Moore Is Less:

Benjamin Moore At War With The Doctrine Of Reasonable Expectations

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At its simplest, the doctrine of objectively reasonable expectations states that the insured should not suffer because of complexities in an insurance policy created by the insurance industry. Rather, courts should respect the expectation of the insured that when it purchased insurance coverage, it successfully externalized risk. Robert Keeton’s classic 1970 law review article explicating the doctrine was heavily rooted in recent, revolutionary New Jersey case law, and the New Jersey Supreme Court has recently affirmed the ascendancy of the doctrine. Robert E. Keeton, Insurance Law Rights at Variance with Policy Provisions, 83 Harv. L. Rev. 961 (1970); Zacarias v. Allstate Ins. Comp., 168 N.J. 590, 595 (2001).

The New Jersey Appellate Division in Benjamin Moore & Co. v. Aetna Cas. & Sur. Co., et al., A-4423-01T2F (Jan. 14, 2003) faced a classic ‘reasonable expectations’ conundrum. The court could apply the language of the insurance policy mechanically to deprive the insured of coverage, or look to the overall purpose of general liability insurance to maximize coverage. The Appellate Division chose the former. The Supreme Court should reverse.

Benjamin Moore concerned a long term, continuous trigger situation in which each successive primary insurance policy had a deductible. The Appellate Division faced the following issue: When coverage stretches over numerous primary policies each with a deductible, should the insured be responsible for one deductible or numerous ones? The Appellate Division mechanically found that if the insured triggered multiple policies, it also triggered multiple deductibles. Relying heavily on the recommendation of a special master in another environmental insurance coverage case, the court held that “each policy in question here was triggered by exposure to [the insured’s] lead paints. Under the unambiguous terms of the policies issued to [the insured], [the insurer’s] obligation to pay damages applied only to the amount of insurance remaining after deducting the deductible amount.” Benjamin Moore, A-4423-001T2F at 14. As a result of the application of each successive deductible, the insured, despite buying insurance every year, received no coverage.

Owens-Illinois And Carter-Wallace

is rooted in the limitations of those decisions by the Supreme Court. In those cases, the Court first
determined that when property damage or bodily injury occurred over consecutive policy periods,
each policy must respond under a ‘continuous trigger’ theory of coverage. The Court specifically
held that “when progressive indivisible injury or damage results from exposure to injurious con-
ditions for which civil liability may be imposed, courts may reasonably treat the progressive injury
or damage as an occurrence within each of the years of a CGL policy.” Owens-Illinois, 138 N.J. at
478-79. The resolution of this ‘trigger’ issue created the allocation issue. Id. at 446. If numerous
policies must respond, how much must each pay?

Owens-Illinois discussed the two different approaches. Owens-Illinois, and insureds generally,
argued for the ‘pick and choose’ or ‘joint and several’ approach. Id. at 464. Pursuant thereto,
each and every insurer on the risk during the trigger period is responsible for ‘all sums’ that the
insured becomes legally obligated to pay and therefore the insured may choose any policy year
to respond in full to the loss. Id. The chosen insurer(s) may then seek contribution from other
triggered insurers — but not from the insured. Id. The Appellate Division decision in Owens-
Illinois adopted this approach. Id. at 445. The other approach, championed by insurers, is to
allocate a portion of the damages to each triggered year, including an allocation to the insured
for any year(s) when it did not have insurance in place. Id. at 464.

The Supreme Court adopted the latter, so-called “pro rata” approach as a matter of public policy.
Id. at 475. The Court noted that there was little difference between the two approaches, the key
factor being whether the onus of contribution rested on the insured or the targeted insurer. Id. at
467. One issue troubled the Court above all others — would the insured who did not purchase
insurance in some years get a free ride? Under the ‘pick and choose’ approach, the Court rea-
soned that the insured who purchased insurance in one year out of ten received the same cover-
age as the insured who purchased coverage in every year. Id. at 473. This perceived unfairness
led the Supreme Court to allocate liability annually, with the insured being responsible for those
years in which it purposefully chose not to purchase insurance. Id. at 479. Moreover, to further
its risk transfer and reasonable expectation analysis, the Court established an allocation construct
that weighted each party’s share of responsibility based on “time on the risk” (i.e., the number of
years and sometimes days that an insurer covered a risk) and “degree of risk assumed” (i.e., the
amount of coverage limits provided by the insurer in proportion to total available limits during
the trigger period). Id. As a result, years in which the insured purchased more total insurance
would bear a greater share of the loss than years in which less insurance was purchased. Id.

The Supreme Court did not find one allocation approach ‘right’ and the other one ‘wrong.’ The
Court based its decision on a single public policy factor: encouraging policyholders to buy ade-
quate insurance. Id. at 472-3. Indeed, the Court held that an insured may be allocated a share
of responsibility only if a period of “no insurance” reflects “a decision by [the insured] to assume
or retain a risk, as opposed to periods when coverage for a risk is not available[.]” Id. at 475.
Recognizing that long-term injury claims are complex and that apportioning costs for those claims
could not be accomplished with “scientific certainty,” the Court concluded by emphasizing its
willingness to re-examine this issue if necessary. Id. at 478-79.

Less than five years later, the Court did just that in Carter-Wallace, supra, analyzing the sticky
allocation question of how to allocate between primary and excess insurers. There, the Court
established that New Jersey’s pro rata method of allocation rejects both straight horizontal ex-
haustion (i.e., all primary coverage must be exhausted before any excess carrier pays) and linear
exhaustion (i.e., the insurers in year 2 of the trigger period pay nothing until all of the insurers
on the risk in year 1 pay in full). Carter-Wallace, 154 N.J. at 325-26. Instead, damages are
allocated to each policy year based on the total available limits in that policy year in relation to
the total available limits over the entire trigger period. Once a portion of the damages is allo-
cated to a particular policy year, the primary carrier in that year must pay its limit in full before
the first layer excess carrier must pay anything and so on. Id. at 327.
Again, the Court’s decision was grounded in public policy:

this approach makes efficient use of available resources because it neither minimizes nor maximizes the liability of either primary or excess insurance, thereby promoting cost efficiency by spreading costs. That method also promotes simple justice by respecting the distinction between primary and excess insurance while not permitting excess insurers unfairly to avoid coverage in long-term, continuous-trigger cases.

Id. (citation omitted).

**New Jersey Insurance Law Principles**

It is well settled that “the fundamental principle of insurance law is to fulfill the objectively reasonable expectations of the parties.” Werner Industries, Inc. v. First State Ins. Co., 112 N.J. 30 (1988). “[C]ourts will enforce only the restrictions and the terms in an insurance contract that are consistent with the objectively reasonable expectations of the average insured.” Meier v. New Jersey Life Ins. Co., 101 N.J. 597, 612 (1986); see also Allen v. Metropolitan Life Ins. Co., 44 N.J. 294 (1965) (holding that “an insured’s reasonable expectations in the transaction may not justly be frustrated and courts have properly molded their governing interpretative principles with that uppermost in mind”). “When members of the public purchase policies of insurance they are entitled to the broad measure of protection necessary to fulfill their reasonable expectations. They should not be subjected to technical encumbrances or to hidden pitfalls and their policies should be construed liberally in their favor to the end that coverage is afforded to the full extent any fair interpretation will allow.” Kievit v. Loyal Protective Ins. Co., 34 N.J. 475, 482 (1961).

Thus, the Court has held that “the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations.” Sparks v. St. Paul Ins. Co., 100 N.J. 325, 338-39. “The key question [when determining the effect of policy language becomes] what, objectively, was the reasonable expectation of [an insured] when [it] obtained the liability insurance from the insurer.” American Nurses Association v. Passaic General Hospital, 98 N.J. 83, 88 (1984). Most recently, the Court noted that:

[j]insurance contracts are complex instruments. They are issued to assist individuals to plan rationally for the unforeseen challenges of an unpredictable future. For such transactions to be sustainable, both sides must be able to rely on the plain meaning of the contracts into which they respectively enter. Courts should construe insurance policies against the insurer, consistent with the reasonable expectations of insureds, when those policies are overly complicated, unclear, or written as a trap for the unguarded consumer.

Zacarias, 168 N.J. at 604. These are the principles that govern New Jersey insurance law, and the Appellate Division inexplicably ignored them in Benjamin Moore.

**The Role Of Deductibles**

Until very recently, the insured purchasing insurance did not think of what trigger or allocation theory might apply to its claim. Indeed, the first major asbestos coverage decisions addressing these concepts did not even issue until the early 1980s after the termination of most of the policies in dispute in Benjamin Moore. Historically, an accident occurred at a single time and place,
as in the classic slip and fall or fender bender. When a policyholder purchased coverage in for example 1980, it thought that it purchased coverage for accidents occurring in 1980. And if a policyholder chose a deductible, it did so because it chose to internalize the first portion of a loss. If an insured obtained a policy for $100,000 with a $10,000 deductible, the insured’s objectively reasonable expectation was that it would pay the first $10,000 of a loss, and that the insurer would pay the balance.

As an insured entered into consecutive policies, each with a limit of $100,000 and a deductible of $10,000, the insured’s expectation did not change. The insured retained the first $10,000 of loss, and externalized the rest. The insured could not foresee two decades of continuing judicial battles over trigger and allocation, nor the result that the Supreme Court would hold that consecutive policies would apply.

In this regard, it is important to understand the role of a retained limit or a deductible. “Its functional purpose is simply to alter the point at which an insurance company’s obligation to pay will ripen.” American Nurses, 98 N.J. at 88. Contrary to the court’s holding in Benjamin Moore, there is no language in a standard liability insurance policy that may be construed to mean that either the insured or its insurers expected that per occurrence retained limits could apply consecutively to a single loss, so that the retained limit would effectively devour coverage. Insurance policies should not be given strained interpretations that destroy their basic purpose: to provide coverage. “The general and New Jersey rule is that ‘insurance contracts must, whenever possible be . . . strictly construed against the insurer in order to afford protection which the insured sought in applying for insurance.’” Mahon v. American Casualty Co., 65 N.J. Super. 148 (App. Div. 1961), cert. denied 34 N.J. 472 (1961), quoting Schneider v. New Amsterdam Casualty Co., 22 N.J. Super. 238, 242 (App. Div. 1952).

Moreover, there is no justification for the assumption, as employed by Benjamin Moore, that a continuous trigger creates a series of occurrences that all relate to the same loss. Indeed, such an assumption is directly contrary to policy language drafted by the insurers that defines a single occurrence as “an accident or series of accidents arising from one event or exposure of persons or property to conditions which results, during the policy period, in personal injury or property damage . . .” Thus, damage over ten years is a single occurrence, to which a single deductible should apply.

Benjamin Moore also ignores the fact that a pro rata allocation methodology assumes that policy limits and deductibles will be paid at a rate of less than 100% of the original stated limits under a continuous trigger theory of coverage. Assume that a court establishes a ten year trigger period for a loss of $1,000,000. Assume further that insurers in each year issued a policy with a $1 million limit of liability. Applying a pro rata allocation, the insurer in each year would be required to pay only 10% of its stated policy limit. Several courts outside of New Jersey have recognized that insureds are entitled to the same pro-rated treatment with respect to deductibles. See e.g., Peco Energy Co. v. Boden, 64 F.3d 852 (3d Cir. 1995)(applying Pennsylvania law)(holding that a pro-rated deductible must be applied to comply with the parties’ reasonable expectations); La Farge Corp. v. Hartford Casualty Ins. Co., 61 F.3d 389, 401 (5th Cir. 1995)(holding that “the policy provides that the deductible will apply to each occurrence; it is at best ambiguous as to what happens when the insurer is held liable for only part of a continuous occurrence”); E.I. du Pont de Nemours and Co. v. Admiral Ins. Co., 1995 WL 654020 at *16 (Del. Super. 1995)(holding that a pro-rata allocation method “cannot be used to defeat coverage paid for [the policyholder]. Consequently, if an insurer will be held liable for one-tenth of the clean-up costs, the deductible will be reduced commensurate with the fraction of liability.”).
Conclusion

Benjamin Moore turns the doctrine of reasonable expectations on its head. The insured that purchased a policy of $100,000 each year with a deductible of $10,000 and then has a loss of $100,000, has no coverage. This is fundamentally at odds with over 40 years of doctrinal development of New Jersey insurance law. The insured should not be victimized by the application of a judicially constructed coverage theory developed years after the insured purchased its policies. The Supreme Court should take Benjamin Moore’s appeal and rectify the Appellate Division’s misconstruction of New Jersey’s pro rata allocation method with respect to deductibles. ■