Court of Appeal No. E041425

IN THE COURT OF APPEAL OF CALIFORNIA
FOURTH APPELLATE DISTRICT, DIVISION TWO

STATE OF CALIFORNIA,
Appellant,

vs.

CONTINENTAL INSURANCE COMPANY as successor-in-interest to the policy issued by Harbor Insurance Company, CONTINENTAL CASUALTY COMPANY, CNA CASUALTY COMPANY OF CALIFORNIA, EMPLOYERS INSURANCE OF WAUSAU, HORACE MANN INSURANCE COMPANY, STONEBRIDGE LIFE INSURANCE COMPANY, formerly known as J.C. Penney Life Insurance Company, successor to Beneficial Fire & Casualty Insurance Company, and YOSEMITE INSURANCE COMPANY,
Respondents.

CONTINENTAL INSURANCE COMPANY as successor-in-interest to the policy issued by Harbor Insurance Company, CONTINENTAL CASUALTY COMPANY, CNA CASUALTY COMPANY OF CALIFORNIA, EMPLOYERS INSURANCE OF WAUSAU, HORACE MANN INSURANCE COMPANY, STONEBRIDGE LIFE INSURANCE COMPANY, formerly known as J.C. Penney Life Insurance Company, successor to Beneficial Fire & Casualty Insurance Company, and YOSEMITE INSURANCE COMPANY,
Cross-Appellants.

vs.

STATE OF CALIFORNIA,
Cross-Respondent.

Riverside County Superior Court Case No. 239784, c/w Case No. RIC-381555
The Honorable E. Michael Kaiser

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

AMICUS CURIAE BRIEF OF CENTER FOR COMMUNITY ACTION & ENVIRONMENTAL JUSTICE AND UNITED POLICYHOLDERS IN SUPPORT OF THE STATE OF CALIFORNIA

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APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF OF CENTER FOR COMMUNITY ACTION & ENVIRONMENTAL JUSTICE AND UNITED POLICYHOLDERS

Pursuant to Rule 8.200(c) of the California Rules of Court, Center For Community Action & Environmental Justice ("CCAEJ") and United Policyholders ("UP") (collectively "*Amici*"), jointly as amicus curiae, request leave to file an *amicus curiae* brief in support of Plaintiff, Appellant, and Cross-Respondent the State of California. *Amici's* counsel is familiar with the issues in this case and with the scope of their representation.

CCAEJ is a non-profit organization with its main office located in Riverside, California. The CCAEJ's goal is to bring groups of people together to find opportunities for cooperation, agreement and problem solving. CCAEJ works with community groups in developing and sustaining democratically based, participatory organizations that promote involvement of a diverse segment of the community in ways that empower. CCAEJ accomplishes this by facilitating and providing assistance in the following areas: information/publications; direct, "hands-on" assistance with groups; outreach, referral and network development; and training and leadership development. CCAEJ creates partnerships with organizations that are working on issues related to environmental justice, social justice and economic development. The partnerships are created to broaden agendas and effectively disseminate resources. The goal of CCAEJ is to build a strong movement for change that recognizes the connections between environmental and worker exploitation, and oppression on the basis of race, gender, sexual orientation and class, and incorporates that connection in the primary activities of

CCAEJ. CCAEJ accomplishes this goal by actively seeking opportunities to bring together groups of people working on a variety of social, economic and environmental justice issues.

UP was founded in 1991 as a non-profit, 501(c)(3) organization dedicated to educating the public on insurance issues and consumer rights. UP is funded by donations and grants from individuals, businesses, and foundations. The organization monitors legal and marketplace developments that impact policyholders and participates in formulating public policy on insurance transactions. UP offers practical guidance on coverage and claims issues to property and business owners and advocates, including disaster relief personnel, attorneys, and adjusters at www.uphelp.org.

CCAEJ and UP are unaffiliated national organizations mutually concerned with the important insurance coverage issues in this case which will have a widespread impact on policyholders, third-party beneficiaries entitled to the policyholder's insurance recovery, and the general public, not only in California, but also nationwide.

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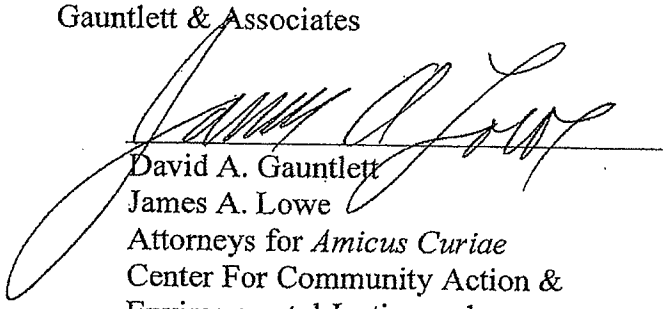
Amici believes it can bring additional perspective to certain issues that were not addressed in the parties' briefs. Because of their substantial interest in the issues before the Court in this case, *Amici* respectfully request permission to file the brief submitted herewith for the Court's consideration.

Dated: May 21, 2008

Respectfully submitted,
Gauntlett & Associates



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I. INTRODUCTION

Although the general liability insurance policies at issue and California law more than adequately support a ruling against Respondents, *Amici* respectfully brings to this Court's attention the following issues in further support of the legal arguments set forth in the briefs submitted by Appellant the State of California:

- Considerations of public welfare and the potential widespread impact of the issues being decided on this appeal;
- The overreaching nature of the erroneous offset as applied against Appellant without first making the policyholder whole;
- Respondents' opportunistic breach of their insurance policies in the face of well established California law and the policyholder's reasonable expectations.
- Drafting history support for California's well established application of "all sums" to general liability occurrence policies;
- Stonebridge's attempt to benefit from its own affirmative destruction of historical policies available to pay historical long-tail claims; and
- The clear annualization of limits given Appellant's course of dealings with Respondents.

Although some of these issues may not be dispositive for the resolution of this case, the principles underlying all of them place the complex insurance issues on appeal in a broader context. Moreover, the arguments presented before this Court by Respondent insurance companies seek to overturn longstanding California law and minimize coverage, not only for remediation of the Stringfellow Class I Hazardous Waste Facility, but to the detriment of policyholders and the general public in connection with all insurance policies sold in California.

II. ARGUMENT

A. Respondents' Unsupported Reinterpretation Of The Express Language In General Liability Policies Has Far Reaching Detrimental Effects.

Insurance has long been recognized in California as a vital asset to protect the public interest, especially in the remediation of long-term environmental contamination under State and Federal laws and regulations. Thus, all of the issues in this appeal have significant impact upon the public at large, from parents caring for a child involved in a car accident who potentially would be limited in their ability to recover the full amount of their damages under the offset rule espoused by Respondents, to families who will find that parties liable for remediation of hazardous wastes in their community suddenly no longer have adequate general liability insurance because the broad "all sums" insuring language of general liability policies was tossed aside by the insurance companies.

It has long been understood that the purpose of liability insurance is not only to protect policyholders, but also to protect third party beneficiaries to whom policyholders are liable. *See, e.g., Price v. Wells Fargo Bank*, 213 Cal. App. 3d 465, 475 (1989) (including insurance among businesses "being highly regulated industries performing vital public services substantially affecting the public welfare."). The Supreme Court of California has recognized that the insurance industry must be concerned with the public welfare and interest:

> The insurers' obligations are ... rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest

> seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements ....

Egan v. Mutual of Omaha Ins. Co., 24 Cal. 3d 809, 820 (1979) (approvingly quoting William M. Goodman & Thom Greenfield Seaton, *Foreword: Ripe for Decision, Internal Workings and Current Concerns of the California Supreme Court*, 62 Cal. L. Rev. 309, 346-347 (Mar. 1974)).

Insurance industry representatives leave no doubt as to the significant regulatory function in our society served by insurance companies:

> One function of insurance is 'surrogate regulation'. When an insurer chooses to insure a given activity, it evaluates and monitors the insured's performance. When the insured risk is adequately defined, the insurer, by offering reduced premiums or conditioning the sale of insurance on adequate loss-control measures, can encourage the insured to take steps to minimize the potential for loss or to internalize costs.

Brief of *Amici Curiae* Ins. Envtl. Litig. Assoc. Brief of *Amici Curiae* Insurance Environmental Litigation Association, New York State Insurance Association, Utica Mutual Insurance Company, Utica Fire Insurance Company of Oneida County, N.Y. and Empire Insurance Company at 36-37, (dated May 10, 1989) *Technicon Elec. Corp. v. Atlantic Mutual Ins. Co.*, (N.Y.) (No. 08811/85) *cited in* Eugene R. Anderson *et al.*, *A.B.A. Manual for Complex Insurance Coverage Litigation: A Prescription for Insurance Nullification*, 7 Fordham Envtl. L.J. 55, 64 n.53 (1995) (Fall, 1995) ("A group of insurance companies and anti-policyholder advocacy organizations filed an amicus brief stating that, '[o]ne function of insurance is 'surrogate regulation.'").

Similarly, a textbook used to train insurance industry professionals confirms that insurance companies have an obligation to the public interest:

> Insurance contracts are different from other commercial contracts because insurance is more a necessity than a matter of choice. Therefore, insurance is a *business affected with a public interest*, as reflected in legislative and judicial decisions.

1 James J. Lorimer, *et al.*, *The Legal Environment of Insurance* at 179 (4th ed. 1993) (emphasis in original).

As insurance companies have long profited[1] from their public service status, so must they meet their public service obligations. Instead, as demonstrated in Appellant's briefs, the positions taken by Respondents disregard and attempt to overturn well established California law with respect to:

- "Offset" – by allowing insurance companies to completely escape any payment at all at the expense of the policyholder and regardless of whether or not the policyholder has been paid for its entire underlying loss and thus been "made whole";
- "All Sums" – by significantly reducing the value of policies purchased over multiple years (e.g., construction defects, bodily injury or property damage resulting from pollution, asbestos or other continuous or progressive conditions) intended to cover very high-value liability exposures triggering multiple policy periods;

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[1] The insurance industry is "a $2.3 trillion financial industry," with a $1 billion yearly allowance for "coverage litigation," that is, funds specifically earmarked to pay attorneys, to fight policyholders. U.S. House of Representatives, Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, 103rd Cong., 2d Sess., Wishful Thinking: A World View of Insurance Solvency Regulations, at iii (Letter of Transmittal) (Comm. Print Oct. 1994); *see also Miller v. Fluharty*, 500 S.E.2d 310, 318 n.10 (W. Va. 1997) ("This disparity [of bargaining power between an insurance company and claimants] is apparent in the fact that insurance companies spend over $1 billion annually in litigation battles against policyholders."); Leslie Scism, *Tight-Fisted Insurers Fight Their Customers to Limit Big Awards*, Wall St. J., Oct. 15, 1996, at 1.

- "Stacking" – by eliminating all but a single policy year worth of coverage despite separate insurance contracts being sold for separate premiums in different policy periods by different parties;
- "Number of Occurrences" – by restraining policyholders with very high value claims from accessing "per occurrence" limits promised by their insurance companies;
- "Annualization" – by limiting policyholders with multi-year policies to single year limits without supporting insuring language; and
- "Lost Policies" – by allowing insurance companies to benefit from their decision to destroy insurance policies they knew were still effective for long-term liabilities.

Although legal authority and a plain reading of the liability policies at issue are sufficient to reject Respondents' arguments, as further detailed herein, established California law should not be overturned merely to minimize existing coverage obligations and provide a windfall to the insurance companies while at the same time failing to satisfy the policyholder's underlying loss. Especially where, as here, the adoption of Respondents' arguments would harm not only Appellant, but vast numbers of other policyholders, third-party beneficiaries, and the general public.

B. Respondents' Misapplication Of Offsets Is Overreaching And Harmful To All Policyholders And The General Public.

1. Offsets Must Only Be Taken Against The Underlying Liability.

Respondents' liability for breach of their general liability insurance policies must not be "offset" by settlements until Appellant recovers all of the State's own liability for cleanup of the Stringfellow Class I Hazardous Waste Facility. It is well established under California law that a policyholder must be "made whole" prior to any reduction of the insurance companies' obligation:

> It is a general equitable principle of insurance law that, absent an agreement to the contrary, an insurance company may not enforce a right to subrogation until the insured has been fully compensated for [his or] her injuries, that is, has been made whole.

Hodge v. Kirkpatrick Dev., Inc., 130 Cal. App. 4th 540, 553 (2005) (emphasis added) (citing *Barnes v. Independent Auto. Dealers of California*, 64 F.3d 1389, 1394 (9th Cir. 1995) and *Sapiano v. Williamsburg Nat. Ins. Co.*, 28 Cal. App. 4th 533 (1994).

Accordingly, any equitable offset allowed by Respondents against Appellant, must be taken against the Appellant's underlying liability as opposed to Respondents' own liability to Appellant for breach of contract. *See Plut v. Fireman's Fund Ins. Co.*, 85 Cal. App. 4th 98, 106 (2000) (offset against insurance company's limits allowed only after determination that policyholder was made whole for its losses).

The Trial Court's ruling, therefore, upsets the fundamental purpose of the remedy of an equitable offset. An equitable remedy should not be applied so that a breaching insurance company escapes paying a single penny of its policy limits whereas the policyholder is awarded nothing despite covered losses well in excess of any of its recoveries for those losses. The Trial Court's inequitable ruling not only is contrary to California law, but, if adopted by other Courts, potentially has far reaching deleterious effects upon all types of insurance policies.

2. All Policyholders From Individual Homeowners To Large Corporations Potentially Are Harmed By Respondents' Disregard For The "Make Whole" Rule.

An offset may only be applied against a policyholder's total underlying loss. Offsets against policy limits as proposed by Respondents have the potential to

devastate not only the policyholder, but also tort claimants who would not be compensated if the Courts do not enforce the policies of otherwise impecunious entities. The United States Supreme Court has considered the public interest of insurance and the resultant public responsibilities imposed upon insurance companies. Similar to the California Supreme Court's recognition of the public interest component to insurance as set forth above, the United States Supreme Court stated:

> The contracts of insurance may be said to be interdependent.
>
> They cannot be regarded singly, or isolatedly [sic], and the effect of their relation is to create a fund of assurance and credit, the companies becoming the depositories of the money of the insured, possessing great power thereby, and charged with great responsibility.

German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 414 (1914).

The special nature of an insurance company's relationship with its policyholders and the public has also been long recognized even by insurance industry outsiders. At least as far back as 1921, Dean Roscoe Pound recognized the public duties of insurance companies beyond solely contractual obligations:

> [W]e have taken the law of insurance practically out of the category of contract, and we have established that the duties of public service companies are not contractual, as the nineteenth century sought to make them, but are instead relational; they do not flow from agreements which the public servant may make as he chooses, they flow from the calling in which he has engaged and his consequent relation to the public.

Roscoe Pound, *The Spirit Of The Common Law* at 29 (1921), http://digitalcommons.unl.edu/lawfacpub/1.

The impact of an affirmation of the Trial Court's ruling and a decision supporting Respondents' position that insurance companies can offset settlements directly against their own policy limits, despite the policyholder's larger liability, impacts insurance policies of every type. For example, the concept that offsets can only be taken against a policyholder's total liability was described in a "Practice Note" in a California practice guide in the context of uninsured motorist claims. Cal. Civ. Prac. Torts, § 38:5 (2008) *("To determine what offset or reduction is to be given the uninsured motorist carrier, the policy must be analyzed. If it speaks in terms or "damages" to the insured, the offset or reduction is from the total amount of the injury, and not the policy amount.").* (emphasis added) Uninsured motorist claims limit the cases in which an insurance company's uninsured motorist liability may operate against other liabilities to three situations in which uninsured motorist payments may be reduced. These reductions, however, potentially allow insurance companies to receive a windfall at the expense of their policyholder if the amount offset is against the policy limits instead of the injury. Only a rule requiring offsets to be taken after the policyholder is made whole can protect a policyholder's right to receive full compensation for the total amount of an injury resulting from an accident with an uninsured motorist.

The significance of examining the entire liability was addressed by the California Court of Appeals with respect to an uninsured motorist claim brought by Lonny Cothron, a claimant injured in an automobile accident with an uninsured motorist. *Cothron v. Interinsurance Exch. of the Auto. Club of S. Cal.,* 103 Cal. App. 3d 853 (1980). In that case, the Court of Appeals held that: "The total amount of a claimant's

damage appear to be relevant to the extent the determination thereof is necessary to arrive at an award up to and including the policy limit ...." *Cothron* at 861. Respondents' position taken in this appeal would alter this analysis by allowing an insurance company to offset an individual policyholder's settlement with other parties regardless of whether or not the policyholder was fully compensated for injuries resulting from an automobile accident.

During the course of the case and this appeal, Respondents specifically have cited to and misapplied leading California cases applied to individual consumers. In their appellate brief, Respondents misrepresented the law of offsets allowed under an individual homeowners' policy in *Plut v. Fireman's Fund Ins. Co.*, 85 Cal. App. 4th 98 (2000). In *Plut*, John and Karen Plut's home was damaged when Roto-Rooter flooded the first floor of their home during the course of toilet repairs. Additionally, during the course of restoring their personal belongings using ISI, an interior services company, the truck containing the Plaintiffs' belongings was stolen. The Pluts entered into settlements with Roto-Rooter and ISI and brought a claim against their homeowners' insurance company.

In *Plut*, the Court only permitted the insurance companies to offset settlements after the policyholder was compensated for its "total" property loss and thus made whole. *Plut* at 106 (emphasis added) ("The jury's finding regarding breach of contract damages is well within the policy limits, and the record otherwise indicates that this finding is an assessment of the Pluts' total property losses. Accordingly, we conclude that the award against Fireman's Fund for breach of contract was intended to make the

Pluts whole with regard to their property losses."). Respondents' arguments, if adopted, would have allowed the insurance company to offset the Pluts' Roto-Rooter and ISI settlements for a windfall, even if the Pluts did not recover sufficient funds to repair their home or replace their stolen property.

Respondents' arguments would force every policyholder in California – including individual accident victims such as Lonny Cothron and homeowners such as the Pluts – with a contested coverage claim to engage in litigation prior to any other settlements in order to avoid having an offset taken off the policy limits. In the mean time, those same policyholders would be unprotected and required to fend for themselves.

The *Plut* case's "make whole" rule was relied upon in other cases such as *Chong v. State Farm Mutual Automobile Insurance Co.*, 428 F. Supp. 2d 1136, 1139 (S.D. Cal. 2006). In that case, Kathleen Chong filed a putative class action regarding the application of the "make whole" rule to her automobile insurance policy. Among other things, the United States District Court for the Southern District of California attempted to predict the breadth of the make whole rule under state law. Specifically, whether or not attorney's fees and expenses should be accounted for prior to an offset. The District Court predicted that, "the California Supreme Court would follow the well-reasoned out-of-state decisions which hold that the policyholder's litigation expenses must be taken into account when determining whether the policyholder has been made whole." *Chong* at p. 1144.

If Respondents' over reaching arguments were to prevail, not only would attorneys fees and costs not be considered with respect to the "make whole" rule, no expenses incurred by the policyholder at all – including direct damages due to injuries – would matter, because only the policy limits would determine the amount against which an offset would be taken by the insurance companies. Any degradation of *Plut* potentially erodes insurance for all policyholders, including individual consumer policyholders.

The issue of offsets often comes up in the individual context rather than the commercial context. Respondents have not hesitated to frame their argument in a broad context, for example, by relying upon insurance treatises referring to individual consumer insurance with respect to rules for preventing net gain offset against "the net loss suffered by a person designated to receive insurance benefits." Robert E. Keeton and Alan I. Widiss, *Insurance Law, A Guide to Fundamental Principles, Legal Doctrines and Commercial Practices*, § 3.6(a)(2) at 192 (West 1988) (emphasis added). Respondents' mistreatment of such broad reaching analysis is unfounded and demonstrates the fundamental error in their understanding of offsets in the context of insurance. The right of offset applies only to limit a double recovery of the policyholder's total underlying loss: "insurance arrangements are structured to provide funds to offset a loss either wholly or partly, and the payments made by an insurer generally are limited to an amount that does not exceed what is required to restore the insured to a condition relatively equivalent to that which existed before the loss occurred." *Id.* § 3.1(a) at 135; *see also* § 3.4(a)(3) at 166 ("In the event a tort claim by a third party produces legal liability, there

is no possibility that an insured will derive a net economic benefit so long as the insurance proceeds are ultimately used either to pay a liability claim or to indemnify an insured who has paid such a claim.").

The "make whole" rule for offsets is fundamental to all insurance, not merely the commercial general liability insurance at issue here. Well established California law, and as well as present and future California cases, are in jeopardy due to the Trial Court's erroneous rulings and Respondents' overreaching arguments seeking to deny the benefits of the make whole rule to all policyholders, including individual policyholders such as homeowners and automobile drivers.

3. Respondents Wrongly Argue That Making The Policyholder Whole Within The Insurance Companies' Limits Is Punitive And Against Public Policy.

While rejecting public policy arguments, Respondents themselves turn to public policy by appealing to the notion that "[t]here is no element of punishment in the measure of damages for breach of contract." Respondents' Brief at 142. Respondents allege that making the policyholder whole would constitute a "double insurance recovery". *Id.* As set forth above, however, the rule against "double recovery" requires first that Appellant recover the total amount of its underlying liability to cleanup the Stringfellow site. Here, any realistic calculation clearly shows that Appellant will not recover the several hundreds of millions of dollars required to clean-up the Stringfellow Acid Pits. Settlements with its insurance companies can never be a windfall for Appellant and should not be a windfall for Respondents.

The true public policy concerns here are the consequences of Respondents total escape from liability for their breach of contract where other insurance companies settled and Appellants' actual loss far exceeds its coverage limits. Any offset, let alone an offset of their entire policy limits, under those circumstances results in a windfall for Respondents. Equitable offsets should not be used to provide a windfall to insurance companies to the detriment of the policyholder and public interests. Allowing a minority of intransigent non-settling insurance companies to profit from the policyholder's settlements with non-breaching insurance companies where the policyholder has not been "made whole" discourages settlement by insurance companies contrary to public policy. *Western S.S. Lines, Inc. v. San Pedro Peninsula Hosp.*, 8 Cal. 4th 100, 110 (1994) (recognizing California's "strong public policy strongly in favor of encouraging settlement of litigation."); *Villa v. Cole*, 4 Cal. App. 4th 1327, 1338 (1992) ("it is a well-established public policy in this state that settlements of litigation are favored and should be encouraged").

Furthermore, holdout insurance companies benefiting from continuously litigating after their co-defendants settle, even to the point of an adverse jury verdict, will encourage other breaching insurance companies to:

- Break insurance contracts;
- Engage in lengthy "scorched earth" litigation;
- Assert invalid insurance defenses; and
- Waste the Court's resources.

Such litigation tactics should not be encouraged where, as here, Respondents total policy limits constitute only a small portion of Appellant's remaining liability post-all other settlements. A "double recovery" clearly is impossible here, even if Respondents paid their entire limits.

C. Respondents' Misinterpretation Of The Language In Their Commercial General Liability Policies Defies Policyholders' Objectively Reasonable Expectations

Respondents have betrayed their promise of certainty to their policyholder. California law is well established regarding the issues on appeal. Respondents should not be permitted to overturn well settled California law merely to escape liability here and, as a result, minimize coverage for policyholders statewide.

For example, with respect to the "all sums" issue, Respondents admit that they agree with the Appellant and "recognize" that leading California cases *Armstrong*, *FMC*, and *Stonewall* "reject pro rata allocation in favor of 'all sums.'" Respondents' Reply Brief at 12. Thus, the purpose of limiting or eliminating coverage based upon the "all sums" issue, particularly after the trial court ruled against Respondents on that particular issue, demonstrates that the insurance companies are engaging in "opportunistic breach".

This type of opportunistic breach of contract is wholly inconsistent with the purposes of insurance and inconsistent with Respondents' arguments that they are raising legitimate contractual defenses to coverage. A policyholder has no where to turn when an insurance company decides to engage in an opportunistic breach.

> With the growth of claims that have taken years to manifest themselves and the size of the class of potential claimants, many insurance companies faced with such claims have run for cover rather than coverage. The small print suddenly has been magnified, and insurance companies can be seen scurrying about the courts of this country in search of ways to avoid honoring their policies.

Sandoz, Inc. v. Employer's Liab. Assur. Corp., 554 F. Supp. 257, 258 (D.N.J. 1983).

Commentators have recognized that opportunistic breach by insurance companies against their policyholders is especially inappropriate, because contract law remedies cannot truly "make whole" a policyholder wrongfully denied insurance coverage. Unlike other products, or contracts generally, breach of an insurance policy does not involve a third party vying for what the insurance company has already promised to sell to the policyholder – the policyholder's insurance coverage. Rather, the insurance company merely wants to hold on to the policyholder's money for as long as it can:

> With regard to claims for small amounts of money, the insurance company has some incentive to refuse payment because little likelihood exists that the claimant will pursue the claim. As for large claims, the insurance company may find it profitable to delay payment as long as possible to keep for itself the time value of the amount due. Finally, prolonged delays in payment may make the insured more willing to settle for less than the amount due, particularly if the insured is financially desperate.

See Mark Pennington, *Punitive Damages For Breach of Contract: A Core Sample From The Last Ten Years*, 42 Ark. L. Rev. 31, 53-54 (1989).

In a February 1985 letter to shareholders, Chairman Warren Buffet of Berkshire Hathaway, Inc., the corporate parent to several insurance companies, recognized the obligations and unique qualities of an insurance company:

> The buyer of insurance receives only a promise in exchange for his cash. The value of that promise should be appraised against the possibility of adversity, not prosperity. At a minimum, the promise should appear able to withstand a prolonged combination of depressed financial markets and exceptionally unfavorable underwriting results.

Letter from Warren Buffet, Chairman of the Board [of Berkshire Hathaway Inc.], to the Shareholders of Berkshire Hathaway Inc. (Feb. 25, 1985), http://www.berkshirehathaway.com/ letters/1984.html.

It is fundamental within the insurance industry that an insurance policy is broader than typical contractual commitments. Indeed, a textbook used to train insurance company personnel emphasizes that an insurance policy is more than a mere contractual right:

> Notwithstanding the often stated opinion that the insurance contract is affected with a public interest, insurers often view their policies as simple contractual obligations between parties. While an insurance policy does represent a contractual commitment, the attitudes of the general public, the legislatures, and the courts make clear that the insurance agreement is viewed as having broader ramifications than a mere contract. The public has a definite interest in the reliability of the insurance product. Insurance involves an obligation that affects the public interest as well as the policyholder and therefore is necessarily subject tot certain restrictions.

1 James J. Lorimer *et al.*, *The Legal Environment of Insurance* at 179 (4th ed. 1993).

The upfront payment of premiums for a contingent future event requires that insurance companies owe their policyholders a long term obligation. Unfortunately, contract damage rules create incentives for parties to breach when the subject matter of the contract can be devoted to a more valuable use. Such an opportunistic breach

particularly is inappropriate because, although aware of the inherent limitations of standard form language, insurance companies tout the benefits of its use:

> For the insurance system to function, insurers need to be able to predict their insureds' potential losses based upon known categories of risks.... That is why policies are written on standard forms. Standardization enables ISO [Insurance Services Office] to track the claims experience of the defined coverages nationwide which in turn enables insurers to set realistic premiums and reserves. This is possible only if the words have the same meaning in New York and Washington as they do in California. Standardization also promotes the consumer interest by providing well-defined coverages which permit insureds to know what they are buying and to evaluate it comparatively.

Real Parties in Interest's [Industrial indemnity Company and Industrial Insurance Company of Hawaii, Ltd.] Opening Brief on the Merits at 36-37, *Bank of the West v. Superior Court*, 2 Cal. 4th 1254 (1992), (No. S019556) *cited in* Eugene R. Anderson *et al.*, *Environmental Insurance Coverage In New Jersey: A Tale of Two Stories*, 24 Rutgers L.J. 83 (Fall 1992).

The doctrine of reasonable expectations helps protect policyholders from the effects of the tremendous disparity in bargaining power between the insurance companies and policyholders in interpreting insuring language. Many courts have recognized that "the bargaining power of an insurance carrier vis-à-vis the bargaining power of the policyholder is disparate in the extreme." *Hayseeds, Inc. v. State Farm Fire & Cas. Co.*, 352 S.E.2d 73, 77 (W. Va. 1986). As noted by the Supreme Court of California:

> [T]he relationship of insurer and insured is inherently unbalanced; the adhesive nature of insurance contracts places the insurer in a superior bargaining position. The availability of punitive damages is

> thus compatible with recognition of insurers' underlying public obligations and reflects an attempt to restore balance in the contractual relationship.

Egan v. Mutual of Omaha Ins. Co., 24 Cal. 3d 809, 820 (1979).

The disparity exists even where the policyholder possesses "both legal sophistication and substantial bargaining power," because it "has little bearing on the construction of the specific [standard-form] policy language...." *AIU Ins. Co. v. Superior Court*, 51 Cal. 3d 807, 824 (1990).

One California trial court captured the essence of what motivates all too many insurance companies to deny insurance coverage:

> [A] lot of people who regarded themselves as rather powerful got together and [rode] roughshod over [the policyholder] because they viewed him as someone who was powerless and unable to fight back.

Oral Ruling by Hon. Judith Whitmer Kozloksi, *West American Ins. Co. v. Freeman*, No. 36032 (County of San Mateo) *quoted in West American Ins. Co. v. Freeman*, 44 Cal. Rptr. 2d 555, 564 (Ct. App. 1995) *review granted* 48 Cal. Rptr. 2d 777 (Cal. Dec 14, 1995) *review limited* 48 Cal. Rptr. 2d 897 (Cal. Jan 08, 1996); *review dismissed* 59 Cal. Rptr. 2d 668 (Cal. Dec 11, 1996).[2]

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[2] The appellate decision was superseded by the California Supreme Court's grant of review but publication was not reinstated upon dismissal of the grant of review. The decision of the appellate court is cited by *amici* solely for its quote of the trial court after hearing argument on a motion for a new trial.

Accordingly, this court should uphold the policyholder's reasonable expectation from the clear language in general liability policies and established California law.

D. Drafting History Further Supports The "All Sums" And "Stacking" Of Multiple Policies For Long Term Liabilities.

The basic indemnity agreement in commercial general liability (or "CGL") insurance policies promises to pay "all sums" of the policyholder's liability, not just an allocated share. In 1966, the standard-form CGL policy was revised to provide occurrence-based coverage. The 1966 occurrence-based coverage uniformly was recognized to cover liability arising from gradual pollution. *See, e.g., New Castle County v. Hartford Acc. & Indem. Co.*, 933 F.2d 1162, 1197 (3d Cir. 1991), *rev'd on other grounds*, 970 F.2d 1267 (1992); *Morton Int'l, Inc. v. General Accident Ins. Co. of Am.*, 629 A.2d 831, 849-850 (N.J. 1993); *United States Fid. & Guar. Co. v. Specialty Coatings Co.*, 535 N.E.2d 1071, 1077 (Ill. App. Ct. 1989).

These policies typically contain no provision limiting the insured's coverage to an allocated share, although they do contain "other insurance" clauses potentially allowing the insurance company to apportion coverage with other insurance companies (as supposed to the policyholder). Although the policy requires that damage occur during the policy period, once that requirement has been satisfied and coverage is triggered, the scope of the indemnity agreement extends to "all sums" of the insured's property damage liability, not just damage during the policy period. The fact that the

"policy period" language was inserted in the occurrence definition and not the indemnity clause is a clear demarcation establishing that the "all sums" indemnity obligation is not subject to an allocation by policy period.

Accordingly, CGL insurance policies, such as the liability policies at issue here, were drafted by the insurance industry with the intention that all policies in effect during any period from first exposure or deposit of waste through and including the discovery or manifestation of the pollution damage, apply to business activity such as the disposal of wastes.

For example, Gilbert L. Bean, a senior official of IELA Member, Liberty Mutual Insurance Company, was a principal drafter of the 1966 CGL "occurrence" policy. In a 1965 address concerning the new policy, Bean stressed that "it is in the waste disposal area that a manufacturer's basic premises-operations coverage is liberalized most substantially." Bean illustrated his point as follows:

> [T]he policy in force when a particular injury or damage takes place is the one which applies, regardless of when the causing accident took place. So if the injury or damage from waste disposal should continue after the waste disposal ceased, as it usually does, it could produce losses on each side of a renewal date, and in fact over a period of years, with a separate policy applying each year..... Manufacturing risks producing insecticides, plant foods, fertilizers, weed killers, paints, chemicals, thermostats or other regulating devices, to name a few, have severe gradual [property damage] exposure. They need this protection and should legitimately expect to be able to buy it, so we have provided it.

G.L. Bean, *The New Comprehensive General and Automobile Program, The Effect on Manufacturing Risks*, presented at the Joint Forms Mutual Insurance Teleconference, November 15-18, 1965 at 6 and 10 ("Bean"), *quoted in* Carl A. Salisbury, *Pollution*

Liability Insurance Coverage, The Standard Form Pollution Exclusion And The Insurance Industry: A Case Study in Collective Amnesia, 21 Envtl. L.J. 356, 364 (1991) (emphasis added).

Bean further explained in a July 1966 memorandum how the occurrence policies would stack policy limits:

> Limits are rendered annually for gradual BI (bodily injury) or PD (property damage) from a single occurrence or common exposure to conditions, whether on the same or successive policies in one or more carriers. If the gradual BI or PD extends past one or more policy anniversary dates the limits will pyramid, whereas previously all injury or damage from one accident was attributed back to the policy during which the accident occurred.

Summary of Broadened Coverage Under New GL Policies With Necessary Limitations To Make This Broadening Possible, § IV at 3, *quoted in* Laurence A. Silverman and Phillip C. Essig, *Stacking of Policy Limits and Joint and Several Liability of Insurers in Cases Involving Long-Term, Cumulative Injury or Damage*, 369 PLI/Lit 45, 57 (Practising Law Institute 1989) (emphasis added).

In other words, the CGL "occurrence" insurance policy was drafted with the intention that multiple policies provide insurance coverage for pollution damages, even when those damages resulted from a long-term business activity such as the disposal of wastes. For example, INA's Secretary, Lyman Baldwin, gave an address in 1965 in which he noted the "occurrence" policy's coverage for such routine exposure cases as property damage caused by the fumes emitted by a chemical plant:

> In some exposure types of cases involving cumulative injury, it is possible that more than one policy will afford coverage. Under these circumstances, each policy will afford coverage to the bodily injury

> or property damage with occurs during the policy period (emphasis added).

See Comments of L. J. Baldwin, Secretary of Underwriting for the Insurance Company of North America, *Address before the American Society of Insurance Management 6* (Oct. 20, 1965) (emphasis added), *quoted in* Eugene R. Anderson, *et al.*, *Insurance Coverage Litigation*, Sec. 1.06, 1-35 (Aspen Law & Business 2007) (emphasis added).

The Insurance Services Office, Inc. ("ISO"), a trade association of insurance companies which develops standard form policies and rates for use by the insurance industry,[3] has since confirmed the broad "all sums" coverage available under the standard general liability insurance policy form:

> [T]he standard [CGL policies] provide coverage for injury which occurs during the policy period, regardless of when the exposure to harmful condition takes place, or when injury become known or manifest. Under this concept, if an injury results from cumulative exposure over a period o time, it will be covered during the period of exposure.

Minutes of General Liability Rules and Forms Committee Meeting of March 28, 1978, GLRF-78-8 *quoted in* 2 Madden & Owen on Prods. Liab. § 32:8, n.16 (3d Ed. April 2008).

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[3] The United States Supreme Court has observed the following regarding standard form insurance policies and ISO: "Insurance Services Office, Inc. (ISO), an association of approximately 1,400 domestic property and casualty insurers... is the almost exclusive source of support services in this country for CGL insurance. ISO develops standard policy forms and files or lodges them with each State's insurance regulators; most CGL insurance written in the United States is written on these forms." *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 772 (1993) (citations omitted).

The issue of stacking was addressed by the insurance industry again in the late 1970s when a number of insurance companies complained that the "occurrence" policy language was:

> ... not desirable because it pyramids the limits available to the insured for losses resulting from continuous or repeated exposures over multiple policy periods.

ISO Memorandum to Members of the General Liability Rules and Forms Committee (Apr. 18, 1978) (enclosing minutes of meeting of Mar. 28, 1978) *quoted in* Howard Ende *et al.*, *Liability Insurance: A Primer For College And University Counsel*, 23 JCUL 609, 690 (Spring 1997).

Statements by insurance industry representatives with respect to the asbestos and DES problems further support this proposition. According to a memorandum describing an April 21, 1977 insurance industry meeting with respect to coverage for asbestos and DES related diseases:

> The majority view was that coverage existed for each carrier th[r]oughout the period of time the asbestosis condition developed, i.e. from the first exposure through the discovery and diagnosis. The majority also contended that each carrier on risk during any part of that period could be fully responsible for the cost of defense and loss.

To Provide For The Compensation Of Individuals Who Are Disabled As A Result Of Occupational Exposure To Toxic Substances, To Regularize The Fair, Adequate , And Equitable Compensation Of Certain Occupational Exposure To Toxic Substances, To Regularize The Fair, Adequate, And Equitable Compensation Of Certain Occupational Disease Victims, And For Other Purposes: Hearing on H.R. 3175 Before the

Subcommittee on Labor Standards of the H. Comm. on Education and Labor, 98th Cong. 236-37 (1983) (Memorandum of Meeting of Discussion Group, Asbestosis, April 21, 1977 held under the auspices of the American Mutual Insurance Alliance and American Insurance Association).

Insurance buyers have long been led to believe by the insurance industry that coverage for damage that took many years to become apparent was provided by each and every policy in force over many years. Accordingly, policyholders had the reasonable expectation that each CGL policy for each year would provide coverage for pollution liability and cleanup costs over a period of time. That principle is particularly significant with respect to pollution because if pollution claims arising out of "old" activities are going to be covered by insurance, those claims must be insured by "old" CGL insurance policies.

E. Course Of Dealing Evidence Should Be Considered In Support Of Annualizing Limits.

One of the issues of general concern raised by Appellant appeal is the extent to which California courts deciding insurance disputes may consider and rely upon the course of dealing between insurance companies and their policyholders in order to find and resolve ambiguities in insurance policies. In Appellant's appeal, the issue arises in connection with the annualization question, that is, whether a single limit or three annual limits applies to each occurrence during a three-year policy period. However, the course of dealing issue is not confined to that question, and is of general interest to all California policyholders. In any number of substantive coverage questions, the course of

dealing prior to a coverage dispute can provide highly probative evidence of the parties' intent, and should be considered by the courts.

In the present appeal, Appellant argued that three separate "each occurrence limits" should be paid under each of its three-year policies, based on the course of dealings between Appellant and the various insurance companies which issued identical policies comprising its liability insurance program. For example, in Appellant's Opening Brief ("AOB"), Appellant noted evidence which the trial court erroneously excluded. The excluded evidence showed that the policies were reviewed annually, with certain underwriters changing at annual anniversary dates; premiums negotiated annually; claims being paid as if the limit applied annually, with at least forty-five separate claims documents identifying annual rather than three-year policy periods; and policy tracking systems, reserve sheets, and claim collection forms also identifying annual limits. AOB at 73 – 74. Based on that course of dealing in the performance of policies issued as part of the same program in which all Appellant's insurance companies participated, Appellant had the objectively reasonable expectation that the "each occurrence" limit of its three-year policy applied annually, and it appeared that the insurance companies participating in that program had a similar understanding. *Id.*

Respondents argued that such extrinsic evidence was properly excluded. *See* Combined Respondents' Brief and Opening Cross-Appellants' Brief ("RB") at 102 – 111. In particular, Respondents urged that Appellant's extrinsic evidence should be ignored because "[e]xtrinsic evidence is admissible, if at all, only if it is probative of the disclosed mutual intent of the parties at the time of contracting." RB at 103 (citing *Bank*

of the West v. Superior Court, 2 Cal. 4th 1254, 1264 (1992). Respondents are mistaken, and extrinsic evidence should be considered for the reasons set out in the Appellant's Reply Brief and Answer to Cross-Appellants' Briefs ("ARB"). *See* ARB at 73 – 75.

A recent California Court of Appeals decision highlights additional reasons why courts should consider extrinsic evidence relating to the "course of dealing" under insurance policies *after* the time of contracting, as Appellant argues in support of its annualization appeal. In *Employers Reinsurance Co. v. Superior Court,* 161 Cal. App. 4th 906 (2008), Justice Croskey reiterated the general rules governing the admissibility of "course of performance" evidence. His opinion makes clear that the trial court erred here by excluding evidence of the course of dealing in handling claims and renewals of Appellant's insurance policies, even if such dealings occurred after the "time of contracting."

Justice Croskey first emphasized that "course of dealing" evidence can be used not only to resolve ambiguous policy language, but also to identify it in the first place:

> Extrinsic evidence can be offered not only 'where it is obvious that a contract term is ambiguous, but also to expose a latent ambiguity.' (*Southern Pacific Transportation Co. v. Santa Fe Pacific Pipelines, Inc.*, 74 Cal. App. 4th 1232, 1241, 88 Cal. Rptr. 2d 777 (1999).) Such evidence is admissible when '"relevant to prove a meaning to which the language of the instrument is reasonably susceptible."' (*Ibid.*)
>
> The use of 'course of performance' evidence as extrinsic evidence is acknowledged in case law and was ultimately codified in Code of Civil Procedure section 1856. (Cal. Law Revision Com. com., reprinted at 20A West's Ann. Code of Civ. Proc., (2007 ed.) foll. § 1856, p. 11.) As with all extrinsic evidence, course of

> performance evidence can be used not only to interpret an ambiguity, but also to reveal one in language otherwise thought to be clear. (*Ibid.*)

Employers Reinsurance, 161 Cal. App. 4th at 920.

Next, Justice Croskey reconciled the use of course of performance evidence with the parole evidence rule. The rule prohibits "evidence of any prior agreement or of a contemporaneous oral agreement" in conflict with an integrated writing. Cal. Code Civ. P. § 1856(a). However, it also expressly permits the terms of an integrated writing to "be explained or supplemented by course of dealing or usage of trade or by course of performance." *Id.* § 1856(c). Post-contracting performance also may "supplement or qualify the terms of the agreement." Cal. Com. Code § 1303(d). *See generally Employers Reinsurance*, 161 Cal. App. 4th at 920 -921.

These rules reflect the "practical" rationale for admitting course of performance evidence:

> '[W]hen a contract is ambiguous, a construction given to it by the acts and conduct of the parties with knowledge of its terms, before any controversy has arisen as to its meaning, is entitled to great weight, and will, when reasonable, be adopted and enforced by the court. ... The reason underlying the rule is that it is the duty of the court to give effect to the intention of the parties where it is not wholly at variance with the correct legal interpretation of the terms of the contract, and a practical construction placed by the parties upon the instrument is the best evidence of their intention.' *(Universal Sales Corp. v. Cal. etc. Mfg. Co.,* 20 Cal. 2d 751, 761-762, 128 P.2d 665 (1942)). 'The conduct of the parties after execution of the contract and before any controversy has arisen as to its effect affords the most reliable evidence of the parties' intentions.' (*Kennecott Corp. v. Union Oil Co.,* 196 Cal. App. 3d 1179, 1189, 242 Cal. Rptr. 403 (1987)). 'This rule of practical construction is predicated on the common sense concept that "actions speak louder than words." Words are frequently but an

> imperfect medium to convey thought and intention. When the parties to a contract perform under it and demonstrate by their conduct that they knew what they were talking about the courts should enforce that intent.' (*Crestview Cemetery Assn. v. Dieden*, 54 Cal. 2d 744, 754, 8 Cal. Rptr. 427, 356 P.2d 171 (1960)).

Employers Reinsurance, 161 Cal. App. 4th at 921.

Applied to the present case, these principles require consideration of the insurance companies' course of conduct before any dispute arose with Appellant. That conduct shows that the policies as written did not squarely resolve whether a single limit or three separate annual limits would apply in each three-year policy period, and that the parties intended three separate annual limits.

Accepting Respondents' arguments to the contrary would be inconsistent with the practical rationale for considering course of performance evidence. There is no better evidence of how insurance policies were understood than how the parties performed before coverage disputes arose. The courts and California policyholders (*i.e.* the public) would be best served in the present appeal by following Justice Croskey's reasoning in *Employers Reinsurance*.

Amici recognize that the result in *Employers Reinsurance* was to exclude course of dealing evidence, but that result followed from a very different set of facts. In that case, the proffered evidence related to the parties' dealings under claims-handling agreements which were entered *after* coverage disputes arose, and which in fact were intended to help resolve the coverage disputes. *Employers Reinsurance*, 161 Cal. App. 4th at 912-914, 923 – 925. Here, Appellant's evidence relates to dealings long

before the present coverage dispute, and hence, should be considered under the principles and precedent discussed by Justice Croskey in *Employers Reinsurance.*

F. The "Preponderance of the Evidence" Standard Is the Correct Standard for Proving Lost Insurance Policies.

The "preponderance of the evidence" is and should be the standard for proving lost insurance policies under California law. Stonebridge fails to support the application of a higher burden of proof, and sound public policy and precedent require affirming the preponderance of the evidence standard.

In Stonebridge Life Insurance Company ("Stonebridge")'s Cross-Appellant's Reply Brief ("Stonebridge Reply"), Stonebridge concedes that the "caselaw from other jurisdictions holding that [the preponderance of the evidence standard] of proof is applicable to proving the terms of a missing insurance policy." Stonebridge Reply at 22. Stonebridge fails to further acknowledge, however, that the preponderance of the evidence standard is the traditional standard of proof in civil trials, and that courts depart from this standard only in circumstances where the danger of fraud is present, such as in lost will or oral contract cases. Because the fraud prevention rationale typically is absent in a lost insurance policy case, the majority of courts in this context adopt a preponderance of the evidence standard.[4] California should continue to follow suit.

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[4] *Kleenit, Inc. v. Sentry Ins. Co.*, 486 F. Supp. 2d 121, 126 (D. Mass. 2007); *PSI Energy, Inc. v. Home Ins. Co.*, 801 N.E.2d 705, 722 (Ind. Ct. App. 2004); *Century Indemn. Co. v. Aero-Motive Co.*, 254 F. Supp. 2d 670, 679-80 (W.D. Mich. 2003); *Coltec Indus. Inc. v. Zurich Ins. Co.*, No. 99C1087, 2002 WL 31185789, at *4 (N.D. Ill., Sept. 30, 2002); *Lincoln Elec. Co. v. St. Paul Fire & Marine Ins. Co.*, 210 F.3d 672, 688 (6th Cir. 2000); *Rubenstein v. Royal Ins. Co. of Am.*, 694 N.E.2d 381, 384-85 (Mass. App. Ct.

(footnote continued)

Treatises on insurance policy interpretation agree that the standard of proof in an insurance case is normally a "preponderance of the evidence". 19 Couch on Insurance 2d § 79:319, 345 (Rev. Ed.) (1983). In addition, the Ninth Circuit Court of Appeals has acknowledged that the "preponderance of the evidence standard" applies to proving lost insurance policies. *National American Ins. Co. v. Certain Underwriters at Lloyd's London*, 93 F.3d 529, 534, n. 11 (9th Cir. 1996). In *National American*, the Ninth Circuit, discussed the insurance company's argument for a stricter standard under California law and held that the insurance company's "position is without authority." *Id.*

It remains clear that California law never has recognized a heightened evidentiary burden with regard to the burden of proving lost insurance policies.[5] Stonebridge's argument to the contrary, which attempts to equate insurance policies with other "instruments" subject to heightened proof requirements, is convoluted at best. Adopting Stonebridge's argument would be contrary to the majority of state and federal

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1998), *aff'd in part on other grounds*, 708 N.E.2d 639 (Mass. 1999); *Borough of Sayreville v. Bellefonte Ins. Co.*, 728 A.2d 225, 228 (N.J. Super. Ct. App. Div. 1998); *Gold Fields Am. Corp. v. Aetna Cas. & Sur. Co.*, 661 N.Y.S.2d 948, 950 (Super. Ct. 1997); *Americhem Corp. v. St. Paul Fire & Marine Ins. Co.*, 942 F. Supp. 1143 (W.D. Mich. 1995); *Servants of Paraclete, Inc. v. Great American Ins. Co.*, 857 F. Supp. 822, 827-28, *amended in part on other grounds*, 866 F. Supp. 1560 (D.N.M. 1994); *Sears, Roebuck & Co. v. Seneca Ins. Co.*, 627 N.E.2d 173, 177 (Ill. App. Ct. 1993); *Remington Arms Co. v. Liberty Mutual Ins. Co.*, 810 F. Supp. 1420, 1425 (D. Del. 1992); *Turner v. Ewing*, 232 So.2d 468, 472 (La. 1970).

[5] The Supreme Court has not specifically resolved the degree of proof required to prove a lost insurance policy. *Dart Indus., Inc. v. Commercial Union Ins. Co.*, 28 Cal. 4th 1059, 1072, n.4 (2002). However, the Supreme Court in *Dart Industries* did apply the preponderance of the evidence standard in reversing the Court of Appeal and ruling that a policyholder need not prove the specific language used in the lost policy.

courts that have reached this issue, and is unsupported by any of the cases cited by Stonebridge.

Accordingly, this court should affirm that the "preponderance of the evidence" standard applied by the trial court is the correct standard of proof for lost insurance policies under California law. In addition, as set forth below, Stonebridge is in no position to take advantage of its own destruction of viable liability insurance policies.

1. Insurance Companies Have a Duty to Retain Copies of Their CGL Policies Because They Know That Subsequent Long-Tail Claims Will Implicate These Policies.

Insurance companies selling "occurrence" – based comprehensive general liability ("CGL") insurance policies like Appellant's have long been aware that they might be called upon to defend or indemnify "long-tail" claims – that is, claims that may be discovered and reported long after expiration of the policy period. From the outset, occurrence-based insurance was not only understood, but intended, to respond to long-tail environmental claims, in particular.

As set forth above, the insurance industry drafters of the 1966 occurrence-based comprehensive general liability insurance policy understood that claims for gradual pollution damage were covered. Accordingly, a principal drafter of the standard-form 1966 CGL policy stressed to underwriters that under the occurrence coverage provides insurance for "gradual [property damage] exposure. Bean at 6-10; see also Robert Sayler and David Zolensky, *Pollution Coverage and the Intent of the CGL Drafters: The Effect of Living Backwards*, 1 Mealey's Lit. Rep.: Insurance 4425, 4432 (1987) ("Sayler & Zolensky").

In a paper highlighting the broadened coverage under the 1966 CGL policy, that drafter explained that the 1966 revised form would provide:

> coverage for gradual [bodily injury claims] or gradual [property damage claims] resulting over a period of time from exposure to the insured's waste disposal. Examples would be gradual adverse effect of smoke, fumes, air or stream pollution, contamination of water supply or vegetation.

Alabama Plating Co. v. United States Fid. & Guar. Co., 690 So.2d 331, 335 n.4 (Ala. 1996), Thomas R. Reiter and John K. Ballie, *Better Late Than Never: Holding Liability Insurers to Their Bargain Regarding Unforeseen, Gradual Pollution Under Pennsylvania Law*, 5 Dick. J. Env. L. Pol. 1, 16-17 (1996) ("Reiter & Baillie").

Indeed, in the late 1970s, the Insurance Services Office ("ISO"), an association of more than one thousand property or casualty insurers, began to develop a revision of the standard CGL form then in use. *In re Insurance Antitrust Litigation*, 723 F. Supp. 464, 469 (N.D. Cal. 1989) (overturned on other grounds). As recounted by the United States District Court for the Northern District of California:

> In 1984, ISO filed or lodged with state insurance departments two proposed new policy forms for CGL insurance. These forms substantially modified coverage previously available to the insured. One of the forms was a "claims-made" policy under which coverage was limited to claims made during the policy period regardless of when the occurrence out of which the claim arose had taken place. This represented a reduction in the coverage available under the previous CGL policy form which was an "occurrence-based" form; under that form, the insured was covered for claims arising out of occurrences during the policy period, no matter when asserted, thus exposing insurers to so-called "long tail risks" that could arise long after the policy period. The proposed claims-made form reduced that exposure and shifted the risk of future claims to the insured.

Id. (emphasis added).

Hence, insurance companies such as Stonebridge which sold occurrence-based liability insurance were on notice that their policies might be triggered decades after they were issued, and that these policies eventually might be the subject of litigation. It therefore is only fair that they should be required to maintain copies of the policies they have sold. *See, e.g., In re Cecconi*, 366 B.R. 83, 110 (N.D. Cal. 2007) ("As soon as a potential claim is identified, a litigant is under a duty to preserve evidence which it knows or reasonably should know is relevant to the action.")

An insurance company is in the business of providing insurance – unlike its policyholders, who purchase insurance policies, but hope never to need them. Because an insurance company's only business is "insurance," it should have the burden of maintaining a copy of its product – its insurance policies.

2. Insurance Companies Should Not Be Rewarded For Destroying Their Policies By Placing A Heightened Burden Of Proof On Policyholders.

As noted above, liability insurance companies know that their "occurrence" based policies might respond to claims for the indefinite future. Hence, destroying or failing to maintain records of such policies is tantamount to spoliation of evidence, which courts in California and elsewhere do not reward.

"Spoliation is the destruction or significant alteration of evidence, or the failure to preserve property for another's use as evidence, in pending or future litigation." *Hernandez v. Garcetti*, 68 Cal. App. 4th 675, 680 (1998). When a party has intentionally concealed or destroyed evidence, that party's "failure to produce evidence may allow for the inference that the evidence would have been unfavorable to the party." *Hicks v.*

KNTV Television, Inc., 160 Cal. App. 4th 994, 1010 (2008). *See also* Tama K. Kirby and Thomas T. Steele, *Consequences of Document Destruction in Commercial Litigation*, in *Destruction of Evidence* 335, 340 (Jamie S. Gorelick *et al.* eds.) (1989) (finding that an adverse inference may be made if "the party destroying documents had notice that the documents were relevant to the opposing party's claims and ... the destruction was intentional.").

If an insurance company destroys all evidence of its insurance policies, despite knowing that the insurance policies could be relevant in a future action with policyholders, courts should apply the spoliation doctrine against the insurance companies and interpret all policy provisions in favor of the policyholder.

Courts previously have applied the spoliation doctrine against an insurance company which destroyed policy records. In *Prudential Insurance Co. of America v. Lawnsdail*, 15 N.W. 2d 880 (Iowa 1944), an insurance company argued that a policy was invalid; the issue on appeal was whether false statements in the application were made by the policyholder or by the insurance company's agent. The policyholder's application was a crucial piece of evidence, and it had been destroyed by the insurance company. The Court ruled that the insurance company's argument that the document had been destroyed in accordance with a document retention practice was "not satisfactory." *Id.* at 883. The *Prudential* court elaborated that:

> Apparently this was the only record which would show the history of the application and policy. The destruction of the record by [the insurance company] under such circumstances, authorizes an inference which tends to corroborate the evidence adduced by appellant.

Id.

The same result should be applied in this case with any inferences regarding the destroyed policy records applying against Stonebridge.

Moreover, applying a higher standard of proof will encourage insurance companies to destroy their policies in the hopes of avoiding coverage. As one court stressed:

> [T]he insurer is chargeable with knowledge that its liability on Comprehensive General Liability ("CGL") policies might well extend for many years beyond the end of the policy period. ... In light of the conflicting policy issues involved, this court can not find a strong reason for imposing a higher burden of proof on insureds under these circumstances. The higher standard urged by [the insurance company] would only serve to encourage carriers to destroy policies as soon as possible in the hope that those who had paid for insurance would be unable to produce the policies after the lapse of a substantial period. This court finds nothing unfair in holding the plaintiff to the usual preponderance of the evidence standard of persuasion where the carrier, which is in the business of selling policies, chooses to keep no records at all of those policies.

Gold Fields Am. Corp. v. Aetna Cas. & Sur. Co., 661 N.Y.S.2d 948, 951 (Sup. Ct. 1997) (emphasis added).

The routine and intentional destruction of insurance policy records that may be relevant to future actions is an unreasonable practice that can prevent policyholders from realizing the benefits of their insurance policies and which contravenes California law.[6] This practice should not be tolerated by California courts.

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[6] One California appellate court stated: "[t]he insurer should have records of all of its 'occurrence' policyholders since the 'long tail' effect of such policies obligates it to provide coverage at any time in the future for claims based upon the insured's conduct

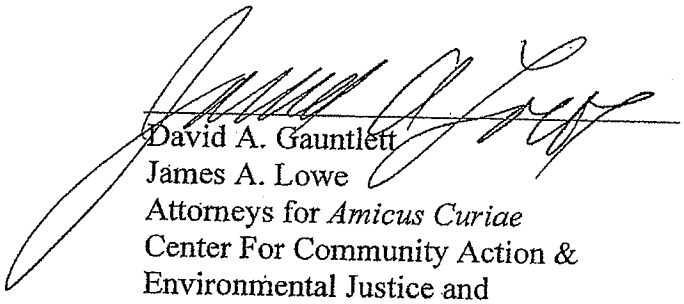
(footnote continued)

III. CONCLUSION

For the reasons set forth above *Amici* respectfully request that this Court grant the appeal of Appellant Cross-Respondent the State of California and deny Respondents Cross-Appellants insurance companies' cross-appeal.

Dated: May 21, 2008

By: GAUNTLETT & ASSOCIATES



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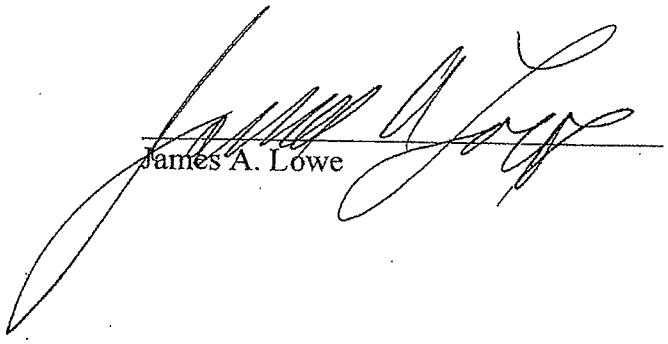
during the policy period." *Middleton v. Imperial Ins. Co.*, 34 Cal. 3d 134, 140, n. 9 (1983).

CERTIFICATE OF WORD COUNT

[California Rules of Court, Rule 14(c)(1)]

Pursuant to Rule 14(c) of the California Rules of Court, I hereby certify that this brief contains 9,660 words, including footnotes. In making this certification, I have relied on the word count of the Microsoft Word word-processing program used to generate the brief.



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Proof of Service

STATE OF CALIFORNIA)
) SS
COUNTY OF ORANGE)

I, PEGGY MURRAY, am employed in the aforesaid County, State of California; I am over the age of 18 years and not a party to the within action; my business address is Gauntlett & Associates, 18400 Von Karman, Suite 300, Irvine, California 92612.

On May 21, 2008 I served the foregoing **APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF** and **AMICUS CURIAE BRIEF OF CENTER FOR COMMUNITY ACTION & ENVIRONMENTAL JUSTICE AND UNITED POLICYHOLDERS IN SUPPORT OF THE STATE OF CALIFORNIA** on the interested parties in this action by overnight mail, placing a true copy thereof, enclosed in a sealed envelope, addressed as follows:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this document was executed on May 21, 2008, at Irvine, California.

Peggy Murray
Signature of Declarant