New Jersey Law on the Unavailability of Asbestos Insurance

By John T. Waldron III – August 2, 2012

By the mid-1980s, asbestos liabilities had grown dramatically in the tort system, setting off alarm bells in the insurance industry. The reaction of the insurance industry was simple and clear: An "asbestos curtain" descended across the insurance programs of corporate America, as insurers almost entirely ceased selling asbestos products insurance to insureds whose risk profile indicated that it could get swept into the emerging crisis. Around that time, a manufacturer, distributor, or installer of asbestos-containing products, particularly one with pending asbestos claims, could not have purchased meaningful risk-transfer insurance coverage for asbestos-related products claims, except perhaps in limited circumstances.

This development had, and continues to have, important consequences for policyholders seeking to access the asbestos insurance that they purchased prior to the mid-1980s. Specifically, under New Jersey law (and certain other states' laws), if asbestos insurance was not reasonably available for purchase for a given time period, the insured will not be responsible for such time periods in the calculation of who bears responsibility for the asbestos claims in question.[1]

As a result, the insurers have every economic incentive to argue that—notwithstanding their concerted abandonment of asbestos insurance—asbestos insurance was allegedly "available" to their asbestos-related policyholders after the mid-1980s. When pressed to provide support for this revisionist history, these insurers rarely can locate any relevant examples of such insurance. They were not foolish enough to sell it, but they are certain some other insurer (perhaps a now-insolvent one) did. But there are precious few examples of such insurance in the reported case law, and the handful that exist are easily explained as unique instances that do not demonstrate that asbestos insurance was reasonably available to other relevant policyholders.

Lacking actual evidence of available asbestos insurance from the mid-1980s forward, insurers recently have begun teaming up with law and economics professors who purport to provide a theoretical explanation of why asbestos insurance should have been reasonably available. Of course, these economists miss the point—whether a rational insurer should have sold asbestos insurance or not (and it is not clear that selling asbestos insurance in the face of a rising tide of asbestos claims would have been rational), they almost universally did not.

Undeterred by the facts of what actually happened, these insurers (and their selected expert witnesses) claim that, in essence, insurance is always available; it is simply a matter of adjusting the premium to reflect the correct pricing of the risk. In other words, every policy has its price, and insurance is never truly unavailable.
This vision—or, more accurately, mirage—is not innocuous. It is deliberately designed to shift a share of the substantial amount of asbestos costs from the insurers—insurers who were paid premiums to accept this very risk—to their policyholders. It is an open question whether insurers should have been permitted to abandon the marketplace in the mid-1980s and to refuse to continue selling asbestos insurance to the policyholders who needed it the most when they needed it the most. But there can be no question that the marketplace was closed for business to such policyholders. Fortunately, as discussed below, a number of courts, including the New Jersey court that has most recently addressed the issue, have rejected the insurers' revisionist history and found that asbestos insurance was not reasonably available to the insureds in question beginning in the mid-1980s.

**Why the Unavailability of Asbestos Insurance Coverage Is Relevant**

Whether asbestos insurance coverage was reasonably available during a given time period is relevant because, under the laws of New Jersey and certain other states, that fact can affect whether such time period is included in the calculation of the shares (frequently pro rata) of the involved parties.[2]

For instance, under the "continuous trigger of coverage" approach adopted by the New Jersey Supreme Court in its landmark ruling in *Owens-Illinois, Inc. v. United Insurance Co.*, an asbestos bodily injury claim is deemed to trigger all liability insurance policies in effect from the time of the claimant's first exposure to asbestos through the time of manifestation of the asbestos-related disease or injury. The New Jersey Supreme Court also explained that the amounts attributable to each such claim are to be "allocated," or spread, among the triggered insurance years on a weighted pro-rata basis that takes into account both the number of annual periods that each insurer was on the risk as well as the total limits of liability sold by that insurer.[4]

The supreme court further held that asbestos liabilities are not allocable to periods of time in which insurance coverage for such liabilities was not reasonably available to the policyholder (in contrast to periods in which such insurance was available, but the policyholder deliberately chose to self-insure).[5]

For example, assume that the policyholder purchased $2 million in asbestos products insurance in Year 1 and another $2 million in Year 2, and deliberately chose to self-insure rather than purchase another $2 million in reasonably available asbestos products insurance in Year 3. Assume further that there was one asbestos claim asserted against the insured, the claim was settled by the insured for $3 million, and the claim involved an allegation of first exposure to asbestos in Year 1 and manifestation of asbestos-related disease and claim assertion in Year 3. Under New Jersey's weighted pro rata allocation law, the insured would be responsible for $1 million because it chose to self-insure for Year 3. However, if instead of being available in Year 3, the asbestos insurance was not reasonably available, no portion of the $3 million settlement would be allocable to the insured on account of Year 3. Rather, because the absence of insurance was not a
deliberate choice by the insured, Year 3 would be excluded from the coverage period (or "block") used to determine the weighted pro rata shares of the insurers.

Proving the Availability of Asbestos Insurance Coverage

New Jersey law places the burden of proving the availability of insurance coverage at a specified time on the insurer.[6] Placing the burden of proving the unavailability of insurance on the policyholder would be inconsistent with the New Jersey Supreme Court's reluctance to place a negative burden of proof on a party in coverage cases.[7]

Insurers often contend that asbestos insurance must have been reasonably available to a given insured after the mid-1980s because certain other insureds were able to obtain asbestos coverage during that period. However, despite the fact that they have undoubtedly conducted extensive searches, insurers have generally not located many such relevant instances. The examples they proffer typically involve unique circumstances that do not speak to the availability of asbestos coverage for those insureds whose risk profiles indicated that they may be the target of asbestos claims. For that reason, the insurers' reliance on these one-off instances should be rejected.

As a threshold matter, the insurers' argument applies the wrong standard. The standard under New Jersey law is not whether it was impossible for any insured to buy any insurance covering its asbestos-related products risks. The standard is whether such insurance was reasonably available to the particular insured in question.[8]

For instance, insurers have cited as evidence the fact that John Crane, Inc., was apparently able to buy primary (but not excess) coverage from Kemper from 1944 to 2001.[9] But John Crane's insurance is irrelevant because it reflects circumstances that were unique to that insured:

- John Crane was apparently able to buy insurance from Kemper after 1987 because, thanks to the decades that Kemper had sold insurance to it, Kemper by 1987 would already have been responsible for a substantial percentage, if not the entirety, of John Crane's liabilities. Because John Crane's asbestos liabilities would be allocated largely to Kemper whether it stopped selling or continued to sell insurance to that insured in 1987, Kemper apparently made an underwriting decision that, by continuing to sell insurance to John Crane, Kemper would at least be paid some additional premium. Kemper apparently was trying to earn its way out of a financial hole. It failed.[10]
- John Crane's post-1987 "insurance" involved virtually no risk transfer: The insurance limits were $2 million per year, but the premiums were $1.5 million per year.
- Kemper apparently sold such insurance only after the mid-1980s to John Crane; hence, this one-off situation does not support the notion that asbestos coverage was reasonably available to other insureds.
The other instances frequently cited by insurers are similarly irrelevant, involving policies issued mainly in the 1980s for small amounts of coverage to insureds with an underwriting profile that typically did not suggest significant exposure to asbestos risk:

- **Westchester Fire Insurance Co. v. Treesdale, Inc.**[11] The insured had a primary and an umbrella policy (each providing a mere $1 million in coverage) for 7/1/1990–91, but the insurer contended (supported by substantial evidence) that such policies were intended to incorporate asbestos exclusions.

- **National Union Fire Insurance Co. v. Porter Hayden Co.**[12] The insured had a primary policy for 4/1/1987–88, providing a mere $1 million in coverage, with no excess asbestos coverage.

- **Plastics Engineering Co. v. Liberty Mutual Insurance Co.**[13] The insured had one primary policy for 1/1/1986–89 ($1 million in limits) and one umbrella policy for 1/1/1986–88 ($10 million in limits), both presumably purchased in late 1985.

- **Pennsylvania General Insurance Co. v. Park-Ohio Industries, Inc.**[14] The insured had one primary policy expiring on 2/1/1988 (presumably issued in early 1987); this case involves a single asbestos claim.

In sum, the fact that a few smaller entities may have been able to buy minimal asbestos insurance during or shortly after the mid-1980s does not help an insurer carry its burden of proving that insurance was reasonably available to other insureds, particularly those with underwriting profiles that differ from the underwriting profiles of the insureds at issue in such cases.

**Available Insurance Requires Risk Transfer**

In the absence of evidence that risk-transfer asbestos insurance was reasonably available to the insured, insurers are often relegated to arguing that an "alternative" (read: no risk-transfer) approach was available. These insurers claim that *Owens-Illinois* recognized the viability of "alternatives" to "market" or "traditional" insurance in deciding whether asbestos insurance was available. This is simply a misreading of *Owens-Illinois*.

In *Owens-Illinois*, the New Jersey Supreme Court explicitly noted that insurance requires the transfer of risk.[15] Nothing in *Owens-Illinois* even hints that "available insurance" may include any "alternative" approach in which risk is not transferred.

In this regard, insurers have suggested that *Owens-Illinois* treated insurance from a captive insurer (typically a subsidiary of the insured) the same as insurance bought from an insurer. While the insured in *Owens-Illinois* used a captive insurer from 1977 to 1985, this fact is irrelevant because (1) the *Owens-Illinois* captive insurance was 100 percent reinsured with various insurers and hence did involve the transfer of risk, not self-insurance;[16] and (2) the period in question was prior to the universal inclusion of asbestos exclusions in general liability policies in the mid-1980s and hence does not undermine the notion that asbestos insurance was not reasonably available from that point forward.
In sum, nothing in *Owens-Illinois* suggests that self-insurance or other alternative approaches in which risk is not transferred can constitute "available insurance."[17] Indeed, if self-insurance or other "alternative" approach in which risk is not transferred were deemed to be "available insurance," insurance would always be "available," thus rendering meaningless the issue of whether insurance was available. The insurers' misreading of *Owens-Illinois* should be rejected.

As a corollary to their argument that the insured had alternative approaches available to it, insurers often contend that an insured's own internal accounting reserves constituted self-insurance that satisfies the standard under *Owens-Illinois* for reasonably available asbestos insurance.[18] By treating self-insurance as actual insurance, this approach would stand *Owens-Illinois* on its head.

**Case Law Rejects the Insurers' Position**
The New Jersey Supreme Court and Appellate Division have made clear that so-called self-insurance does not constitute insurance. For instance, in *American Nurses Ass'n v. Passaic General Hospital*, the Appellate Division held that a deductible or "self-insured sum" under a liability policy did not constitute insurance:

[S]o-called self-insurance is not insurance at all. It is the antithesis of insurance. The essence of an insurance contract is the shifting of the risk of loss from the insured to the insurer. The essence of self-insurance, a term of colloquial currency rather than of precise legal meaning, is the retention of the risk of loss by the one upon whom it is directly imposed by law or contract.[19]

The New Jersey Supreme Court affirmed this ruling, confirming that insurance, by definition requires the transfer of the risk of loss to an insurer whose primary business is to sell insurance:

As a matter of common understanding, usage, and legal definition, an insurance contract denotes a policy issued by an authorized and licensed insurance company whose primary business it is to assume specific risks of loss of members of the public at large in consideration of the payment of a premium.[20]

This common-sense distinction between insurance and self-insurance in *American Nurses* is consistent with other insurance principles articulated by various courts:

- For instance, courts have noted that insurance requires the transfer of risk.[21]
- Further, insurance requires a contract between an insured and an insurer.[22]
- The policy is to be "issued by an authorized and licensed insurance company whose primary business it is to assume specific risks of loss of members of the public at large."[23] Risk-shifting agreements, such as private indemnity agreements, do not constitute insurance where "affording the indemnity is not the primary business of the indemnitor and [the risk-shifting agreement] is not subject to governmental regulation."[24]
Moreover, as its name suggests, the "premium" charged is intended to be somewhat greater than the expected losses so that the insurer can profit thereby.[25]

In sum, so-called self-insurance, including the internal reserves of an insured that insurers have tried to characterize as "self insurance," cannot constitute available insurance of the kind envisioned by the Owens-Illinois court in determining how to allocate responsibility for asbestos liabilities. In essence, the insurer argument is that non-insurance is the equivalent of available insurance, which again would stand Owens-Illinois on its head.

The Insurers' Case Law Is Easily Distinguishable

Trying to avoid the inescapable conclusion that the absence of insurance does not constitute insurance, insurers have on occasion relied on several cases that have nothing to do with product liability insurance. Specifically, they cite cases in which an entity is required by statute to purchase insurance (such as automobile or workers' compensation insurance) or to qualify for an exemption to that statutory mandate and obtain a "certificate of self-insurance" from the relevant governmental agency. These insurers are trying to take advantage of the fact that, under the statutory schemes at issue, a qualified self-insurer is treated as an insurer (who issued a policy to itself). Their cases are obviously inapplicable to traditional risk-transfer product liability insurance.

First, as the American Nurses court noted, these limited instances of statutorily mandated "qualified self-insurance" are clearly distinguishable from the more common scenario in which an entity has the option to simply go uninsured (or the entity has no insurance reasonably available to purchase):

"We are aware that within the general, imprecise and amorphous concept of self-insurance there is one type of self-insurance which does have a legally-recognized identity and a clearly defined consequence. We refer to the situation in which compulsory liability insurance is mandated by a statute which also provides that a person subject to the mandate may, in accordance with specified standards and upon a satisfactory showing of financial ability to bear the risk, be exempted from the obligation to purchase insurance upon issuance by a designated administrative officer or agency of a certificate of self-insurance. . . ."

". . . While there is support for the view that qualified self-insurance constitutes other insurance, we have been unable to find any authority at all for the thesis that any other kind of so-called self-insurance constitutes other insurance.[26]

Second, the insurers' cases explicitly agree with American Nurses that "so-called self-insurance is not insurance at all. It is the antithesis of insurance."[27] Like the court in American Nurses, these courts distinguish ordinary self-insurance (referring to someone such as an insured who does not or cannot obtain coverage) from qualified self-insurance (referring to an insured who meets the requirements to obtain an exemption from statutorily mandated insurance but must then stand in the shoes of such an insurer).[28]
Third, these cases involve the liability of a qualified self-insurer as an insurer, not as a tortfeasor.[29]

Fourth, the reason that qualified self-insurers are treated as insurers is to satisfy the legislative intent and public policies underlying the statutory scheme. For instance, in *Ryder/P.I.E. Nationwide, Inc. v. Harbor Bay Corp.* , the New Jersey Supreme Court noted the strong public policy to protect persons wrongfully injured by motor vehicles, as well as the rule that statutorily required coverage must be broadly construed, in ruling that the qualified self-insurer owed coverage to the tortfeasor.[30]

Indeed, these cases did not even involve the question of whether insurance was available; they all involved situations in which insurance was reasonably available, but the entity chose to qualify as a self-insurer under the statutory exemption.

In sum, the insurers' cases are clearly distinguishable and do not address (let alone refute) the New Jersey Supreme Court's ruling that self-insurance does not constitute insurance.

**Sybron Conflicts with New Jersey Law**

In the absence of evidence that asbestos insurance was reasonably available to a particular insured, insurers have adopted the tactic of trying to twist the meaning of what "reasonably available" means. Specifically, insurers—often in conjunction with law and economics professors who seek to provide expert testimony—argue that insurance can never truly be "unavailable." Instead, according to such proffered professors, insurance is always theoretically "available" if the policyholder is willing to pay a high enough premium.

One court has been sympathetic to this view. In *Sybron Transition Corp. v. Security Insurance of Hartford*, the Seventh Circuit Court of Appeals, applying New York law, noted its uncertainty regarding whether insurance can be unavailable: "Indeed, we do not know what it means (or could mean) to say that coverage for a particular risk is 'unavailable.'"[31]

But even assuming *arguendo* that the *Sybron* court were concluding that insurance cannot be unavailable, this holding would be simply contrary to New Jersey law, as the New Jersey Supreme Court has made clear that asbestos insurance coverage can be unavailable.[32]

In fact, the *Sybron* court did not even understand the purpose of insurance, thus demonstrating that that decision does not reflect New Jersey law, under which the state supreme court has noted the importance of encouraging the purchase of insurance.[33]

Ultimately, in relying on *Sybron*, insurers typically contend that the reason an entity is uninsured should not matter under a pro rata allocation method. But that is precisely why *Sybron* (applying New York law) conflicts with New Jersey law—under *Owens-Illinois*, the New Jersey Supreme Court held that the reason an entity is uninsured does matter:
"When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable."[34]

Thus, *Sybron* is irrelevant as it conflicts with New Jersey law.

**Recent Developments: The Policyholder Prevails in Honeywell**

In the most recent decision by a New Jersey court to address the availability of asbestos insurance, the court in *Continental Ins. Co. v. Honeywell International Inc.* correctly held that asbestos insurance was not reasonably available to Honeywell beginning in the 1986/1987 period.[35]

In *Honeywell*, the insurers of Allied-Signal Inc. (a relevant predecessor of Honeywell International Inc.) inserted asbestos exclusions in Allied-Signal's policies beginning on April 1, 1986 (at the primary insurance level) and on April 1, 1987 (at the excess insurance level). Despite undisputed testimony by the policyholder's witnesses that asbestos insurance was not reasonably available to it at that point, the insurers disputed the unavailability of asbestos insurance. Specifically, the insurers in *Honeywell* employed all four of the tactics discussed above.

Rejecting all of those arguments, the *Honeywell* court held that the insurers had failed to create a factual dispute regarding the availability of asbestos insurance. Accordingly, on July 22, 2011, the court granted the policyholder's motion for summary judgment and ruled that asbestos insurance was not reasonably available to it beginning in the 1986/1987 period.

**Conclusion**

An important element of asbestos coverage disputes under New Jersey law is the question of when asbestos insurance coverage was reasonably available, or unavailable, to the specific policyholder at issue. Because of their own abandonment of the asbestos insurance marketplace in the mid-1980s, insurers have been scrambling in these coverage litigations to concoct a basis for claiming that asbestos insurance was nevertheless available to such insureds. These tactics have included (1) relying on a handful of cases in which small companies with unique underwriting profiles were able to purchase a limited amount of coverage for a brief period of time; (2) arguing that "alternative" approaches constituted available insurance under *Owens-Illinois* despite the lack of risk transfer involved; (3) contending that internal reserves or other mechanisms that the insurers characterize as "self-insurance" satisfy the requirement of available insurance under *Owens-Illinois*; and (4) relying on *Sybron* and the perspective that insurance can never be truly "unavailable" in an (allegedly) rational world. As demonstrated by the recent decision in *Honeywell*, courts applying New Jersey law should reject these attempts by insurers to rewrite history and to punish policyholders for the insurers' own abandonment of the asbestos insurance marketplace in the mid-1980s.

**Keywords:** insurance coverage, litigation, asbestos insurance, availability of coverage, transfer of risk, New Jersey
John T. Waldron III is a partner with K&L Gates LLP, Pittsburgh.

* John T. Waldron III is a partner in the Pittsburgh office of K&L Gates LLP, a law firm that regularly represents policyholders in insurance coverage disputes, including several policyholders in asbestos-related insurance coverage disputes. The views expressed herein are those of the author and not necessarily those of the law firm or its clients. This article is for informational purposes only and does not contain or convey legal advice. The information herein should not be used or relied upon in regard to any particular facts or circumstances without first consulting with a lawyer.


[6] See Chemical Leaman Tank Lines v. Aetna Cas. Ins. & Sur. Co., 177 F.3d 210, 231 (3d Cir. 1999) (interpreting New Jersey law to hold that "the insurers should bear the burden of proving that insurance coverage was available"); Champion Dyeing & Finishing Co. v. Centennial Ins. Co., 355 N.J. Super. 262, 271–73 (N.J. Super. Ct. App. Div. 2002) (holding that insurer failed to meet its burden to show that "insurance could have been purchased that covered the precise risk that manifested, not simply that EIL insurance covering undefined risks was available" and that "insurance was available at the time of manifestation and that conditions of coverage at that time were not such as to preclude indemnification").


"available' means, 'Available to an entity such as Uniroyal using all reasonable efforts to procure same'") (quoting and following trial court opinion).


[10] Since 2003, Kemper has been in voluntary run-off under the supervision of the Illinois Department of Insurance.


[18] Insurers have claimed that Owens-Illinois supports their position that a policyholder's internal reserve is equivalent to insurance. But in Owens-Illinois, the court nowhere suggests that a reserve constitutes insurance. Indeed, the court noted in passing that the insured created a reserve in 1980 (138 N.J. at 445) but never even hints that the existence of that reserve was relevant to any allocation issue.


[20] Am. Nurses Ass'n, 98 N.J. 83, 90 (N.J. 1984) (quoting Appellate Division decision). Indeed, the New Jersey Supreme Court went on to note that, while insurance by definition involves the shifting of risk, not all risk-shifting agreements constitute insurance contracts. American Nurses Ass'n, 98 N.J. at 90.

[22] See, e.g., Group Life & Health, 440 U.S. at 211 n.7 (stating that insurance means "a contract whereby, for a stipulated consideration, called a premium, one party undertakes to indemnify or guarantee another against loss by a certain specified contingency or peril, called a risk, the contract being set forth in a document called the policy" (quoting Webster's New International Dictionary of the English Language 1289 (unabr. 2d ed. 1958))).

[23] American Nurses Ass'n, 98 N.J. at 90 (quoting Appellate Division decision).


[25] See, e.g., Group Life & Health, 440 U.S. at 211 ("[S]uch losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it." (quoting 1 Couch, Cyclopedia of Insurance Law 1:3 (2d ed. 1959))).


[30] Ryder, 119 N.J. at 408–11; see also Fellhauer, 838 N.E.2d at 138 (automobile financial responsibility statute "enacted for the purpose of protecting the public from negligent drivers of rented vehicles"); Loven, 626 N.W.2d at 200 (no-fault benefit statute is "based on the concept of compensation, regardless of fault" for automobile accidents).

[31] Sybron Transition Corp. v. Sec. Ins. of Hartford, 258 F.3d 595, 599 (7th Cir. 2001).

Mgmt. Corp., 73 F.3d 1178, 1204 (2d Cir. 1995) (rejecting any allocation to the insured for years after 1985 when "asbestos liability insurance ceased to be available" and stating "[t]here is no reason to believe that any bargaining occurred with respect to the asbestos exclusion clauses").

[33] Compare Sybron, 258 F.3d at 600 ("It is a little unclear why corporations buy insurance at all."), with Owens-Illinois, Inc., 138 N.J. at 472–73 ("Because insurance companies can spread costs throughout an industry and thus achieve cost efficiency, the law should, at a minimum, not provide disincentives to parties to acquire insurance when available to cover their risks. Spreading the risk is conceptually more efficient.").

[34] Owens-Illinois, Inc., 138 N.J. at 479 (emphasis added).

JOIN
If you are an ABA Section of Litigation member and wish to subscribe to this newsletter, it's free if you join the Insurance Coverage Litigation Committee.

The views expressed in Coverage are those of the authors and do not necessarily reflect the position of the American Bar Association, Insurance Coverage Litigation Committee, Litigation Section, the editorial board of Coverage, the LexisNexis Group, or the authors’ employers. The publication of articles in Coverage does not constitute an endorsement of opinions or legal conclusions which may be expressed. Coverage is published with the understanding that the Insurance Coverage Litigation Committee is not engaged in rendering legal or professional services. Readers are invited to submit articles, comments or case notes on any aspect of insurance litigation. Publication and editing are at the discretion of the editors. Because of time constraints, galleys or proofs are not forwarded to authors.