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In This Issue

Walter Andrews is a partner in the McLean, VA office of Hunton & Williams. His practice focuses on complex insurance coverage litigation and counseling. In the past two decades, Mr. Andrews has been a leading figure in coverage litigation with respect to nursing home claims, Y2K claims, environmental and toxic tort claims and first party insurance disputes arising out of the events of 9/11. He can be contacted at wandrews@hunton.com.

Syed Ahmad is an associate in the McLean, VA office of Hunton & Williams. His practice focuses on complex insurance coverage litigation and counseling. He can be contacted at sahammad@hunton.com.

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Long-Term Professional Liability Cases: Who Is Responsible For Nursing Home Claims?

By Walter J. Andrews and Syed S. Ahmad¹

I. Introduction

Often in professional liability cases, such as nursing home litigation, the underlying claim spans several years. This, in turn, leads to several insurance policies potentially being implicated. Under certain circumstances, policyholders may have an incentive to tender the claim to one particular insurer or under one particular policy. For example, certain policies may have a low deductible or contain higher aggregate limits. In such a situation, an insurer's obligations are determined by several, and somewhat interrelated, issues. This article discusses the different approaches courts have utilized when deciding these coverage issues.²

A hypothetical is illustrative. Assume that the insured is a company that operates nursing homes. One of the residents files a lawsuit after having stayed at the facility for 10 years. The resident alleges generally that the nursing home was negligent throughout the entire residency period. In addition, the lawsuit contains several specific allegations – pressure sores that developed on specific dates, weight loss that spanned several months, and dehydration that occurred over several years. Assume that during this 10-year period, there are several primary liability policies and excess policies in effect. Some of the primary policies provide general liability coverage and others provide professional liability coverage.

There are many coverage issues that this hypothetical raises:

- Which, if any, of the policies are triggered by the

underlying lawsuit?

- How should any loss be allocated?
 - Can the policyholder choose any primary policy?
 - Will the chosen carrier be responsible for the entire loss?
 - If the policy limits under a particular primary policy are exhausted, which other policies may be triggered?
- Does the underlying lawsuit constitute one “occurrence”?

As described below, courts that have resolved some of these coverage issues have reached different results. For example, based on the hypothetical above, some courts have held that all applicable primary liability policies have to be exhausted before any excess policy is triggered. Other courts have rejected this approach. This article discusses illustrative case law and analyzes how the decisions can significantly impact an insurer’s coverage obligations for long-term professional liability claims.

II. Coverage Issues

A. Trigger of Coverage

Whether a particular liability policy is triggered depends on the policy language. There is a difference between professional liability policies and general liability policies. Professional liability policies are generally triggered by, among other requirements, a negligent act, error, or omission that occurred during the policy period.³ In contrast, general liability policies are triggered by, among other requirements, “bodily injury” that occurs during

the policy period.

Some nursing home claims could conceivably trigger both professional liability coverage and general liability coverage. In such cases, a court would have to decide which coverage applies to determine the applicable policy language and trigger of coverage. For example, the professional liability coverage may contain provisions that are more favorable to a particular party than analogous provisions in the general liability coverage.⁴ For example, in *Royal v. Hartford*, the underlying lawsuit was a wrongful death action brought against a nursing home. The nursing home was insured under two primary policies that were issued by two different carriers. After one of the carriers settled the underlying lawsuit, it brought a subrogation action against the other carrier to recover half of the settlement costs. The “other insurance” clauses in the policies governed how liability would be shared between the carriers. The carriers disagreed regarding which coverage, and consequently which “other insurance” clauses, applied to the underlying claim.

In deciding the issue, the court disregarded “the specific legal theories advanced by the parties.”⁵ Rather, the court focused on the actual facts alleged. For example, the underlying lawsuit alleged that the nursing home’s failure to properly render medical and nursing care caused the patient to develop infections and skin ulcers. Based on these allegations, the court concluded that the “gravamen of the plaintiffs’ allegations is negligent medical care;” thus, the professional liability coverage applied.⁶

The difference between a claim under professional liability coverage and general liability coverage is meaningless if the negligent act, for example, occurs during the same policy period as all of the bodily injury. For example, a nursing home may be negligent for failing to adequately monitor a resident’s weight. This negligence may lead to preventable weight loss. If both of these events – the alleged negligence

and the weight loss – occurred only in one policy period, then only one particular policy will be triggered regardless of whether the policy provides professional liability coverage or general liability coverage.

However, the distinction between professional liability policies and general liability policies can be significant if the alleged wrongdoing and bodily injury span several years. Case law illustrates this distinction. For example, in *Doe v. Illinois State Med. Inter-Ins. Exch.*, 599 N.E.2d 983 (Ill. Ct. App. 1992), the insured-doctor was sued for alleged negligent treatment of a patient. The jury in the underlying lawsuit returned a verdict for \$1.5 million. There were two relevant professional liability policies, one in effect from July 1983 until July 1984 and another from July 1984 until July 1985. Each policy was triggered by, among other things, “personal injury arising out of the rendering or failure to render, during the policy period, professional services.”⁷ The carrier argued that only the July 1983-July 1984 policy was triggered. The court noted that the doctor was allegedly negligent during the July 1984-July 1985 policy because he prescribed medication without monitoring its side effects and failed to adequately control the patient’s elevated blood sugar. Accordingly, the court ruled that both policies were triggered.⁸

Cases interpreting general liability policies involve different issues and can reach a different result. For example, in *Keene Corp. v. Ins. Co. of North Am.*, 667 F.2d 1034 (D.C. Cir. 1981), the underlying lawsuit involved thousands of plaintiffs seeking damages for diseases allegedly caused by exposure to asbestos products. The relevant policies provided general liability coverage and were in effect from 1961 until 1980. In determining which policies were triggered, the court ruled that “the language of each policy at issue in this case clearly provides that an ‘injury,’ and not the ‘occurrence’ that causes the injury, must fall within a policy period for it to be covered by the policy.”⁹

The different approaches in *Doe* and *Keene* result from the different types of policies at issue in each case. The distinction that these two cases illustrate can be significant under the nursing home hypothetical described above. For example, the underlying lawsuit contains allegations of pressure sores that developed on specific days. The negligence that caused the pressure sore to develop may have occurred during year one. The pressure sore, however, may have developed in year one but may not have healed until year two. Under a professional liability policy, the only relevant event – the negligent act – occurred during year one and only the professional liability policy in effect at that time could be triggered. In contrast, under a general liability policy, the only relevant event – the “bodily injury” – is the pressure sore, which occurred during year one and did not heal until year two. Therefore, the general liability policies in effect during both years could be triggered.

B. Underlying Liability and Allocation

Once it is determined that a particular policy is triggered, questions remain regarding the extent of the nursing home’s liability and how the underlying claim should be allocated between different insurers and between different policies. In addition, the allocation issue involves the relationship between primary policies and excess policies. This section discusses how different courts have resolved these allocation issues.

1. Underlying Liability

Several states have enacted legislation attempting to limit nursing home liability.¹⁰ Furthermore, in addition to bringing ordinary negligence claims, plaintiffs generally prefer to bring statutory claims because, among other reasons, the statutes typically allow plaintiffs to collect attorney fees under certain circumstances.¹¹ Some courts have recently limited the circumstances under which these statutory claims can be brought, such as the court in *Knowles v. Beverly Enterprises-Florida*.¹² In

Knowles, the deceased resident's wife sued the nursing home alleging that her husband had suffered from pressure sores, permanently locked limbs, and dehydration because of the nursing home's neglect. The lawsuit was filed under Florida's nursing home resident's bill of rights. The trial court ruled that the claim was invalid because the resident died from heart disease, not from the alleged negligence. The case was appealed to the Florida Supreme Court, which held that the nursing home residents' bill of rights allow survivors to sue the nursing home only if the alleged negligence causes the resident's death.¹³ The *Knowles* decision applies to cases filed before May 15, 2001, when the law was explicitly changed to allow survivors to bring statutory claims against nursing homes even if the resident's death was not caused by the alleged negligence.

2. Joint and Several/"All Sums" v. *Pro Rata*

As described above, the policyholder may choose to tender an underlying claim to one particular insurer or under one particular policy. In this regard, courts have adopted essentially two different approaches: (1) joint and several allocation, which is also referred to as the "all sums" approach; and (2) *pro rata* allocation. Under the joint and several allocation method, the insurer chosen by the policyholder is required to provide coverage without taking into account other triggered insurance policies.¹⁴ The insurer can subsequently seek reimbursement from other carriers that also provided coverage for the underlying loss.¹⁵ In contrast, under the *pro rata* allocation method, the insurer chosen by the policyholder is required to contribute a portion of the entire claim.¹⁶ This portion is determined by using different methods, which are discussed below.

For example, in *Texas Prop. and Cas. Ins. Guar. Ass'n v. Southwest Aggregates*, 982 S.W.2d 600 (Tex. Ct. App. 1998), the court adopted the joint and several allocation method. The insured was a Texas company in the

business of selling sand and gravel. In 1987, the insured was named a defendant in several lawsuits alleging exposure to silicosis over several decades. Two different carriers had issued general liability policies that were in effect from 1983 until 1989. All of these policies were triggered by the underlying lawsuits.

One of the carriers argued that the court should adopt *pro rata* allocation. Specifically, "when coverage under consecutive, non-overlapping policies issued by different insurance companies is triggered by a claim of injury occurring across all the policy periods, each insurer's duty to defend is determined by a ratio of that insurer's 'time on the risk' over the total time period for which damage is claimed to have occurred."¹⁷ The insured argued that, "[w]hile insurers may apportion defense costs among themselves any way they choose, ... each insurer whose policy obligations are triggered independently owes the insured a *complete defense*."¹⁸ The court agreed with the insured and adopted the joint and several allocation method. "[A]n insurer's duty to defend its insured on a claim occurring partially within and partially outside of the policy period is not reduced *pro rata* by the insurer's 'time on the risk' or by any other formula."¹⁹

In contrast to the result in *Southwest Aggregates*, the Fourth Circuit in *Spartan Petroleum Co. v. Federated Mut. Ins. Co.*, 162 F.3d 805 (4th Cir. 1998) adopted *pro rata* allocation. The insured had leased a lot in South Carolina for use as a gasoline service station. Subsequently, the insured discovered that the gasoline storage system at the site had been leaking. The insured was sued because of groundwater contamination on the adjoining property and sought coverage under a general liability policy.

In the coverage action, the Fourth Circuit analyzed how the loss should be allocated. The court began by noting that under South Carolina law, which governed the coverage issues, the injury-in-fact/continuous trigger applied. Under

the injury-in-fact/continuous trigger, a policy is triggered if it was in effect when an injury occurs and continuously thereafter during the progressive damage. The court then concluded that the *pro rata* allocation method, based on the “time on the risk” method, was appropriate to apportion liability.²⁰ The court offered a hypothetical to explain its holding. Assume that an injury occurs in year one, and the damage continues over three years. Also assume that Carrier 1 issued a policy that was in effect during the first relevant year and Carrier 2 issued policies that were in effect during the second and third relevant years. Under the court’s approach, Carrier 1 would be liable for one-third (1/3) of the damages and Carrier 2 would be liable for two-thirds (2/3) of the damages.

In addition to the “time on the risk” method, courts use different criteria when applying *pro rata* allocation.²¹ For example, a loss can be allocated based on the limits of coverage under each of the triggered policies, with each policy contributing in proportion to its limits relative to the other triggered policies.²² Thus, where a claim triggers two different policies, the first of which contains an aggregate limit of liability of \$1 million and the second containing an aggregate limit of \$500,000, following a *pro rata by limits* approach, the *pro rata* share under the first policy would be 2/3 – *i.e.*, the \$1 million limit divided by \$1.5 million of all available limits. The share under the second policy would be 1/3 – *i.e.*, \$500,000 limit divided by \$1.5 million of all available limits. Other courts calculate *pro rata* allocation using a combination of “time on the risk” and the policy limits methods.²³

The different allocation methods can have a significant impact on an insurer’s liability for long-term professional liability claims. The nursing home hypothetical discussed above is illustrative. Under the joint and several allocation method, the insured can seek coverage for the entire loss under any triggered policy. That particular insurer would then be liable to the policyholder for the entire loss, even if the

loss occurred over the 10-year residency period. That insurer could subsequently seek reimbursement from other insurers under contribution or indemnity theories. In contrast, the *pro rata* allocation method would reduce the insurer’s liability based on how long the carrier was “on the risk.” As noted above, however, some jurisdictions apportion the loss based on each policy’s limits, which could lead to different results.²⁴

3. Horizontal Exhaustion v. Vertical Exhaustion

In addition to allocating a claim over several years, there is another allocation issue involving the relationship between primary policies and excess policies. Excess policies provide coverage when the policy limits of the applicable primary policies are exhausted. Courts have reached different results in resolving this issue. Under “horizontal exhaustion,” an excess policy is triggered only after *all* triggered primary policies are exhausted.²⁵ In contrast, under “vertical exhaustion,” an excess policy is triggered after the primary policy *underlying* the excess policy is exhausted.²⁶

For example, the Maryland Court of Special Appeals adopted horizontal exhaustion in *Mayor and City Council of Baltimore v. Utica Mut. Ins. Co.*, 802 A.2d 1070 (Md. Ct. Spec. App. 2002). In *Mayor and City Council of Baltimore*, the underlying lawsuit was brought by the City of Baltimore against numerous entities deemed responsible for the installation of asbestos-containing building materials. The coverage action involved various primary policies, excess policies, and umbrella policies. The court ruled on many coverage issues, including the applicable trigger of coverage and allocation. The court held that the continuous trigger applied and that liability should be allocated under the *pro rata* method.²⁷

In addition, the court adopted horizontal exhaustion. This approach, said the court, “is consistent with our application of the continuous trigger and *pro-rata* allocation.”²⁸ The court also

emphasized that horizontal exhaustion “is consistent with the expectation of the parties that a higher tier of coverage would be reached only when the limits of the primary policy had been exhausted.”²⁹ Finally, the court ruled that the excess policies were not triggered because the underlying loss, after being allocated over the relevant 20-year period, did not exhaust all of the primary policies.³⁰

In contrast, other courts have adopted vertical allocation, such as the court in *Dayton Independent School District v. National Gypsum Company*.³¹ The insured in *Dayton* was in the business of manufacturing and distributing various construction and building products. The underlying lawsuit alleged asbestos-related property damage. The coverage dispute involved different primary policies and excess policies that were in effect between 1978 and 1985. The court first held that the continuous trigger of coverage applied. Moreover, each carrier was liable for “all sums” that the insured shall be obligated to pay. In determining the excess carrier’s obligations, the court ruled that an excess policy is triggered “once the limits immediately underlying a given excess policy are exhausted.”³² The insured “is not obligated to first exhaust all underlying insurance in every policy period before it can proceed to obtain indemnification from its excess carriers.”³³

Whether a court applies horizontal exhaustion or vertical exhaustion can significantly impact excess carriers. The nursing home hypothetical described above is illustrative. Assume the underlying claim alleges negligent acts and “bodily injury” that occurred during each year of the entire 10-year residency period. Under this scenario, all of the primary liability policies would be triggered. Under horizontal exhaustion, no excess policy would be triggered until the policy limits under all 10 primary policies have been exhausted. For underlying claims that do not involve large losses, this could result in no excess policy being triggered. In contrast, under vertical exhaustion, the policy limits for only one primary policy

would have to be exhausted. Consequently, an excess policy is much more likely to be triggered if vertical exhaustion applied. This could also result in other primary policies not having to provide coverage until the policy limits of the excess policy were exhausted.

C. Number of Occurrences/Claims

In addition to the applicable trigger of coverage and allocation issues, the nature of the “occurrence” is also relevant in determining liability for an underlying claim. Insurance policies often contain per-occurrence limits, which reduce coverage regardless of the policy’s aggregate limit. Whether the per-occurrence limit applies is based on what constitutes an “occurrence.” “Occurrence” in most general liability policies is defined as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.”

When determining whether an underlying claim constitutes one “occurrence,” the majority of courts utilize the “cause” test.³⁴ For example, in *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56 (3d Cir. 1982), the underlying lawsuit was a class action brought because of alleged sexual discrimination in the insured’s employment practices. At issue was whether the underlying lawsuit constituted one “occurrence.” The court reasoned that there was a single “occurrence” if there is “one proximate, uninterrupted, and continuing cause,” which results in “all of the injuries and damages.”³⁵ In the underlying lawsuit, all potential liability was premised on the discriminatory employment practices. The court characterized this as the “common source” of the liability and ruled that there was only one “occurrence.”³⁶

Professional liability policies typically contain different language. In *Friedman Professional Mgmt. Co. v. Norcal Mut. Ins. Co.*, 15 Cal. Rptr.3d 359 (Cal. Ct. App. 2004), for example, the underlying lawsuits alleged medical malpractice. The first underlying lawsuit was

brought because of alleged negligence during the patient's surgery. The insured had supplied the wrong pump and fluids which caused vaginal bleeding. The second underlying lawsuit alleged sexual battery and invasion of privacy that occurred during the same surgery.³⁷

The policies defined "occurrence" as a "single act or omission or series of related acts or omissions involving direct patient treatment."³⁸ At issue was how the term "related" should be interpreted. The court quoted a California Supreme Court decision holding that the term "'related' as it is commonly understood and used encompasses both logical and causal connection."³⁹ The court explained that the insured provided the wrong pump and fluids, which led to the patient's vaginal bleeding. The battery claims arose from the insured's attempt to stop the bleeding. The court concluded that "there can be absolutely no doubt that the battery and invasion of privacy claims were *causally* related to the malpractice claim."⁴⁰

Determining whether an underlying claim constitutes one "occurrence" can be difficult in nursing home litigation. For example, under the nursing home hypothetical discussed above, the "occurrence" could be based on company-wide negligence, such as inadequate training of the entire staff.⁴¹ The "occurrence" could also be based on specific allegations in the underlying lawsuit. For example, the development of pressure sores could constitute one "occurrence," while a resident's weight loss could constitute a separate "occurrence." In some cases, however, the distinction may not be clear. This issue will naturally need to be decided on a case-by-case basis.

III. Conclusion

There are several coverage issues that will significantly impact an insurer's obligations for long-term professional liability claims. As this article demonstrates, courts have often

reached opposite results when resolving these matters. In addition, jurisdictions remain that have not adopted a particular position on some of these coverage issues. These factors place increased significance on determining which jurisdiction's law will govern a potential coverage dispute. Over time, as case law develops further, there will be more guidance on handling long-term professional liability claims.

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Endnotes

1. The opinions expressed in this article are solely those of the authors and do not reflect those of Hunton & Williams or its clients.
2. Specifically, this article discusses allocation of long-term professional liability cases and related issues. However, there are several other common coverage issues that may arise. For example, nursing home claims often raise the issue of how the expected/intended exclusion applies to the insured corporation. *See, e.g., RJC Realty Holding Corp. v. Republic Franklin Ins. Co.*, 808 N.E. 2d 1263 (N.Y. 2004) (holding that employee's intentional act should not be attributed to insured corporation because employee's conduct was not "foreseeable and a natural incident of the employment"). In addition, in some jurisdictions, insurance coverage for punitive damages is against public policy. *See, e.g., Morrison v. Hugger*, 369 So.2d 614 (Fla. Dist. Ct. App. 1979) (punitive damages not insurable because "to provide insurance against an intentional act is against public policy"). An analysis of these coverage issues and other potentially applicable defenses is outside the scope of this article.
3. In addition, many professional liability

policies provide “claims made” coverage. This generally requires that, to trigger coverage, a “claim” has to be made during the policy period.

4. *See, e.g., Royal Ins. Co. of Am. v. Hartford Underwriters Ins. Co.*, 391 F.3d 639 (5th Cir. 2004) (applying Texas law).
5. *Id.* at 641.
6. *Id.* at 642.
7. *Doe*, 599 N.E.2d at 988.
8. *Id.* at 991.
9. *Keene*, 667 F.2d at 1040; *see also Zurich Ins. Co. v. Raymark Indus., Inc.*, 514 N.E.2d 150 (Ill. 1987) (holding that general liability policy is triggered if claimant suffered some cognizable “bodily injury,” “sickness” or “disease” during the policy period).
10. *See, e.g., Turner v. Southwest Louisiana Hosp. Ass’n*, 876 So.2d 1237 (La. Ct. App. 2003) (discussing Louisiana’s statutory cap of \$500,000 for medical malpractice damages).
11. *See, e.g.*, Fla. Stat. § 400.023(1) (West 2004).
12. *Knowles v. Beverly Enterprises-Florida, Inc.*, No. SC00-1910, 2004 WL 2922097 (Fla. Dec. 16, 2004).
13. *Id.* at *7-8.
14. *See J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993) (adopting “all sums” allocation).
15. *See Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994) (interpreting Missouri law) (“in the absence of a provision in the policy to the contrary, the insured may recover the full amount of his loss from any insurer, leaving the latter to seek contribution”).
16. *See generally, Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980) (interpreting Illinois and New Jersey law).
17. *Southwest Aggregates*, 982 S.W.2d at 604.
18. *Id.* (emphasis in original).
19. *Id.* at 607.
20. *Spartan Petroleum*, 162 F.3d at 812.
21. Courts generally allocate loss only across those years in which coverage remains available for the loss at issue. However, some courts allocate to insurers only for those years that the insured procured coverage, with no portion of the loss being allocated to an insurer for periods where the insured elected to not procure insurance or where the insured elected to procure insufficient insurance. *See, e.g., Stonewall Ins. Co. v. Asbestos Claims Mgmt.*, 73 F.3d 1178, 1203 (2d Cir. 1995) (“When periods of no insurance reflect a decision . . . to retain a risk . . . to expect the risk bearer to share in the allocation is reasonable.”). Under this line of cases, the *insured* is responsible for the portion of the loss allocated to uninsured periods.
22. *See, e.g., Argonaut Ins. Co. v. Transport Indem. Co.*, 492 P.2d 673 (Cal. 1972).
23. *See, e.g., Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 993-94 (N.J. 1994) (allocating the loss “on the basis of the extent of the risk assumed, *i.e.*, proration on the basis of policy limits, multiplied by years of coverage”).
24. *See, e.g., Armstrong World Indus. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690 (Cal. Ct. App. 1996) (allocating claim based on policy limits); *cf. Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368 (E.D.N.Y. 1988) (in underlying lawsuit involving millions of plaintiffs exposed to “Agent Orange,” the court apportioned liability based on percentage of “Agent Orange” sold during each policy year as this provided an approximation of the injury that occurred during each policy period).

25. *AAA Disposal Systems, Inc. v. Aetna Cas. & Sur. Co.*, 821 N.E.2d 1278 (Ill. Ct. App. 2005).
26. *Dayton Indep. School Dist. v. Nat'l Gypsum Co.*, 682 F. Supp. 1403 (N.D. Tex. 1988), *rev'd on other grounds*, *W.R. Grace & Co. v. Cont'l Cas. Co.*, 896 F.2d 865 (5th Cir. 1990).
27. *Mayor and City Council of Baltimore*, 802 A.2d at 1076.
28. *Id.* at 1105.
29. *Id.*
30. *Id.*
31. *Dayton Indep. School Dist. v. Nat'l Gypsum Co.*, 682 F. Supp. 1403 (N.D. Tex. 1988) (applying vertical exhaustion), *rev'd on other grounds*, *W.R. Grace & Co. v. Cont'l Cas. Co.*, 896 F.2d 865 (5th Cir. 1990).
32. *Id.* at 1411 (emphasis added).
33. *Id.*
34. *See, e.g., CSX Transp., Inc. v. Cont'l Ins. Co.*, 680 A.2d 1082 (Md. 1996) (“[b]y far the vast majority of courts that have considered the [number of “occurrences”] issue view it from the perspective of causation”); *Mason v. Home Ins. Co. of Illinois*, 532 N.E.2d 526 (Ill. 1988). In contrast, few courts use what is the “effect” test. Under this test, instead of focusing on the “cause” of the alleged injury, courts evaluate the effect or result of the accident or “occurrence” for which coverage is being sought. *See, e.g., Dow Chem. Co. v. Associated Indemnity Corp.*, 727 F. Supp. 1524, 1526 (E.D. Mich. 1989). New York courts utilize the “unfortunate event” test in determining whether a claim constitutes a single “occurrence” or multiple “occurrences.” *Arthur A. Johnson Corp. v. Indem. Ins. Co. of North Am.*, 164 N.E.2d 222 (N.Y. 1959). This test is similar to the “cause” test.

See In re Prudential Lines, Inc., 158 F.3d 65 (2d Cir. 1998) (for asbestos bodily injury claims, concluding that each claimant’s injury constituted a separate “occurrence” because the “unfortunate event causing personal injury is the exposure” to asbestos, which occurred “at different points in time”).

35. *Appalachian*, 676 F.2d at 61.
36. *Id.*
37. *Friedman*, 15 Cal. Rptr.3d at 361-65.
38. *Id.* at 365.
39. *Id.* at 369.
40. *Id.*
41. *See Chemstar, Inc. v. Liberty Mut. Ins. Co.*, 797 F. Supp. 1541 (C.D. Cal. 1992) (concluding that 28 property damage claims arising out of product defect constitute one “occurrence” because of manufacturer’s failure to warn of hazard).