No. S244737

IN THE SUPREME COURT

OF THE STATE OF CALIFORNIA

MONTROSE CHEMICAL CORPORATION OF CALIFORNIA,

Petitioner,

v.

SUPERIOR COURT OF THE STATE OF CALIFORNIA,
COUNTY OF LOS ANGELES,

Respondent.

and

CANADIAN UNIVERSAL INSURANCE COMPANY, INC., et al.,

Real Parties in Interest,

After a Decision by the Court of Appeal
Second Appellate District, Division Three, Civil Case No. B272387
Los Angeles County Superior Court Case No. BC005158
The Honorable Carolyn B. Kuhl
The Honorable Elihu M. Berle

APPLICATION OF UNITED POLICYHOLDERS FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF APPELLANT AND BRIEF *AMICUS CURIAE*

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APPLICATION OF UNITED POLICYHOLDERS FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

Pursuant to California Rules of Court, rule 8.520(f), proposed amicus, United Policyholders ("UP"), hereby respectfully applies to this Court for leave to file the accompanying Brief of *Amicus Curiae* in Support of Montrose Chemical Corporation of California, in the above-captioned case.[1]

United Policyholders is a non-profit organization based in California that serves as a voice and information resource for insurance consumers in the 50 states. The organization is tax-exempt under Internal Revenue Code §501(c)(3). UP is funded by donations and grants and does not sell insurance or accept money from insurance companies.

UP's work is divided into three program areas: *Roadmap to Recovery*™ (disaster recovery and claim help for victims of wildfires, floods, and other disasters); *Roadmap to Preparedness* (insurance and financial literacy and disaster preparedness); and *Advocacy and Action* (advancing pro-consumer laws and public policy). UP hosts a library of tips, sample forms and articles on commercial and personal lines insurance products, coverage and the claims process at www.uphelp.org.

UP monitors the insurance sales, claims and law sectors, conducts surveys and hears from a diverse range of individual and

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[1] No party or counsel for any party authored any portion of the brief. No party or counsel for any party made a monetary contribution intended to fund the preparation or submission of the brief. No person or entity other than the *amicus curiae*, its members and its counsel made a monetary contribution intended to fund the preparation or submission of the brief. (California Rules of Court, rule 8.520(f)(4).) The undersigned represents UP on a *pro bono* basis.

business policyholders throughout California on a regular basis. The organization interfaces with state regulators in its capacity as an official consumer representative in the National Association of Insurance Commissioners. UP provides topical information to courts via the submission of *amicus curiae* briefs in cases involving insurance principles that matter to people and businesses.

UP's consumer surveys recently assisted this Court in *Association of California Insurance Companies v. Jones* (2017) 2 Cal.5th 376, and this Court has adopted UP's arguments in *TRB Investments, Inc. v. Fireman's Fund Ins. Co.* (2006) 40 Cal.4th 19 and *Vandenberg v. Super. Ct.* (1999) 21 Cal.4th 815. UP has filed *amicus curiae* briefs in nearly 400 cases throughout the United States.

UP seeks to fulfill the "classic role of *amicus curiae* by assisting in a case of general public interest, supplementing the efforts of counsel, and drawing the court's attention to law that escaped consideration." (*Miller-Wahl Co. v. Commissioner of Labor & Indus.* (9th Cir. 1982) 694 F.2d 203, 204.) This is an appropriate role for *amicus curiae*. As commentators have stressed, an *amicus curiae* is often in a superior position to "focus the court's attention on the broad implications of various possible rulings." (Robert L. Stern et al., *Supreme Court Practice* (6th ed. 1986) 570-571 (citation omitted).)

UP is familiar with all the briefs that have been previously filed in this case. UP has experience with the legal issues of this case, and believes its experience in these issues will make its proposed brief of assistance to this Court. UP has an interest in ensuring that all policyholders may freely and efficiently access the entirety of their insurance coverage portfolios to protect themselves and third party claimants against the risks of a long-tail loss triggering numerous different policies spanning several policy periods.

UP therefore respectfully requests leave to file the attached *amicus curiae* brief presenting additional authorities and discussion in support of Appellant's arguments.

DATE: September 21, 2018 Respectfully submitted,

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INTRODUCTION

The dispute here concerns "other insurance" clauses, that is, provisions in liability insurance policies that purport to address what happens if more than one insurance policy covers a particular loss. The problem arises when, as another court put it nearly 50 years ago, "an Insurer who has written the policy and taken the Assured's premium" later invokes the "other insurance" clause in its policy to direct its policyholder "to go elsewhere [for coverage] ... because another insurer is, or ought to be, or may be, liable for the whole, half, or part of a loaf." *Marwell Constr., Inc. v. Underwriters at Lloyd's, London* (Alaska 1970) 465 P.2d 298, 300 (*quoting American Fidelity & Cas. Co. v. St. Paul-Mercury Indem. Co.* (5th Cir. 1957) 248 F.2d 509, 510 (citations omitted)).

In this instance, the dispute arises in the context of a multi-year insurance program, with each year having primary and excess liability insurance policies. Under those circumstances, what consideration if any, should California courts give to "other insurance" clauses in excess liability policies when a policyholder asks multiple insurers to indemnify it against claims for damage spanning successive policy periods? Specifically:

i) May the policyholder access the limits of a higher-level excess insurance policy in one year upon exhausting the immediately underlying coverage in the same policy period in accordance with the higher-level policy's insurance agreement, if the excess policy contains a clause stating that it is excess of "other insurance"? That was the holding of the Court of Appeal in *State of California v. Continental Ins. Co.* (2017) 15 Cal.App.5th 1017 (*Continental II*), which this Court declined to review on December 20, 2017; or

ii) Must the policyholder exhaust the limits of every lower-level policy in every potentially-triggered year before it can call upon a policy at

any higher level to indemnify it, even if the insuring language of each excess policy does not expressly and unambiguously require the policyholder to do so? That is the result urged by the Insurers here, and was the holding of the Court of Appeal below.

The issue presented by this case is the latest iteration of an ongoing dispute between companies like Montrose and their insurers about how to allocate "long tail" losses (from asbestos, product liability, construction defect, toxic tort, or environmental liabilities that develop over many years) among the successive years and layers of liability policies that may provide coverage. This Court has previously addressed these issues in the following contexts, which help frame the issues before the Court today.

In *Montrose Chem. Corp. v. Admiral Ins. Co.* (1995) 10 Cal.4th 645, this Court held that when a policyholder faces liability for an underlying claim involving continuous or progressive injuries, a "continuous trigger" of coverage applies. Specifically, for the environmental claims against Montrose, this Court held that every insurance policy in effect from the time property damage began until final judgment was entered years later against the company in the underlying action potentially applied.

In *Aerojet-General Corp. v. Transport Indem. Co.* (1997) 17 Cal.4th 38, this Court adopted an "all sums" approach to allocating liability to the successive years of policies that apply to such a loss, and rejected the "pro rata" approach favored by the insurance industry. Under the "all sums" approach, when an insurer promises to pay "all sums" the insured becomes legally obligated to pay as damages, each successive insurer has a "separate and independent" duty to the insured which "extends to all specified harm caused by an included occurrence, even if some such harm results beyond the policy period." *Id.* at 56-57, 70 (citations omitted). This Court rejected the insurers' argument that the insured was required to collect a "pro rata" share of its loss from each successive insurer on the risk for a continuing

injury, so that a portion of the loss should therefore be "allocated" to the policyholder if it was uninsured in some years. The Court held that even though the "insurers may be required to make an equitable contribution ... among themselves" the "insured is not required to make such a contribution together with insurers." *Aerojet*, 17 Cal.4th at 73.

In *Dart Industries, Inc. v. Commercial Union Ins. Co.* (2002) 28 Cal.4th 1059, this Court held that "other insurance" clauses do not affect the policyholder's coverage rights vis-à-vis its insurers, but instead apply only to contribution claims between insurers at the same level of coverage after they have paid the loss. *Id.* at 1078, fn. 6.

> When multiple policies are triggered on a single claim, the insurers' liability is apportioned pursuant to the 'other insurance' clauses of the policies [citation] or under the equitable doctrine of contribution [citations]. That apportionment, however, has no bearing upon the insurers' obligations to the policyholder. [Citation.] A pro rata allocation among insurers 'does not reduce their respective obligations to their insured.' [Citation.] The insurers' contractual obligation to the policyholder is to cover the full extent of the policyholder's liability (up to the policy limits).

Id. at 1080 (*quoting Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.* (1996) 45 Cal.App.4th 1, 105-06).

In *State of California v. Continental Ins. Co.* (2012) 55 Cal.4th 186 (*Continental*) – in which Montrose appeared as an amicus curiae – this Court held that when a continuous injury claim triggers multiple years of liability insurance, the insured is permitted to collect its loss in full up to the combined limits of the policies in whichever year or years it selects, with the selected insurers being entitled subsequently to seek contribution from other insurers on the risk during other years of the loss. This "'all-sums-with-stacking' rule means that the insured has immediate access to

the insurance it purchased" and "does not put the insured in the position of receiving less coverage than it bought." *Id.* at 201.

Against the weight of the foregoing authority, the Insurers urge this Court to rule that standard "other insurance" clauses in excess policies require policyholders such as Montrose to "horizontally exhaust" their insurance unless the policies clearly state otherwise. The Insurers' position is contrary to California law for at least the following reasons:

First, California law is clear that issues of coverage are decided by the language of the insurance policy construed under the statutorily-imposed rules of contract interpretation. The proposed presumption of "horizontal exhaustion" directly conflicts with those rules where, as here, the policies were written as "specific excess" policies and promise to attach upon the exhaustion of the vertically underlying policies.

Second, California law draws a clear distinction *between* (i) coverage disputes between policyholders and insurers *and* (ii) disputes between insurers seeking to reapportion losses they have paid on account of covered claims. Policyholder-insurer coverage disputes are governed by contract law; inter-insurer disputes are governed by equitable principles of subrogation and contribution. "Other insurance" clauses are generally irrelevant to policyholder-insurer disputes, but frequently considered in inter-insurer disputes. The Insurers ignore this distinction, and rely extensively on inter-insurer equitable apportionment cases to argue, *inter alia*, that "other insurance" clauses should be construed as limiting their obligations to Montrose.

Third, this Court has made clear in prior decisions such as *Montrose*, *Aerojet* and *Continental* that each policy triggered by a continuing loss is obligated to pay up to its limits, without any deduction for amounts attributable to periods in which the policyholder had other insurance or no insurance. Any other approach would deny a policyholder's right to obtain

"immediate access to the insurance it purchased[.]" *Continental*, 55 Cal.4th at 200-01. The Insurers disregard this, contending that they are entitled to withhold payment of otherwise covered amounts on account of "other insurance" allegedly available in other policy periods, even if that other insurance is not even "recoverable." Answering Brief ("AB") at 20 (citing language the Insurers contend allows them to defer payment on account of "other insurances ... whether recoverable or not...."). That approach not only deprives the policyholder of "immediate access" to its insurance, but also impermissibly puts it in the position of "receiving less coverage than it bought." *Continental*, 55 Cal.4th at 201.

Fourth, this Court has made clear that an insurer cannot avoid coverage unless the alleged exception is both conspicuous and phrased in clear and unmistakable terms. *Haynes v. Farmers Ins. Exch.* (2004) 32 Cal.4th 1198, 1204-05. Even if an insurer meets those "two rigid drafting rules" (*id.* at 1211), it still cannot avoid coverage unless it can show its coverage-restricting interpretation is the "only reasonable one." *MacKinnon v. Truck Ins. Exch.* (2003) 31 Cal.4th 635, 655. The Insurers' attempts to avoid coverage on account of the supposed existence of "other insurance" do not withstand the scrutiny of these rules, and must therefore fail.

For the foregoing reasons, and as discussed in greater detail below, *amicus curiae* respectfully request to decline the Insurers' efforts to avoid coverage on account of "other insurance."

ARGUMENT

I. A BLANKET RULE REQUIRING HORIZONTAL EXHAUSTION WOULD IMPERMISSIBLY RE-WRITE POLICIES, LIKE THOSE AT ISSUE HERE, THAT WERE WRITTEN ON A "SPECIFIC EXCESS" BASIS.

The key to any insurance coverage dispute is the language of the insurance policy. As this Court explained 28 years ago, whether an

insurance policy provides coverage "is to be found solely in the language of the [applicable insurance] policies, not in public policy considerations." *AIU Ins. Co. v. Super. Ct.* (1990) 51 Cal.3d 807, 818; *see also Cunningham v. Universal Underwriters* (2002) 98 Cal.App.4th 1141, 1148 (the court's "focus must be upon 'the language of the policy itself, not upon 'general' rules of coverage that are not necessarily responsive to the policy language.'") (*quoting Am. Cyanamid Co. v. Am. Home Assur. Co.* (1994) 30 Cal.App.4th 969, 978). In urging this Court to adopt a general rule of "horizontal exhaustion," the Insurers here disregard this basic principle of insurance policy construction.

Interpretation of insurance policy provisions is governed by the mutual intent of the parties. Civ. Code § 1636; *Bay Cities Paving & Grading, Inc. v. Lawyers' Mut. Ins. Co.* (1993) 5 Cal.4th 854, 867. Intent is to be inferred, if possible, from the language of the policy itself. Civ. Code § 1639, *Bay Cities*, 5 Cal.4th at 867; *Montrose,* 10 Cal.4th at 666. The "clear and explicit" meaning of the insurance contract provisions, interpreted in their "ordinary and popular sense," controls their judicial interpretation. *Waller v. Truck Ins. Exch., Inc.* (1995) 11 Cal.4th 1, 18.

California law distinguishes between two kinds of excess insurance policies: (1) "specific excess policies," which promise to start paying covered claims as soon as specifically identified policies or limits underlying them are exhausted; and (2) excess policies that do not identify any particular underlying coverage, and start paying only after all primary insurance has been exhausted. H. Walter Croskey, et al., *California Practice Guide: Ins. Litig.* (rev. ed. 2018) ¶¶ 8:236-38.

Courts in California have recognized that whether a policy provides "specific excess" coverage is dictated by the language of that excess policy, not language found in other insurance policies. *See, e.g., Carmel Dev. Co. v. RLI Ins. Co.* (2005) 126 Cal.App.4th 502, 516 (finding a policy to be

"specifically excess" because its "insuring terms" provided that it was "excess to the underlying primary"); *Travelers Cas. & Sur. Co. v. Transcontinental Ins. Co.* (2004) 122 Cal.App.4th 949, 959 (where an excess policy provides that it is excess of specified coverage, it must pay immediately upon exhaustion of that coverage regardless of the existence of other insurance); *20th Century Ins. Co. v. Liberty Mut. Ins. Co.* (9th Cir. 1992) 965 F.2d 747, 757 (finding a policy to provide specific excess coverage when it identified the underlying primary policy).

Here, it is undisputed that each of the 115 policies in Montrose's portfolio expressly provides coverage that attaches in excess of a specific, predetermined amount of underlying coverage in the same policy period. Opening Brief ("AOB") at 17-18; Reply Brief ("RB") at 11, 15. This means that the parties intended the policies to respond to claims as soon as the specified underlying insurance policies or coverage limits identified by them are exhausted. *See Bay Cities*, 5 Cal.4th at 867 (intent is to be inferred "solely" from language of the insurance policy itself).

II. ESTABLISHED PRECEDENT MAKES CLEAR THAT INSURERS CANNOT DEFER OR AVOID THEIR COVERAGE OBLIGATIONS ON ACCOUNT OF "OTHER INSURANCE" CLAUSES.

A. This Court Ruled In *Dart* That Other Insurance Clauses Only Apply In Inter-Insurer Disputes.

In *Dart*, this Court addressed the effect of "other insurance" clauses like those upon which the Insurers rely in this case. 28 Cal.4th at 1078, fn. 6. Rejecting the position advocated by the Insurers here, the Court held that provisions stating that a policy is excess of the policyholder's "other insurance" do not impose conditions or limitations upon the policyholder's contractual coverage rights vis-à-vis its insurers; instead, they only apply to contribution claims between the insurers after one or more of them have paid the insured's loss. This Court explained that the obligation of each

successive insurer to its policyholder "to cover a continuously manifesting injury is a separate issue from the obligations of the insurers to each other." *Id.* at 1080. The latter issue is governed by "the 'other insurance' clauses of the policies [citation] or under the equitable doctrine of contribution [citations]." *Id.* (*quoting Armstrong*, 45 Cal.App.4th at 105-106). "That apportionment, however, has no bearing upon the insurers' obligations to the policyholder," which is "to cover the full extent of the policyholder's liability (up to the policy limits)." *Id.*

The Insurers assert that *Dart* does not apply to excess insurance policies, but applies only when "primary insurers insist that conflicting 'other insurance' provisions make their policies excess to other primary insurers' policies." AB at 36. The Insurers also assert that *Dart* only applies to "other insurance" provisions in policies at the same level of coverage. *Id.* at 36-37.

The holding and rationale of *Dart* are not so limited. To the contrary, *Armstrong*—which this Court quoted with approval in *Dart*—*did* involve excess insurers. The Court of Appeal held there that an "other insurance" clause "does not affect the obligation of the insurers to respond in full" to the policyholder's coverage claim, explaining that "'a policyholder may obtain full indemnification and defense from one insurer, leaving the targeted insurer to seek contribution from other insurers covering the same loss'" according to the "other insurance" provisions in their policies or equitable principles. *Armstrong*, 45 Cal.App.4th at 52 (citation omitted). Consistent with that reasoning, this Court rejected in *Dart* the insurers' contention that an "other insurance" provision is a "condition of coverage" that the policyholder must satisfy as a prerequisite to its coverage claim. 28 Cal.4th at 1078-79.

Implicit in the Insurers' entire argument is the notion that treating "other insurance" provisions as a "condition of coverage," which the

policyholder must satisfy before it is entitled to payment from its insurer, does not prejudice the insured or "defeat the insurers' obligations" because it affects "only the *sequence* in which the policies are accessed, not the total coverage available to the insured." *See* AB at 38.

In *Dart*, however, this Court explicitly rejected the notion that "other insurance" clauses can regulate the sequence in which insurers at different levels must respond to the policyholder's claim for coverage: "'Other insurance' clauses become relevant only where several insurers insure the same risk at the *same level* of coverage. An 'other insurance' dispute cannot arise between primary and excess insurers." *Id.* at 1078, fn.6 (quotation omitted) (emphasis in the original). That conclusion is the only one that is consistent with the Court's holding that an "other insurance" provision is not a "condition of coverage" that the policyholder must satisfy as a prerequisite to its coverage claim. 28 Cal.4th at 1078-79.

Often, moreover, there are "gaps" within horizontal layers of insurance policies that are created by the insolvency of insurers in certain years, or pollution exclusions that are more prevalent in later policies, or a range of other coverage issues. It can be expensive and time-consuming to litigate such issues. Therefore it is not always the case that it is easier, or even possible, for the insured to recover from lower-level insurance policies before it seeks payment from higher-level policies covering the same continuing loss. Treating "other insurance" provisions as a "condition of coverage" that the policyholder must satisfy as a prerequisite to its claim would accordingly prejudice the insured by depriving it of "immediate access to the insurance it purchased," which is ensured only if the policyholder "is entitled to seek indemnification from *any* of the ... insurers on the risk." *Continental*, 55 Cal.4th at 200-01 (emphasis added); *see also Continental II*, 15 Cal.App.5th at 1033 ("[A]s the State aptly points out, 'Under [Continental]'s approach, a court could not determine the amount

any insurer owes without first determining what every insurer owes ....' (Fn. omitted.) For example, if a lower-layer insurer for a different policy period happened to claim that some exclusion in its policy applied, a court could not determine whether Continental's policies were triggered without first determining that exclusion claim. This would deprive the State of the timely indemnity that it bargained for.").

If the Insurers are correct that there are "lower level" insurers ready and willing to pay, a paying "higher level" insurer could seek to reallocate its payment among the other insurers according to whatever equitable rights it might have. *JPI Westcoast Constr., L.P. v. RJS & Assocs., Inc.* (2007) 156 Cal.App.4th 1448, 1466 (excess insurer entitled to recover from primary insurer under subrogation theory). But such re-allocation rights do "not relieve [the insurer] from either its obligation to indemnify or to defend [the policyholder]" in the first instance). *Dart*, 28 Cal.4th at 1080-81. There is accordingly no prejudice to the Insurers in requiring the Insurers to provide their policyholder with "immediate access to the insurance it purchased." *Continental*, 55 Cal.4th at 200-01.

B. Equitable Principles Developed In Inter-Insurer Cases Such As *Community Redevelopment* Are Inapplicable To Disputes Between Policyholders And Their Insurers.

The Insurers mistakenly claim that *Community Redevelopment Agency of City of Los Angeles v. Aetna Casualty & Surety Company* (1996) 50 Cal.App.4th 329 established a "longstanding rule" of horizontal exhaustion that is "eminently 'workable,' ... particularly in cases like this one with large, sophisticated commercial entities on both sides of the insurer-insured transaction." AB at 55, 60. That case was an inter-insurer allocation case regarding defense obligations, not a dispute about insurers' contractual obligations to indemnify their own policyholders. And even in that context, the court held that policy language trumped any general rule of

horizontal exhaustion. *Community Redevelopment* is therefore is inapposite even if what the Insurers say about it is correct.

Community Redevelopment involved a dispute between a primary insurer, United Pacific, and an umbrella insurer, Scottsdale. Following settlement of the underlying construction dispute, United Pacific sought a declaration that Scottsdale was obligated under a theory of equitable contribution to reimburse United Pacific for defense costs it incurred during the pendency of the action. 50 Cal.App.4th at 333, fn. 1. The court ruled against United Pacific, holding that Scottsdale—as the excess insurer—had no duty to reimburse United Pacific for any portion of the defense costs it had paid in fulfilling its primary duty to defend the policyholder. *Id.* at 342.

Community Redevelopment was not the "sea change" the Insurers claim, but instead is just one of many cases that have followed this Court's holding that a primary insurer has no right of contribution from an excess insurer absent "some compelling equitable consideration." *Signal Companies, Inc. v. Harbor Ins. Co.* (1980) 27 Cal.3d 359, 369; *see also Stonewall,* 46 Cal.App.4th 1810; *Continental Ins. Co. v. Lexington Ins. Co.* (1997) 55 Cal.App.4th 637, 647; *Fireman's Fund Ins. Co. v. Maryland Cas. Co.* (1998) 65 Cal.App.4th 1279, 1299; *Reliance Nat. Indem. Co. v. General Star Indem. Co.* (1999) 72 Cal.App.4th 1063, 1078; *JPI Westcoast Constr., L.P.*, 156 Cal.App. at 1466.[1]

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[1] *Community Redevelopment* was not even the first apportionment case to adapt the continuous loss trigger established by this Court in *Montrose* to an inter-insurer dispute involving primary and excess policies, as the Insurers seem to suggest. That honor belongs to *Stonewall Ins. Co. v. City of Palos Verdes Estates* (1996) 46 Cal.App.4th 1810, which was decided several months before *Community Redevelopment.*

Even in the inter-insurer context of *Community Redevelopment*, the court expressly recognized that policy language governed and there was no "general rule" of horizontal exhaustion:

> If an excess policy states that it is excess over a specifically described policy and will cover a claim when that specific primary policy is exhausted, such language is sufficiently clear to overcome the usual presumption that *all* primary coverage must be exhausted.

Id. at 338, 340, fn. 6.

Given that *Community Redevelopment* was an inter-insurer contribution dispute, the court's consideration of the "other insurance" clause in the excess policy was consistent with the long-standing principle this Court acknowledged in *Dart* that post-payment allocation disputes among insurers (unlike contractual coverage disputes between insurers and their policyholders) are governed by "the 'other insurance' clauses of the policies [citation] or under the equitable doctrine of contribution [citations]." 28 Cal.4th at 1080 (*quoting Armstrong*, 45 Cal.App.4th at 105-106).

In inter-insurer allocation disputes that arise after the insured's loss has been fully paid, California courts "generally honor the language of excess 'other insurance' clauses when no prejudice to the interests of the insured will ensue." *Century*, 109 Cal.App.4th 1246, 1257 (*quoting Fireman's Fund*, 65 Cal.App.4th at 1304). Indeed, with one exception all of the California "other insurance" cases cited by the Insurers were apportionment disputes between insurers that took place after the

underlying loss had been paid.[2] The Insurers' assumption that these inter-insurer cases should be applied here, to a policyholder-insurer coverage dispute, misses the mark for at least three reasons.

First, this Court expressly held in *Dart* that "apportionment among multiple insurers must be distinguished from apportionment between an insurer and its insured." 28 Cal.4th at 1080 (*quoting Armstrong*, 45 Cal.App.4th at 105-106). Apportionment pursuant to "other insurance" clauses arises only "[w]hen multiple policies are triggered on a single

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[2] *See Carmel*, 126 Cal.App.4th 502 (dispute among two excess insurers with policies in effect at the same time); *Century Surety Co. v. United Pacific Ins. Co.* (2003) 109 Cal.App.4th 1246 (dispute between successive primary insurers); *Certain Underwriters at Lloyds, London v. Arch Specialty Ins. Co.* (2016) 246 Cal.App.4th 418 (dispute between successive primary insurers); *Continental*, 55 Cal.App.4th 637 (dispute between primary and umbrella insurers that covered joint tortfeasors); *Fireman's Fund Ins. Co.*, 65 Cal.App.4th 1279 (dispute between successive primary insurers); *Hartford Casualty Ins. Co. v. Travelers Indem. Co.* (2003) 110 Cal.App.4th 710 (dispute between primary insurers that covered joint tortfeasors); *JPI Westcoast Constr., L.P.*, 156 Cal.App. 1448 (dispute between primary and umbrella insurers that covered different contracting parties); *Olympic Ins. Co. v. Employers Surplus Lines Ins. Co.* (1981) 126 Cal.App.3d 593 (dispute between primary and excess insurers for apportionment of aviation accident losses); *Peerless Cas. Co. v. Continental Cas. Co.* (1956) 144 Cal.App.2d 617 (dispute between two primary insurers and an excess insurer involving an automobile accident); *Stonewall Ins. Co. v. City of Palos Verdes Estates* (1996) 46 Cal.App.4th 1810 (dispute between primary and excess insurers in successive years); *Travelers Cas. & Sur. Co. v. Century Sur. Co.* (2004) 118 Cal.App.4th 1156 (dispute between successive primary insurers). The one exception is *Padilla Constr. Co., Inc. v. Transportation Ins. Co.* (2007) 150 Cal.App.4th 984, in which the court relied on an excess policy's "other insurance" clause to restrict the coverage available to the policyholder. *Padilla*, discussed in greater detail below, addresses the contract interpretation issues related to "other insurance" clauses.

claim," and then only in disputes about how losses among insurers should be allocated after they are paid. *Id.* The "other insurance" clauses have "no bearing upon the insurers' obligations to the policyholder" to "cover the full extent of the policyholder's liability (up to the policy limits)." *Id.*

Second, as the Insurers acknowledge, under established California law "other insurance" clauses will not be enforced to prejudice the insured. *See* AB at 41 (*quoting Century Surety Co. v. United Pacific Ins. Co.* (2003) 109 Cal.App.4th 1246, 1257). The Insurers brush aside as a trumped-up "parade of horribles" the prejudice Montrose would face if the Insurers' "general rule" of horizontal exhaustion were adopted. AB at 57. But enforcement of the "other insurance" clauses in the manner urged by the Insurers *would* cause substantial prejudice to Montrose, as noted already, including by transferring to Montrose the burden, cost, risk, and delay of pursuing apportionment claims for the benefit of the Insurers. AOB at 55-59.[3]

Third, the Insurers' assumption that courts should freely import the principles developed in inter-insurer allocation cases to policyholder-insurer coverage disputes (particularly when the policyholder is a "sophisticated commercial" actor, AB at 60) fundamentally confuses the two distinct areas of the law. Inter-insurer allocation disputes are equitable in nature, and based on principles of subrogation, contribution or indemnity. *See, e.g., Signal*, 27 Cal.3d at 369; *Fireman's Fund Ins. Co.*, 65 Cal.App.4th at 1297. Policyholder-insurer coverage disputes are contract cases, decided under the rules of interpretation discussed in Sections I and IV.

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[3] Moreover, as discussed in Section IV.B, below, nothing in the text of standard form policies can justify shifting to the policyholder the insurers' burden of pursuing their own subrogation or contribution recoveries.

For the foregoing reasons, this Court should decline the Insurers' invitation to treat *Community Redevelopment* and other inter-insurer equitable allocation cases as providing the precedent applicable to this policyholder-insurer coverage dispute.

The one California case that *amicus curiae* could locate that arguably relied on an "other insurance" clause to restrict an insurer's coverage obligations to its own policyholder, *Padilla*, can be distinguished on the basis of the particular contract language at issue there, if not disapproved for improperly applying principles developed in equitable inter-insurer apportionment cases to a contractual coverage dispute between a policyholder and its insurer.

In *Padilla*, a construction-related loss implicated four years of policies. 150 Cal.App.4th at 989. The insurers in years 2 and 3 were insolvent, leaving only the policies issued in years 1 and 4. *Id.* at 990. The policyholder requested that the defense of the lawsuit be funded 100% by the primary insurer in year 1, and specifically "deselected" the primary insurer in year 4. *Id.* at 990-91. The primary policy for year 1 became exhausted during the pendency of the underlying lawsuit. *Id.* at 991. Seeking to avoid paying the self-insured retention under the year 4 primary policy, the policyholder requested that the umbrella policy in year 1 assume the defense of the underlying case. *Id.* The year 1 umbrella insurer denied coverage, giving rise to the lawsuit. *Id.*

The court in *Padilla* focused its analysis on two provisions of the umbrella policy. The first provision was a standard "other insurance" clause similar to many policies at issue here. *Id.* at 993-94. The second provision was unlike any of the policies at issue here, and specifically addressed the umbrella insurer's "Defense Payment and Related Duties." *Id.* at 994. The "defense" provision stated in relevant part that the insurer would only defend the policyholder against claims "not covered under: a.

'scheduled underlying insurance'; and b. 'unscheduled underlying insurance' ...." *Id.*

Since the exhausted primary policy in year 1 was the only "scheduled underlying insurance," the court focused on whether the year 4 primary policy qualified as "unscheduled underlying insurance" for purposes of the year 1 umbrella policy. *Id.* The definition of "unscheduled underlying insurance" was, in turn, what in any other context would be called an "other insurance" clause. *Id.* at 994-95.

Although the court effectively held that the year 4 primary policy qualified as "unscheduled underlying insurance" for purposes of the year 1 umbrella policy, it did not reach that decision on the basis of the established contract interpretation rules set forth by this Court. That is, it did not consider whether the two "other insurance" clauses were sufficiently conspicuous, or phrased in clear and unmistakable terms, or whether there was a reasonable interpretation of the umbrella policy that would result in coverage.[4]

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[4] Even if the court in *Padilla* had properly applied the rules of contract interpretation, which it did not for the reasons already stated, it would not have supported the Insurers' position here. Unlike the policies issued to Montrose, the insuring clause of the policy at issue in *Padilla* specifically *excluded* from the scope of its defense coverage any claim covered by either "scheduled underlying insurance" or "unscheduled underlying insurance." *Id.* at 994. While that language should have been deemed unenforceable on account of the insurer's failure to meet its burden of describing with any specificity what policies it would consider "unscheduled underlying insurance" and to make clear that it would be the policyholder's burden to pursue that "other insurance" as a precondition to coverage, the exclusionary language in the insuring clause at issue in *Padilla* is readily distinguishable from the kind of "excess other insurance" provision at issue in this case. The same is true of the operative policy language in *Community Redevelopment*, where the insuring clause excluded defense coverage for any claim for which the policyholder had other coverage. 50 Cal.App.4th at 334-35.

Instead, *Padilla* started its analysis from the presumption that California has a "rule of 'horizontal exhaustion ... [that] requires all primary insurance to be exhausted before an excess insurer must 'drop down' to defend an insured, including in cases of continuing loss." *Id.* at 986 (*citing Community Redevelopment*, 50 Cal.App.4th at 339). Working backward from that presumption, the court found it was reasonable to require the year 4 primary policy to defend. *Id.* at 1000.

Padilla also failed to follow the contract interpretation rules this Court has repeatedly ruled apply to policyholder-insurer coverage disputes. For example, it specifically relied on the "great disparity in the premiums charged" by the two insurers as an equitable reason for requiring the Year 4 primary policy to defend in the place of the Year 1 umbrella policy. *Id.* at 1003 But the court would not have considered extrinsic evidence, e.g., evidence of policy premiums, if it had been following the applicable rules of insurance contract construction, given that the court did not identify any ambiguity in the policy language to which such evidence would have been relevant. *See, e.g., George v. Automobile Club of Southern California* (2011) 201 Cal.App.4th 1112, 1121 (extrinsic evidence inadmissible in the absence of an ambiguity).

In short, *Padilla* is of no utility to the Insurers. It failed to follow this Court's holding in *Dart* that "other insurance" clauses have "no bearing upon the insurers' obligations to the policyholder," which are to "cover the full extent of the policyholder's liability (up to the policy limits)." *Dart*, 28 Cal.4th at 1080 (*quoting Armstrong*, 45 Cal.App.4th at 105-106).

III. THE INSURERS' POSITION CONFLICTS WITH DECADES OF PRECEDENT, INCLUDING THIS COURT'S DECISIONS IN *MONTROSE, AEROJET* AND *CONTINENTAL.*

Under the rule urged by the Insurers, the question of whether and when coverage attaches under an excess policy could be determined only

after the coverage obligations of all other policies at lower layers in prior and subsequent years have first been determined. This "rule" not only makes no practical sense, but also is inconsistent with decades of California case law.

As noted already, this Court has consistently held that each insurer on the risk when a continuous or progressive injury occurs is "separately and independently" obligated to indemnify the insured for the entire injury, up to its policy limits. *See Montrose*, 10 Cal.4th at 686; *Aerojet*, 17 Cal.4th at 57 & fn. 10. One predicate on which this conclusion rests is that "property damage that is continuous or progressively deteriorating throughout several policy periods is potentially covered by all policies in effect during those periods." *Montrose*, 10 Cal.4th at 655. Another is that each insurer on the risk when a continuous or progressive loss occurs is "obligated to indemnify the insured *for the entirety of the ensuing damage or injury*." *Aerojet*, 17 Cal.4th at 57, fn. 10 (emphasis in the original). It follows that whether coverage exists for a continuing loss under a policy in one year does not require the insured to establish whether or not there is coverage under other policies in different years: the insured "is entitled to seek indemnification from any of the ... insurers on the risk" to obtain "immediate access to the insurance it purchased[.]" *Continental*, 55 Cal.4th at 200-01.

If the policyholder were required to demonstrate that all lower levels of coverage in prior and subsequent years were exhausted before it could recover under any excess policy, then the policyholder would face protracted coverage litigation before obtaining access to any of its excess coverage, rather than the "immediate" access guaranteed in *Continental*.

Moreover, California courts have uniformly rejected insurer attempts to use a rule of horizontal exhaustion to limit their liability to the insured by requiring it to allocate portions of an insured loss to other policy periods.

See, e.g., *Aerojet*, 17 Cal.4th at 72 (rejecting insurers' attempts to allocate portion of a claim to self-insured periods); *Armstrong*, 45 Cal.App.4th at 55-56 (same). In this respect, too, the horizontal exhaustion rule espoused by the Insurers cannot be reconciled with California law.

Construed in the manner urged by the Insurers, language in many of the Montrose policies would allow higher-level insurers to defer payment to their insured on account of the existence "other insurances ... whether recoverable or not...." AB at 20. If such references to "other insurances" are construed as requiring the policyholder, as a condition of obtaining coverage from its excess insurer in one year, to recover payment from insolvent insurers, or policies with absolute pollution exclusions in later years, the Insurers would undoubtedly seek to hold the policyholder responsible for those unrecoverable limits. This type of "allocation to the insured" has been expressly rejected by this Court. *Aerojet*, 17 Cal.4th at 73 ("An insured is not required to make such a contribution together with insurers."). Accordingly, a clause referring to other insurance "whether recoverable or not" cannot be construed as imposing a condition of coverage that the policyholder must satisfy. *Fireman's Fund Indem. Co. v. Prudential Assur. Co.* (1961) 192 Cal.App.2d 492, 496-97.

IV. UNDER THE APPLICABLE RULES OF INTERPRETATION, "OTHER INSURANCE" CLAUSES CANNOT BE CONSTRUED IN THE MANNER URGED BY THE INSURERS.

The Insurers assert that "other insurance" clauses found in excess policies "require the insured to exhaust 'other insurances' *other than the scheduled underlying insurance* before the excess policy can be accessed." AB at 19 (emphasis in original). The Insurers' proposed rule is contrary to the basic rules of insurance policy construction under California law.

A. "Other Insurance" Clauses Are Not Conspicuous, Nor Are They Phrased In "Clear And Unmistakable" Language.

As discussed in Section I, above, the excess policies issued to Montrose promised that the Insurers would pay upon the exhaustion of a specific, predetermined amount of underlying coverage in the same period. AOB at 17-19. Under the established rules of insurance policy interpretation, these promises of coverage are "interpreted broadly so as to afford the greatest possible protection to the insured." *MacKinnon v. Truck Ins. Exch.* (2003) 31 Cal.4th 635, 648 (citations omitted).

In contrast to the broad, coverage-favoring interpretation that such insuring agreements must be afforded under California law, "'any exception to the performance of the basic underlying obligation must be so stated as clearly to apprise the insured of its effect.'" *Id.* That rule applies to "other insurance" clauses, at least as they are conceptualized by the Insurers, as they would purport to "limit an insurer's liability to the extent that other insurance may cover the same loss[,]" *Dart*, 28 Cal.4th at 1078, fn. 6; *see also id.* at 1078-1079 (affirming trial court's finding that "other insurance" clause functioned as an exclusion).[5]

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[5] If an "other insurance" clause is not treated as an exclusion, it would need to be treated as a condition, not a substantive part of the insuring agreement. *See, e.g., Root v. American Equity Specialty Ins. Co.* (2005) 130 Cal.App.4th 926, 943 (notice provision located in insuring agreement treated as a condition because it "does *not* go to basic coverage but quacks, walks, looks and functions like a condition, not an element of the fundamental risk insured") (emphasis in original). Under the statutory rules applicable to conditions, a party is only obligated to satisfy conditions "imposed upon himself." Civ. Code § 1439. Here, there is nothing in the "other insurance" clauses to suggest Montrose "imposed upon [it]self" the burden of pursuing "other insurance" as a condition precedent to coverage, particularly given that a condition is "strictly interpreted against the party for whose benefit it is created," Civ. Code § 1442. Moreover, even if the

As with any other exception to an insurer's basic obligation to insure, the burden therefore rests upon the insurer to phrase "other insurance" clauses "in clear and unmistakable language.'" *Id.* Not only must the exception be phrased in "clear and unmistakable" language, *id.*, it must "be placed and printed [within the policy] so that it will attract the reader's attention." *Haynes v. Farmers Ins. Exch.* (2004) 32 Cal.4th 1198, 1204–05; *see also id.* at 1211 ("Conspicuous placement of exclusionary language is only one of two rigid drafting rules required of insurers to exclude or limit coverage. The language itself must be plain and clear. 'This means more than the traditional requirement that contract terms be 'unambiguous.' Precision is not enough. Understandability is also required.'") (citations omitted)). Further, this Court has made clear that these rules will be applied "with particular force when the coverage portion of the insurance policy would lead an insured to reasonably expect coverage for the claim purportedly excluded," *MacKinnon*, 31 Cal.4th at 648 (citations omitted), as it undoubtedly did to Montrose, which, under the Insurers' theory, could not determine which policies would provide coverage in year 1 of its program without reviewing the "other insurance" clauses in the (not yet issued) insurance policies in years 2 onward.

Instead of phrasing their purported "other insurance" exceptions in "clear and unmistakable" language and placing them prominently to "attract the reader's attention," virtually all of the Insurers buried the "other insurance" clauses in one or two places within the "Conditions" sections of their policies, labeled "Other Insurance" or "Loss Payable." AB at 21-22.

"other insurance" clauses could be construed in the manner urged by the Insurers, they would be "repugnant to the nature of the interest created by the contract" and therefore "void." Civ. Code § 1441.

Since the record does not contain actual policies, *amicus curiae* provides for illustrative purposes an example of a "Conditions" section from an American Home policy issued to a different insured,[6] with the "Other Insurance" condition highlighted. [7]

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[6] This form is presumably similar to the American Home policies that were issued to Montrose. *See* 1PA6 at 208-9.

[7] Note also that the "Loss Payable" provision here refers to an unspecified "underlying insurer" and "underlying limits," and this phrasing is discussed more specifically in Section V, below. Other policies contain "Loss Payable" provisions that refer to "other insurance." *See* AB at 22 (discussing a Transport policy with a "Loss Payable" provision that discusses "deductions for all recoveries, salvages and other insurance (other than recoveries under the underlying insurance, policies of co-insurance, or policies specifically in excess hereof).")

CONDITIONS

1. **Premium.** Unless otherwise provided the premium for this policy is a flat premium and is not subject to adjustment except as provided in Condition 15 Cancellation. If this policy is subject to audit adjustment, the premium may be based upon the rating basis as set forth in the Declarations during the policy period. Upon expiration of this policy or its termination during the policy period, or at the end of each policy year, the earned premium shall be computed as defined herein. If the earned premium is more than the advance premium paid, the Named Insured shall pay the excess to the company; if less, the company shall return to the Named Insured the unearned portion, subject to the annual minimum premium stated in the Declarations for each twelve months of the policy period, and subject further to the policy minimum premium as stated in the Declarations.
2. **Additional Named Insureds.** In the event of additional Named Insureds as defined in Definition 1 (a) being added hereunder, prompt notice shall be given to the company.
3. **Prior Insurance and Non-Cumulation of Liability.** It is agreed, that if any loss is also covered in whole or in part under any other excess policy issued to the insured prior to the inception date hereof, the company's limit of liability as stated in Item 3 of the Declarations shall be reduced by any amounts due the insured on account of any such loss under such prior insurance.
4. **Severability of Interest.** In the event of claims being made by reason of Personal Injuries, Property Damage or Advertising Liability suffered by one insured herein for which another insured herein is or may be liable, this policy shall cover such insured against whom a claim is made or may be made in the same manner as if separate policies had been issued to each insured herein. Nothing contained herein shall operate to increase the Company's limit of liability as set forth in Insuring Agreement III.
5. **Notice of Occurrence.** Whenever the insured has information from which the insured may reasonably conclude that an occurrence covered hereunder involved injuries or damages which, in the event that the insured should be held liable, is likely to involve this policy, notice shall be sent to the Company as soon as practicable, provided however, that failure to notify the Company of any occurrence which at the time of its happening did not appear to involve this policy, but which at a later date would appear to give rise to claims hereunder, shall not prejudice such claims.
6. **Inspection and Audit.** The Company shall be permitted but not obligated to inspect the Named Insured's property and operations at any time. Neither the Company's right to make inspections nor the making thereof nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of the Named Insured or others, to determine or warrant that such property or operations are safe.
The Company may examine and audit the Named Insured's books and records at any time during the policy period and extensions thereof and within three years after the final termination of this policy, as far as they relate to the subject matter of this insurance.
7. **Maintenance of Underlying Insurance.** The policy or policies referred to in the attached "Schedule of Underlying Insurances", and renewal or replacement thereof not more restrictive, shall be maintained by the Named Insured in full effect during the currency of this policy without alteration of terms or conditions except for any reduction of the aggregate limit or limits contained therein solely by payment of claims. 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 so maintained such policy or policies.
8. **Assistance and Co-operation.** Except as provided by Insuring Agreement II, Defense, the Company shall not be called upon to assume charge of the settlement or defense of any claim made or suit brought or proceedings instituted against the insured, but the Company shall have the right and shall be given the opportunity to associate with the insured or the insured's underlying insurer, or both, in the defense and control of any claim, suit or proceeding relative to any occurrence where the claim or suit involves, or appears reasonably likely to involve the Company, in which event the insured, the underlying insurers and the Company shall cooperate in all things in the defense of such claim, suit, or proceeding.
9. **Appeals.** In the event the insured or the insured's underlying insurer(s) elects not to appeal a judgment in excess of the underlying limits, the Company may elect to make such appeal at its own cost and expense shall be liable for the taxable costs and disbursements and interest incidental thereto, but in no event shall the liability of the company, for ultimate net loss, exceed the amount set forth in Item 3 (a) of the Declarations for any one occurrence plus the cost and expense of such appeal.
10. **Loss Payable.** Liability of the Company under this policy with respect to any occurrence shall not attach unless and until the insured, or the insured's underlying insurer, shall have paid the amount of underlying limits on account of such occurrence. The insured shall make a definite claim for any loss for which the Company may be liable under the policy within twelve (12) months after the insured shall have paid an amount of ultimate net loss in excess of the amount borne by the insured or the insured's underlying insurer(s) or after the insured's Liability shall have been fixed and rendered certain either by final judgment against the insured after actual trial or by written agreement of the insured, the claimant and the Company. If any subsequent payments shall be made similarly from time to time, such losses shall be due and payable within thirty (30) days after proof of loss and been furnished to the Company in a satisfactory form.
11. **Other Insurance.** If other collectible insurance with any other insurer is available to the insured covering a loss also covered hereunder, this insurance shall be in excess of, and shall not contribute with such other insurance. Excess insurance over the limits of liability expressed in this policy is permitted without prejudice to this insurance and the existence of such insurance shall not reduce any liability under this policy.
12. **Application of Salvages — Subrogation.** All salvages, recoveries or payments recovered or received subsequent to a loss settlement under this insurance shall be applied as if recovered or received prior to such settlement and all necessary adjustments shall then be made between the insured and the

There is nothing conspicuous about those provisions, which accordingly cannot be applied to limit the Insurers' basic coverage obligations to their insured. *See Haynes*, 32 Cal.4th at 1204–05 (limitation on coverage placed in "Other Insurance" section of policy was not conspicuous and therefore was unenforceable to limit coverage).

But even if the supposed "other insurance" exception was found to be placed and printed in a sufficiently conspicuous manner, the language employed is not "so stated as clearly to apprise the insured of its effect." *MacKinnon*, 31 Cal.4th at 648. There is nothing in a standard "other insurance" clause that would apprise a policyholder that it will be invoked by the insurer to limit or avoid its basic promise of coverage after the

insured has exhausted the specified directly underlying coverage, if for example the insured happens to purchase more insurance in the future. Neither do "other insurance" clauses explain, let alone in "clear and unmistakable" language, that the insurer will demand—as a pre-condition to payment—that the policyholder shoulder the entire burden of pursuing recoveries from that "other insurance." Rather, all the clauses state is that "the insurance afforded by this policy shall be in excess of and shall not contribute with" "other valid and collectible insurance" that is "available to the Insured." AOB at 20.

"The confusion which these clauses engenders fastens upon the draftsman the obligation of writing a provision which is unequivocal." *Fireman's Fund*, 192 Cal.App.2d at 501. For example, "[i]f the company would limit its liability by the interposition of 'other insurance,' it should at least define the 'other insurance.'" *Id.*

The language of these clauses does not for example "clearly apprise" Montrose that its pre-1971 insurers would assert, as they now do, that coverage is unavailable unless and until Montrose "first resolve[s] the issue of whether the pollution exclusions that appear in most post-1971 policies apply to [its] claim." AOB at 55 (emphasis omitted). Not only would construing the policies in the manner urged by Insurers "deprive" Montrose of "the timely indemnity that it bargained for," *Continental II*, 15 Cal.App.5th at 1033, it would "violate the fundamental principle that in interpreting contracts, including insurance contracts, courts are not to insert what has been omitted[.]" *Safeco Ins. Co. v. Robert S.* (2001) 26 Cal.4th 758, 764 (citations omitted).

Accordingly, under the established rules of insurance policy construction, the Insurers' failure to make the purported "other insurance" limitation conspicuous, and their further failure to phrase the exception in "clear and unmistakable" language that "clearly ... apprise[s] the insured of

its effect" precludes enforcement of the clauses in the manner urged by the Insurers. *See MacKinnon*, 31 Cal.4th at 648; *Haynes*, 32 Cal.4th at 1204–05. No further analysis is required.

B. The Insurers' Interpretation Of The "Other Insurance" Clauses Is Not The "Only Reasonable One," And Therefore Cannot Be Adopted.

Even if the "other insurance" clauses were found to be sufficiently conspicuous and clear to be enforceable, and the Insurers' proffered interpretation reasonable, the clauses still could not be given the effect urged by the Insurers *unless* there were no other reasonable interpretation of this language. As this Court explained in *MacKinnon,* even if an insurer's coverage-limiting interpretation of a purported exception to coverage is considered reasonable, that interpretation should be given effect only if the insurer "establish[es] that its interpretation is the only reasonable one." *MacKinnon*, 31 Cal.4th at 655 (citations omitted). A court's role is not to "select one 'correct' interpretation from the variety of suggested readings[;]" rather, it must find "coverage so long as there is any ... reasonable interpretation under which recovery would be permitted." *Id.* (citations omitted).

In this instance, there are multiple interpretations of the "other insurance" clauses that would avoid the result sought by the Insurers. As one court put it in this context: "In the bewildering complexity of modern insurance policies, which contain legions of clauses that confuse and baffle the insured, we question whether carriers should garner any benefit from [such] occult provisions. Where clarity is so important and simplicity so long delayed, we shall not reward ambiguity." *Fireman's Fund*, 192 Cal.App.2d at 497.

For example, as this Court explained in *Dart*, "other insurance" provisions are best viewed as being designed simply to "prevent multiple

recoveries when more than one policy provided coverage for a particular loss." *Dart*, 28 Cal.4th at 1079; *accord Certain Underwriters at Lloyd's, London v. Arch Specialty Ins. Co.* (2016) 246 Cal.App.4th 418, 437; *Fireman's Fund Ins. Co. v. Maryland Ins. Co.* 1998) 65 Cal.App.4th 1279, 1306. That is, "other insurance" clauses can most reasonably be construed as explaining what will happen if, in the course of adjusting a claim, another insurer makes a payment to or on behalf of the policyholder, without imposing upon the policyholder any affirmative obligation to pursue that "other insurance." *See also* Rest., Liability Insurance § 2 (Proposed Final Draft No. 2, 2018), Reporters' Note (a) ("'other insurance clauses' do not apply to policyholders" at all, but "are included in insurance policies only because there is no other contractual vehicle in which to define how to apportion liability among insurance companies .... Payment of the insured's claim always takes priority over the allocation of the loss between concurrent insurers.") (citations omitted).

"Other insurance" clauses are also reasonably construed as referring simply to other insurance that the *insurer* reserves the right to pursue after making its payment to the insured, to reduce its own loss. *Fireman's Fund*, 192 Cal.App.2d at 496. Interpreting them as requiring the *policyholder* to exhaust coverage in addition to the underlying policies or limits specifically identified in the excess policy itself, as a condition of its entitlement to coverage, would impermissibly render the specific excess provisions of the policy surplusage. *See AIU*, 51 Cal.3d at 827 (citing Civ. Code § 1641 ("The whole of a contract is to be taken together, so as to give effect to every part, if reasonably practicable, each clause helping interpret the other.")).

"Other insurance" clauses may also reasonably be construed as being limited to policies that were issued concurrently with the policy containing the "other insurance" clause, and not applying to policies in effect during

successive policy periods. *See, e.g., Fireman's Fund,* 192 Cal.App.2d at 497 ("We conclude, then, that appellant's policy does not contain a precise other insurance provision applicable to *all* other insurance but a limited declaration applicable solely to the *primary insurer's* other insurance. At best the provision is ambiguous and unclear."); *Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co.* (2002) 98 N.Y.2d 208, 223 [774 N.E.2d 687] ("other insurance" clauses "have nothing to do" with coverage under "policies that were in force during successive years"); *see also In re Viking Pump, Inc.* (2016) 27 N.Y.3d 244, 266 [52 N.E.3d 1144] (same; collecting cases).

Indeed, the same Insurers involved here have successfully argued in other cases that "[c]overage questions arising under a CGL occurrence policy must be resolved based on the facts in existence at the time that the damage occurred," *A.C. Label Co. v. Transamerica Ins. Co.* (1996) 48 Cal.App.4th 1188, 1192, and that coverage cannot be affected by a corporate transaction that takes place after the policy expires; *Cooper Companies v. Transcontinental Ins. Co.* (1995) 31 Cal.App.4th 1094, 1107, fn. 10. If the Insurers are correct that contingencies occurring after the policy expires cannot retroactively affect the intended scope of the coverage it purchased, they cannot also be correct that the insured's decision to purchase additional coverage years or even decades later reduces their coverage. *See, also, Continental II,* 15 Cal.App.5th at 1036 (it would be "paradoxical" if policyholder's prudent decision to purchase additional insurance would make it harder to obtain indemnity from any one insurer).

Construing "other insurance" clauses as being limited to preventing a double recovery, and to concurrent insurance, is reasonable, particularly given a policyholder's reasonable expectations—formed on account of the plain meaning of the insuring agreement—that an excess insurer's policy

will attach upon the exhaustion of a specific, predetermined amount of underlying coverage in the same period. It is also reasonable given that the Insurers' position would transfer to the policyholder the insurer's burden of pursuing apportionment claims and could, in some instances, arguably require the policyholder to make contributions on behalf of insolvent insurers or on account of policies with more restrictive coverage,[8] in violation of this Court's prior decisions. *See, e.g., Aerojet*, 17 Cal.4th at 73 ("An insured is not required to make such a contribution together with insurers.").

Disregarding all of the foregoing considerations, the Insurers argue based on the relative premiums allegedly charged by lower versus higher level excess insurers that horizontal exhaustion "reflects the contracting parties' reasonable expectations about which policies would be called on first[.]" AB at 52-53.[9] However, there is nothing in the record to confirm that when the insurers in this case set their premiums, they considered the lower-level policies that the policyholder might purchase years or decades

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[8] The Insurers contend that they are allowed to defer payment to Montrose on account of the existence "other insurances ..., whether recoverable or not, ..." AB at 20.

[9] It is not clear to *amicus curiae* whether the premiums compared involved policies issued in the same year or, instead, policies issued in different years. To the extent the premium comparison involved policies in the same year, the comparison is invalid, as it necessarily would not involve the premium charged by the actual policies being compared. To the extent the premium comparison involved policies issued in different years, an "apples to apples" would require taking into account numerous factors such as different policy terms, inflation, prevailing interest rates, whether the insurance industry was in a "soft" versus "hard" market, the changing perception of the risks associated with chemical companies generally, and the loss history of Montrose in particular, all of which can change over time.

in the future, let alone had the clairvoyance to predict how much coverage the policyholder might decide to purchase decades later or what the scope of such coverage would be. The notion that insurers, in setting their premiums, do so based upon predictions about what other insurance the policyholder might or might not purchase years and decades in the future, is without any basis.

C. The Result Is The Same No Matter Where In The Policies Insurers Place "Other Insurance" Clauses.

The Insurers' arguments fare no better under insurance policies that bury their references to "other insurance" in the definitions of terms that are used in the insuring agreement, as opposed to placing them in the "Conditions" or other sections of the policy. For example, the American Re-Insurance Company policies define "ultimate net loss" to "mean the sums paid in settlement of losses ... after making deductions for all recoveries, salvages and other insurances ... whether recoverable or not, ..." Petitioner's Appendix of Exhibits, Vol. 1, Ex. 6 ("1PA6") at 123. The term "ultimate net loss" is then used in the insuring agreement, with the insurer promising that it will indemnify the "Insured against ultimate net loss ...." 1PA6 at 122.

This Court has made clear that it "is the function served by policy language, not the location of language in an insurance policy, that is determinative." *Dart*, 28 Cal.4th at 1071 (citations omitted). It therefore does not matter whether an insurer places its reference to "other insurance" in the Conditions section of its policy, an exclusion, the insuring clause, or the definition of covered "ultimate net loss."

This means that regardless of its location, an "other insurance" clause is not a condition to coverage that the policyholder must satisfy before being entitled to payment. *See Continental II*, 15 Cal.App.5th at 1033 ("We see no reason to treat the other insurance clause in this case

differently just because it was repeated and incorporated into the definition of Ultimate Net Loss."); *accord Advent, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA* (2016) 6 Cal.App.5th 443, 468; *Fireman's Fund*, 192 Cal.App.2d at 496-97; *see also Arch*, 246 Cal.App.4th at 432 (moving an "other insurance" clause from the policy's Conditions or exclusion sections into its insuring clause does not change its effect). Indeed the contrary rule would result in "a rash of single clause insurance contracts—long, long, long clauses ... in which [are] packed all the exclusions, conditions, requirements, and the like which now are spread over the many paragraphs of the typical insurance contract." *Root*, 130 Cal.App.4th at 943 (citation omitted).

Accordingly, no matter where in its policy an insurer locates standard "other insurance" language of the type addressed here, an insurer cannot withhold coverage on grounds that another insurer should pay first.

V. "UNDERLYING INSURANCE" MEANS *SCHEDULED* UNDERLYING INSURANCE ABSENT CLEAR AND UNAMBIGUOUS LANGUAGE TO THE CONTRARY.

In addition to the "other insurance" clauses discussed above, the Insurers also argue that vague references to their policies being excess to "underlying insurance" or "other underlying insurance" allow them to defer or escape their explicit promise to attach upon the exhaustion of their policy's specified, predetermined amount of underlying coverage in the same period. AB at 20-22. These contentions fail for similar reasons as discussed above.

A. The Vague References To "Underlying Insurance" Or "Other Underlying Insurance" Do Not Clearly Apprise The Policyholder Of Their Purported Effect, And Therefore Cannot Be Construed In The Manner Urged.

Throughout their brief, the Insurers argue that "other insurance" clauses should have the same effect as clauses that use the term "underlying insurance" or "other underlying insurance." *See* AB at 20-22, 31-32. That

is, the Insurers argue that they should be considered excess of any policy that qualifies as "other insurance," "underlying insurance" or "other underlying insurance." *Id.* But when it comes down to the actual meaning these various provisions have, and how they are used in the policies, the Insurers twist and contort, making internally inconsistent and confusing arguments seeking to conform the meaning of these terms to their desired outcome.

For example, the Insurers argue that the term "underlying insurance" includes both "scheduled" underlying insurance in the same policy year *and* all other lower-level policies issued in other policy periods. AB at 28-29 (arguing that generic references to "underlying insurance" in American Re-Insurance, American Centennial and Lamorak policies require "exhaustion of all underlying insurance, not only specifically scheduled underlying insurance."). But the Insurers then contradict their own suggestion that unqualified terms (such as "underlying insurance") must be given broad, all-encompassing effect, arguing that the unqualified term "'other insurance' cannot by definition be insurance vertically underlying (in the same policy year) the excess policy sought to be accessed[.]" AB at 32. Rather, according to the Insurers, the unqualified term "other insurance" can *only be* understood as referring to "underlying insurance other than the scheduled vertically underlying insurance, including policies from before and after a given policy period." In sum, the Insurers contend that the undefined term "underlying insurance" actually means both "scheduled" and "other" underlying insurance, but "other insurance" means only "other"

underlying insurance" and not "scheduled" underlying insurance.[10] This makes no sense.

The unprincipled, confusing and inconsistent meaning the Insurers give to the undefined terms "underlying insurance" and "other underlying insurance" is fatal to their argument that the policy language in all cases requires horizontal exhaustion. Their inability to identify a cogent, consistent interpretation of these terms that applies across all policies means that if the Insurers had desired for all of the policies to uniformly require horizontal exhaustion, they failed to adequately express that desire through "clear and unmistakable" language that "clearly ... apprise[s] the insured of its [alleged] effect." *See MacKinnon*, 31 Cal.4th at 648; *Haynes*, 32 Cal.4th at 1204–05. The Insurers are therefore not entitled to a ruling that horizontal exhaustion is categorically required under all of their policies.

B. The Unqualified References To "Underlying Insurance" And "Other Underlying Insurance" Are At Best Ambiguous, And Therefore Must Be Construed In Favor Of Coverage.

Even if the vague references to "underlying insurance" and "other underlying insurance" in certain policies were found to be sufficiently conspicuous and clear to be enforceable, and the Insurers' proffered interpretation of those clauses reasonable, the clauses *still could not* be

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[10] There is, of course, nothing about the term "other insurance" that forecloses construing it to include scheduled underlying policies in the same year. Indeed, many of the Policies use "other insurance" as an umbrella term that includes *all* other insurance, including scheduled underlying insurance and excess policies. *See, e.g.*, AB at 27. (discussing deductions made on account of "other insurance ... other than the underlying insurance and excess insurance purchased specifically ...."); *see also* AB at 29 (Transport Indemnity policy uses "other insurance" as though it includes "underlying insurance policies of co-insurance" and "policies specifically in excess hereof").

given the effect urged by the Insurers *unless* there was no other reasonable interpretation of those provisions. *MacKinnon*, 31 Cal.4th at 655 (court must find "coverage so long as there is any ... reasonable interpretation under which recovery would be permitted;" by contrast, a court may rule against coverage only when the insurers' coverage-restricting interpretation is the "only reasonable one.") (citations omitted).

The dispute related to the undefined, unqualified term "underlying insurance" involves two competing interpretations—one that favors coverage and one that restricts coverage. In this context, the coverage-favoring interpretation is that "underlying insurance" is limited to *scheduled* underlying insurance in the same policy year. The coverage-restricting interpretation advanced by the Insurers is that "underlying insurance" *must* be construed as including both the scheduled underlying insurance policies *and* all other policies issued in any other year that have a lower nominal attachment point, whether identified on a schedule or not. AB at 28-29.

The coverage-favoring interpretation is plainly reasonable. To begin with, as the Court of Appeal recognized in *Legacy Vulcan Corp. v. Super. Ct.* (2010) 185 Cal.App.4th 677, the "very existence" of scheduled underlying insurance "suggests that the unqualified term 'underlying insurance" refers to that schedule[d] [underlying insurance]." *Id.* at 691. Further, some of the policies use the term "other underlying insurance" as a means of drawing a distinction between scheduled and unscheduled underlying insurance. *See* AB at 27-28 (identifying the American Centennial and Northbrook policies as including references to "other underlying insurance"). Had the Insurers actually understood "underlying insurance" as including both scheduled and unscheduled underlying insurance, there would be no reason for the Insurers to also use the term "other underlying insurance." But the fact that the Insurers felt compelled

to distinguish between "underlying insurance" and "other underlying insurance" suggests—as the Court in *Legacy Vulcan* held—that "underlying insurance" refers only to scheduled underlying insurance. 185 Cal.App.4th at 691.

The Insurers' attempt to gloss over the distinction between their own references to "underlying insurance" and "other underlying insurance," and treat them as synonymous, violates the fundamental rule of contract interpretation that different words have different meanings. *See, e.g., Foster-Gardner, Inc. v. National Union Fire Ins. Co.* (1998) 18 Cal.4th 857, 880 ("If the word 'suit' was broadened to include claims, in the face of policy language which distinguishes between the two, any distinction between these two words would become superfluous.") (citations omitted). It also would render the word "other" (in "other underlying insurance") superfluous, in violation of the rules of construction. *See* Civ. Code § 1641; *see also London Market Insurers v. Super. Ct.* (2007) 146 Cal.App.4th 648, 662 (declining to adopt interpretation that would render policy language "entirely superfluous").

Based on the foregoing, it is at least reasonable to construe the numerous unqualified references to "underlying insurance" in the policies as being limited to the *scheduled* underlying insurance in the same policy year, and *not* as including all other policies issued with lower nominal attachment points issued at any point in time. It follows, therefore, that the Insurers cannot establish that their coverage-restricting interpretation is the "only reasonable one." *MacKinnon*, 31 Cal.4th at 655 (citations omitted). The Insurers' position must therefore be rejected.

The Insurers' arguments fare no better with regard to "other underlying insurance." In this context, the coverage-favoring interpretation is that "other underlying insurance" is limited to *unscheduled* underlying

insurance issued in the same year.[11] The coverage-restricting interpretation advanced by the Insurers is that "other underlying insurance" may only be reasonably construed as encompassing all unscheduled policies issued at any time that have a lower nominal attachment point. AB at 28-29.

Again, the narrower, coverage-favoring interpretation is at least reasonable. Construed in its "ordinary and popular sense," *Mackinnon*, 31 Cal.4th at 648, the term "underlying" implies that two items have a dependent relationship, with the connection creating that relationship being either physical (*e.g.*, "underlying" bedrock) or logical (*e.g.*, the "underlying" litigation giving rise to the coverage claim). *See, e.g.*, *Webster's Encyclopedic Unabridged Dict. of the English Language* (2d ed. 1996) p. 2062 (defining "underlying" as "lying or situated beneath, as a substratum" and "belonging to an earlier stage in the transformational derivation of a sentence or other structure, belonging to the deep structure"); *see also Black's Law Dictionary* (10th ed. 2014) (defining "underlying" only as "[a]n asset or other factor that gives rise to the rights and obligations in a derivative contract.").

The relationship that *scheduled* underlying insurance has with excess insurance typically *can* be described as "underlying" in both senses of the word. Scheduled underlying insurance is "underlying" in the sense that the excess policies are almost literally built upon the lower level policies, like a tower, and have temporal limits that are either coextensive or at least

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[11] This could happen if, for example, the policyholder cancelled an underlying policy mid-term and replaced it with a new policy not referenced in the excess policy's schedule. Because the schedule of underlying insurance is typically printed at the time the excess policy incepts, underlying policies purchased by the insured during the year time would not appear on the schedule unless the insured provided notice of the new policy and the excess insurer amended the schedule.

overlap. There often is also a logical relationship, as many excess policies "follow-form" to at least some of the terms in the lower-level policies, thereby creating a derivative or interconnected relationship.

In contrast to scheduled underlying insurance, *unscheduled* policies issued in other years *cannot* reasonably be described as "underlying" in either sense of the word. Policies issued in other years are not underneath the excess policies, either physically or temporally. They are better described as being "next to," "preceding" or "following" the policies issued in other years. Nor is there a logical or derivative relationship, as the excess policies do not by their own terms incorporate or otherwise derive obligations from the lower level policies issued in other years. Rather, a higher-level policy issued in 1965, for example, is entirely independent from a lower-level policy issued in 1973. There is no relationship between the two policies besides the fact that they were issued to the same insured. And that, of course, does not give rise to a relationship that can be described as "underlying" in its "ordinary and popular" sense. *Mackinnon*, 31 Cal.4th at 648.

Returning to the interpretation issue at hand, it is simply not true that the only reasonable construction of the undefined term "other underlying insurance" is that it includes policies issued during different policy periods. The addition of "other" to "underlying insurance" does not expand or otherwise transform the meaning of "underlying insurance," but instead qualifies it by referring to only a subset of "underlying insurance." Accordingly, whether qualified by "other" or not, "underlying insurance" must still refer to insurance that is "underlying." And because it is at least reasonable to construe "underlying insurance" as being limited to concurrently issued or temporally overlapping policies, as discussed above, it must also be reasonable to construe "other underlying insurance" as being limited to a subset of such policies.

On account of the foregoing, the Insurers cannot meet their burden of demonstrating that their coverage-restricting interpretation is the "only reasonable one." *MacKinnon*, 31 Cal.4th at 655. The Insurers' position should therefore be rejected.

CONCLUSION

Based on the foregoing, *amicus curiae* respectfully requests that this Court rule in favor of Montrose.

DATE: September 21, 2018

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE
PURSUANT TO CAL. R. CT. 8.520(c)

Pursuant to California Rule of Court 8.520(c), and in reliance upon the word count feature of the software used to prepare this document (Microsoft Word), I certify that the foregoing Brief *Amicus Curiae* of United Policyholders contains 10,554 words, exclusive of those materials not required to be counted under Rule 8.520(c)(3).

DATED: September 21, 2018.

HEATHER W. HABES

PROOF OF SERVICE

Case No. S244737

I am a resident of the State of California and over the age of eighteen years, and not a party to the within action; my business address is Covington & Burling LLP, 1999 Avenue of the Stars, Suite 3500, Los Angeles, California 90067. On September 21, 2018, I served the following documents described as:

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The Honorable Elihu M. Berle Los Angeles Superior Court Department 6 Spring Street Courthouse 312 N. Spring Street Los Angeles, CA 90012	Court of Appeal Second Appellate District Division 3 300 South Spring Street 2nd Floor, North Tower Los Angeles, CA 90013

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I placed the above documents in sealed envelope(s), with postage thereon fully prepaid, for collection and mailing at Los Angeles, California, following ordinary business practices for service on the following parties:

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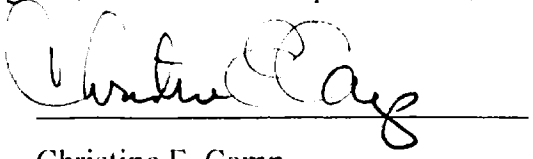

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- **BRIEF *AMICUS CURIAE* OF UNITED POLICYHOLDERS IN SUPPORT OF APPELLANT**

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