer was liable for amounts in excess of the \$250,000 self-insured retention up to the policy limit despite the insured’s bankruptcy preventing it from paying the SIR).

**G. Does the Other Insurance clause in the umbrella/excess policy have a role to play?**

An Other Insurance clause is a self-serving provision in an insurance policy that attempts to make the insurer excess in coverage if another unexhausted policy is available to cover claims. See 12A *Couch on Insurance* § 45:628 (2d ed. 1981).

In some instances, a primary policy contains an Other Insurance clause that converts the policy into excess coverage if a claim triggers two concurrent policies. See 1 *Insurance Claims and Disputes 5th* § 7:1. Under normal circumstances, the policy with such an Other Insurance clause will be given effect and it will function as an excess policy.

**Drop Down.** However, occasionally a party has successfully argued that the insurer with the Other Insurance clause should drop down and provide primary level insurance. For instance, a court in Vermont ordered an insurer with an Other Insurance clause to drop down and be the primary insurer. See *Champlain Cas. Co. v. Agency Rent-A-Car, Inc.*, 168 Vt. 91, 716 A.2d 810 (1998). In that case, a rental car driver caused an accident in which he was killed and the other driver was injured. The injured driver brought claims against the rental car driver’s estate which triggered coverage under both the rental agency’s self-insured limits required by state law and the rental driver’s insurance policy with Champlain Casualty. The Champlain policy contained an Other Insurance clause that attempted to make the policy an excess one over the agency’s self-insurance for the claim because the accident occurred in a non-owned vehicle. The clause stated:

If there is other applicable similar insurance we will pay only our share of the loss. Our share is the proportion that our limit of liability bears to the total of all applicable limits. However, any insurance we provide with respect to a vehicle you do not own shall be excess over any *other collectible insurance*.

*Id.* at 813 (emphasis added). Pursuant to the Motor Vehicle Responsibility Act, the rental car agency had been issued a certificate of self-insurance of \$100,000 and every car lessee was required to sign a form stating:

If required by the financial responsibility laws of the state in which this agreement was executed the company [rental car agency] shall settle or defend, up to the minimum limits required for any one rental vehicle per occurrence, as it considers appropriate, any claim or suit for bodily injury and/or property damage arising out of the authorized use of this vehicle by the renter, renter's spouse or listed additional licensed driver.... These protections, if required, *shall be excess over* any self-insurance certificate, surety bond, financial responsibility bond, cash deposit, or insurance policy or benefit including but not limited to: health and accident, medical, dental insurance and/or disability benefit available to any individual making a claim under this agreement.

*Id.* at 812 (emphasis added). In other words, the agency's self-insurance was supposed to be excess over other available insurance. The court was called upon to decide whether the rental car agency's self-insurance was "other collectible insurance" under the Other Insurance clause in the rental driver's Champlain policy and if so, what do you do when both the agency's self-insurance and the Champlain policy consider themselves excess coverage. In this case, the court held that self-insurance was "other collectible insurance" referred to in the Other Insurance clause of the Champlain policy. However, the court still ruled against Champlain: Champlain must still drop down and provide the primary level of insurance, and the Agency's self-insurance would be excess. *Id.*

Although this case is typical of the dispute that may arise in the case of conflicting excess clauses and one insurer being required to drop down to the primary level, the decision of the Vermont court only represents one approach to resolving the conflict.

**SIR Is Not Other Collectible Insurance.** Some jurisdictions conclude that that self-insurance is not "other collectible insurance," therefore causing the insurer with the Other Insurance clause to drop down. *Id.*; see e.g. *Quick v. National Auto Credit*, 65 F.3d 741, 743 (8th Cir.1995) (qualification as self-insurer under state financial responsibility law did not constitute other valid and collectible insurance); *Farmers Ins. Co. v. Snappy Car Rental, Inc.*, 128 Or.App. 516, 876 P.2d 833, 837 (1994) (certificate of self-insurance does not constitute other valid and collectible insurance). In *Rite Aid Corp. v. Liberty Mut. Fire Ins. Co.*, 414 F. Supp. 2d 508 (M.D. Pa. 2005), one primary policy contained an Other Insurance clause, which stated the policy "does not apply to any portion of a loss for which the insured has available any other valid and collectible insurance,...." *Id.* at 516. A second primary policy had a \$1 million self-insured retention. The first insurer argued that the insured had to bear the first \$1 million of the loss due to the Other Insurance clause (the SIR being "other valid and collectible insurance") but then the insurer admitted in its memorandum of law that a self-insured retention cannot constitute "other insurance." *Id.* at 517. Thus, the court ruled that because the insured did not have any "other insurance" for the first one million dollars in defense costs that were used in defending the underlying action, the first primary insurer is liable for the first million

dollars in defense expenses. *Id.* One can only wonder why the insurer's memorandum of law made this admission.

**Mutually Repugnant.** Other jurisdictions consider competing Other Insurance clauses to be mutually repugnant, and thus void and then apportion the loss among the insurers. See C.C. Marvel, *Apportionment of liability between liability insurers each of whose policies provides that it shall be "excess" insurance*, 69 A.L.R.2d 1122, §1(b). "Where it is impossible to determine which policy provides primary coverage due to identical excess clauses, the clauses are deemed mutually repugnant and neither ... will be given effect." *N.C. Farm Bureau Mut. Ins. Co. v. Hilliard*, 90 N.C.App. 507, 511, 369 S.E.2d 386, 388 (1988)). For instance, the Other Insurance clause in a true excess or umbrella policy may be irreconcilable with the same clause in another umbrella policy, both of which are at risk because primary insurance is unavailable or exhausted. See *Dean v. State Farm Mut. Auto. Ins. Co.*, 518 So.2d 1115, 1117-18 (La.App. 1987) (finding Other Insurance clauses in competing true excess policies mutually repugnant).

**Interpreted Together.** Usually, an Other Insurance clause in a primary policy and one in an excess policy are not interpreted together. This is so because they are different layers of insurance. "Because an excess or secondary policy, by its own terms, does not apply to cover a loss until the underlying primary insurance has been exhausted, an examination of Other Insurance clauses to determine the relative rights and responsibilities of the parties is unnecessary where ... the policies do not provide the same level of protection." *National Union Fire Ins. Co. v. Lawyers' Mutual Ins. Co.*, 885 F.Supp. 202, 207 (S.D.Cal.1995).

However, Other Insurance clauses in primary and excess policies are sometimes interpreted together even though they are different levels of coverage. For instance, the Fifth Circuit came to the rescue of an umbrella insurer who had been required by the district court to drop down because of an Other Insurance clause dispute. The district court had held that the Other Insurance clauses of the primary insurer and umbrella insurer were mutually repugnant and unenforceable. In *Truehart v. Blandon*, 884 F.2d 223 (5<sup>th</sup> Cir. 1989), the umbrella insurer's Other Insurance clause states: "If other collectible insurance with any other insurer is available to the insured covering a loss also covered hereunder ..., the insurance hereunder shall be in excess of, and not contribute with, such other insurance." The Fifth Circuit reversed the district court and agreed with the umbrella insurer that its policy provided excess insurance if, and only if, the insured's liability exceeded the primary coverage of the combined limits of two primary policies, \$400,000. Since the insured's liability did not even come close to that amount, the Fifth Circuit concluded that the umbrella insurer had no duty to drop down to the primary level. *Id.* at 228.

## **I. Umbrella/excess insurer drops down – then what happens?**

### **1. Allocation of defense costs becomes issue**

State and federal courts have considered the issue of allocation of defense costs between

primary and excess insurers; *Defense Costs-Primary and Excess Insurers*, 19 ALR 4th 107. The possible scenarios appear to be many.

**Pro Rata Based On Policy Limits.** Where an excess insurer is required to drop down and share in defense costs with a primary insurer, comparing each insurer's respective coverage provides an appropriate basis for determining responsibility for defense costs. For example, in *United States Fidelity & Guaranty Co. v. Federated Rural Electric Ins. Corp.*, 78 F.Supp.2d 1176, 1181-1182 (D.Kan. 1999), the court required *pro rata* allocation of defense costs based on policy limits; each insurer had coverage of \$1 million out of \$2 million total coverage and should, therefore, be responsible for one-half of the defense costs. In *American States Ins. Co. v. Angstman Motors, Inc.*, 343 F.Supp. 576 (D.Mont. 1972), the Court determined that the excess carrier should contribute a *pro rata* share to the defense costs in accordance with the ratio between its maximum coverage and the maximum coverage of the primary carrier.

**50/50 Split Regardless.** Courts have also held that a primary insurer and an excess insurer should each pay one-half of the defense costs regardless of the limits of the policies, reasoning that defense costs are not related to policy limits but are the same regardless of the policy limits. See *Belmer v. Nationwide Mut. Ins. Co.*, 599 N.Y.S.2d 427, 430 (App.Div. 1993).

**Pro Rata Based On Claim Payment.** As stated by a Kansas court: “[w]here the claim is over the limits of the primary policy and only one insurer undertakes the defense, the primary insurer and the excess insurer will each be liable for a *pro rata* share of the costs of defense in proportion to the amount of the claim each is required to pay. This result does not absolve any carrier from a duty to defend, but places the primary burden on the carrier which has issued primary insurance. It also recognizes the equitable subrogation rights of an insurer which has, by fulfilling its own duty to defend, also fulfilled an obligation owed by another.” *American Fidelity Ins. Co. v. Employers Mut. Cas. Co.*, 593 P.2d 14, 23 (Kan.App. 1979). “It is our view that all obligated carriers who have refused to defend should be required to share in costs of the insured's defense, whether such costs were originally paid by the insured himself or by fewer than all of the carriers.” *Continental Cas. Co. v. Zurich Ins. Co.*, 57 Cal.2d 27, 17 Cal.Rptr. 12, 366 P.2d 455, 460-461 (1961). The *Continental* court held that the costs of defense are payable by all the insurers in the same ratio as the judgment was paid by all the insurers; the court relied upon general principles of equitable subrogation. *Id.* The rationale of the rule is that “no insurer which deliberately breaches its obligation to the insured should be permitted thereby to profit, whether at the expense of the insured, or of an insurer which faithfully discharges its obligation..” *Id.* at 461-462.

The majority view seems to be that defense costs, in cases of coincidental mutual coverage, should be apportioned among insurers in accordance with the contribution to the payment of the loss, unless there are contractual provisions otherwise, and an excess carrier is entitled to reimbursement by the primary carrier for costs of defense where the recovery was within the primary limit. See *Belmer*, 599 N.Y.S.2d at 429-30, citing *Mandell Corp. v. INA*, 125 Misc.2d 390, 479 N.Y.S.2d 452, 454 (1984).

The court in *Belmer* found the excess insurer had a duty to defend, concurrent with the primary insurer, and required the allocation of defense costs to be the same as the allocation used in the settlement of the underlying claim. The repair shop's mechanic employee had been test driving a customer's car when he caused an accident. In explaining its ruling, the court stated it did not accept the view of those courts which require exhaustion of the primary policy prior to transferring the obligation to pay defense costs to the excess insurer and posited its view that the obligation of payment of judgment should equate with the obligation of payment for defense. 599 N.Y.S.2d at 432. The court based its decision on allocation with the following rationale:

it should have been clear from the early stages of the litigation that contribution by the excess carrier was required in judgment or settlement. It is further clear that under tort law the vehicle owner/customer (insured of primary insurer) should have been indemnified by the repair shop (insured of excess insurer). It also appears that while the vehicle owner could effectively be indemnified against the repair shop's employee (driver of the automobile), the repair shop/garage owner could not be indemnified by an employee, acting in the course of employment. It thus appears likely that in a trial of the underlying action there would be a great likelihood of success by the vehicle owner against both the garage and its employee.

*Id.* Thus, the ratio established in the settlement - excess insurer paid \$75,000 and primary paid \$5,000 - was deemed to be the ratio for allocating the defense costs. *Id.*

**Primary Reimburses Excess 100%.** Where the excess carrier provides the defense, generally they have a right to be reimbursed for defense costs where the recovery was within the primary limit or was not yet determined. *Id.* at 430, citing *Travelers Ins. Co. v. Norwich Union Fire Ins.*, 221 Cal.App.2d 150, 34 Cal.Rptr. 406 (1963). In *Western Pacific Ins. Co. v. Farmers Ins.*, 69 Wash.2d 11, 416 P.2d 468 (1966), the Court held the liability policy of an auto repairman excess and the auto owner's policy primary and found that the primary insurer was liable for costs of defense of an action against the repairman for damages resulting from an accident while the repairman was driving the vehicle. The excess carrier assumed the defense and settled the claim for an amount less than the limits of the primary policy and therefore the excess insurer was entitled to be reimbursed for the costs of defense.

**Primary Does Not Reimburse Excess.** Where the primary insurer tenders the *full* amount of its policy, some courts have held that the primary insurer is not required to reimburse the excess insurer for its defense costs incurred after the primary insurer stopped defending. The duty to defend terminated upon payment of the policy limit. See *Belmer*, 599 N.Y.S.2d at 430, citing *U.S. Fire Ins. Co. v. State Farm Fire*, 246 Ark. 1269, 441 S.W.2d 787 (1969). A minority of jurisdictions have held that an excess insurer who handled the driver's defense and negotiated a settlement within the limits of the primary insurance had no right to recover the cost of defense from the primary carrier. The courts

reasoned that the excess insurer had a contractual duty to defend and this duty was separate from indemnification and thus had no right to contribution from the primary insurer for costs of defense, recognizing that the primary insurer also had a duty to provide a defense. See *Belmer*, 599 N.Y.S.2d at 430, citing *Maryland Casualty Co. v. American Family Ins. Group*, 199 Kan. 373, 429 P.2d 931 (1967).

**J. Consequences of umbrella/excess insurer failing to drop down when it should have done so**

**1. ABT Building Products v. National Union Fire (4<sup>th</sup> Cir. 2007): dire consequences of failing to drop down**

A case study in what can go wrong for an excess insurer who fails to drop down can be found in the case of *ABT Building Products Corp. v. National Union Fire Ins. Co. of Pittsburgh*, 472 F.3d 99 (4<sup>th</sup> Cir. 2006).

The insured ABT Building Products Corp. is a manufacturer of hardboard siding, a wood-based product that is sold and affixed to the exteriors of homes. In 1995, homeowners began filing lawsuits against ABT alleging that the siding, when exposed to moisture, humidity and other normal climatic conditions, absorbed moisture and prematurely rotted and deteriorated. Many of the plaintiffs also claimed that those problems had, in turn, resulted in consequential damages to other parts of their homes. *Id.* at 100. ABT and the homeowner plaintiffs had settlement discussions, culminating in an agreement in September 1990 that a national class action was the appropriate vehicle by which to resolve their disputes. The settlement terms were: one of ABT's primary insurers, Employers Insurance of Wassau, agreed to pay ABT the sum of \$1.5 million in compromise of disputed claims and agreed to continue to pay its share of defense costs through July 1999, and of the \$1.5 million settlement, \$1.1 million was allocated to a Wassau primary policy. The settlement released all claims against ABT in the underlying actions for homeowner class members who did not opt out, in exchange for payments to be made by ABT to class members through an agreed-upon twenty-five year claims program. The program required the submission of claims by homeowners and the calculation of the appropriate damage payment by a formula. *Id.* at 108-109.

ABT's excess insurer National Union did not participate in the defense or settlement with ABT and homeowners. Under the terms of the umbrella policy, National Union agreed to cover only "those sums in excess of the retained limit that the Insured becomes legally obligated to pay by reason of liability imposed by law ... because of Bodily Injury, Property Damage, ... that takes place during the Policy Period and is caused by an Occurrence." *Id.* at 131. In addition, National Union shall have the "duty to defend any claim or suit seeking damages covered by the terms and conditions of this policy when: The applicable limits of Insurance of the underlying policies in the Schedule of Underlying Insurance and the Limits of Insurance of any other underlying insurance providing coverage to the Insured have been exhausted by *payment of claims* to which this policy applies." *Id.* at 132.

National Union contended among other things that the \$1 million primary limit had not been exhausted and National Union had no duty to defend because (a) ABT had not exhausted the primary limits before the class settlement and (b) the \$1.5 million settlement did not constitute a “payment of claims” within the meaning of the umbrella policy because the payment was not to third party claimants, the homeowners. *Id.* at 128.

In 2001, ABT filed a bad faith action against National Union alleging improper claim handling relating to the actions brought by the homeowners and alleging underwriting irregularities relating to the issuance of one of the umbrella policies in question. In 2004, a jury rendered a verdict for the insured and the judgment was entered in part as follows: \$2.5 million for breach of duty to defend, \$3.9 million for unfair and deceptive trade practices, trebled to \$11.7 million, and \$2 million in attorneys fees, for a total of \$16.2 mil. plus interest. *Id.* at 128-129.

On appeal, one of the main issues was whether the excess policy language imposed a defense obligation upon National Union when the primary limits have been exhausted by payment of claims to the insured, but not by payment of claims to the 469 third party claimants, whose paid claims at the time of trial had only added up to \$275,000. *Id.* at 128-129. This dollar amount of “*Foster* claims paid to date” was submitted to the trial court shortly before the jury returned its verdict. *Id.* at 133. National Union argued on appeal that the term *payment of claims* should be narrowly construed, excluding all payments other than those made directly to third party claimants against ABT to satisfy judgments or secure the release of claims, and since Wausau paid ABT in order for ABT to make future payments to third party claimants, Wausau's settlement with ABT was not a “payment of claims” under the umbrella policy. *Id.* at 115.

In its opinion issued on December 19, 2006, the Fourth Circuit held that “because the term ‘payment of claims’ clearly does not exclude payments of the kind involved here, we are unable to accept National Union's proffered interpretation.” *Id.* at 116. Key to the court was that the term *payment of claims* “does not restrict the recipient or timing of the payment in question.” *Id.* “National Union, of course, could have sought a more restrictive formulation - such as ‘payment of claims to third parties’ or ‘payment of judgments or settlement agreements enforceable by third parties’- but it did not do so.” *Id.* The court was critical of the insurer’s “narrow construction,” which “effectively would assign it a defense duty that would arise in only one circumstance: when its insured has faced multiple actions, resolved enough of them to exhaust its underlying coverage, and continued to defend the rest.” *Id.* at 117.

This case demonstrates the perils for excess insurers. The cases and treatises plainly state that an excess insurer has no duty to drop down and provide indemnification or a defense before the primary coverage is exhausted. See *Qualcomm, Inc. v. Certain Underwriters At Lloyd's, London*, 161 Cal.App.4th 184, 73 Cal.Rptr.3d 770 (Cal.App. 4 Dist.,2008). However, the insurer in the *ABT Building Products* case was ultimately unable to rely on that general rule and paid a hefty judgment as a result.

**IV. Practical Tips for Claim Examiner to Avoid the “Drop Down” of Excess/Umbrella Policy on Claim**

- A. Study the primary and excess/umbrella policies at issue
  - 1. Know which provisions to hone in on
  - 2. Have the entire policy in front of you
- B. Look for express policy terms in excess/umbrella policy about not dropping down
- C. Does excess/umbrella policy provide coverage in excess of “collectible” underlying insurance?
- D. Look for typically low premium paid for excess/umbrella policy
  - 1. Low premium reflects little or no intent to assume risk of drop down
- E. Sophisticated insured can’t claim ignorance
- F. If insured failed to maintain the primary insurance, drop down is not likely
- G. Does the Other Insurance clause protect from drop down?
- H. Are the primary limits less than required by the excess policy?
- I. Does the excess policy require a defense in certain circumstances?
- J. Excess/umbrella policy not intended to insure against insolvency of primary insurer
  - 1. Excess insurer played no part in selecting primary insurer that is now insolvent
- K. Existence of state insurance guaranty fund
  - 1. Look carefully at statute creating the guaranty fund
  - 2. Statutory limits are often lower than limits of primary policy

**V. Practical Tips for Claim Examiner Seeking “Drop Down” of Excess/Umbrella Policy of Other Insurer**

- A. Study the policies at issue
- B. Excess/umbrella policy has duty to defend provision
  - 1. Often found in umbrella policies, but not in true excess policies
  - 2. Duty to defend law often construes the provision in favor of insured
- C. Look for other terms in excess/umbrella policy that conflict with insuring agreement language
  - 1. Endorsements can inadvertently conflict with coverage form
- D. Does excess/umbrella policy provide coverage in excess of “amounts recoverable” under primary policy?
  - 1. But don’t automatically assume “amounts recoverable” language helps you
  - 2. Lots of case law throughout the country construing it
- E. Does the excess/umbrella policy refer to “applicable” or “collectible” limits of underlying insurance?
- F. Look for higher than usual premium paid for excess/umbrella policy
- G. Look for inexperienced insured

- H.
  1. Court may have more sympathy for unsophisticated insured  
Excess/umbrella insurer participated in selecting the primary insurer now  
insolvent