Insurers' Exposure from Opioid Claims: Time on Risk Approach Reaffirmed Over All Sums

The recent major Ontario Court of Appeal decision *Loblaw Companies Limited v. Royal & Sun Alliance Insurance Company of Canada,* 2024 ONCA 145 (CanLII) was precipitated by five class action lawsuits ("Class Actions") claiming billions of dollars against companies involved in the opioid industry. The defence costs are expected to be very significant. The question who pays these costs and how was a central issue.

The claims span over 20 years beginning in 1996 when the pharmaceutical company, Purdue, started selling the opioid, OxyContin.

The Class Actions were brought by the Government of British Columbia and from opioid user groups from several provinces. The claims were brought against the opioid producers, pharmaceutical companies and distributors of the products including the national grocery chain Loblaw and the national drug store Shoppers Drug Mart, and a company called Sanis, which manufactured two generic opioids ("the Insureds" or "the respondents")

As the Court of Appeal described,

> "[o]ne of the main issues in contention relates to the application judge's conclusion that each of the respondents was entitled to select a single insurance policy under which there was a duty to defend and to require the selected insurer to bear the costs of the defence including those that related to claims outside that insurer's coverage period."

They further explain that

> "[t]he challenge presented by these appeals is what to do with the cost of defending claims that involve allegations of continuous or progressive injury that span many years (long-tail claims) where there are insurance policies with different insurers, different provisions governing deductibles and SIRs, and consecutive rather than concurrent coverage periods and therefore different risks."

Initially, the Insureds brought a coverage application and were successful convincing the application judge that they were entitled to select one insurer of their choice, who insured the Insureds sometime during the 20 year coverage time span, and require that insurer to provide a full defence for all the Class Actions.

Although it was not explicitly stated, in permitting each insured to select one policy each for their defence, the application judge adopted an "all sums" approach to defence costs. Under this theory, it is argued that the policy language mandates that each insurer will pay on behalf of the insured "all sums" which the insured is legally obligated to pay as damages because of bodily injury or property damage. There is no dollar cap on defence costs. Under this theory, the courts have also interpreted the policy language such that the insured is not required to contribute to any of the costs incurred, including for periods where it had no insurance coverage.

The chosen insurer would basically front the entire costs of defence until it could later reallocate the defence costs between insurers.

Insurers in Canada have routinely applied a pro rata time on risk allocation principle for long tail claims, where each insurer will only be responsible for the percentage of defence costs related to how long that particular insurer insured the risk. The insured essentially self- insured for gaps in coverage. As the insurer RSA argued in the appeal, the application judge's decision "improperly allows the respondents to target one insurance carrier over others. This could lead to the absurd result of making an insurer who provided only one day of coverage liable for all upfront defence costs."

RSA had good reason to take this position as it had provided coverage to an insured for a mere eight months of the more than 20 year span of insurance for the opioid claims. Following the allocation approach taken by the application judge, it was possible that the insured could choose RSA to be responsible for the defence of the Class Actions for the entire more than 20 year span. It seems the application judge was not too concerned by this outcome pointing to the fact that the chosen insurer could subsequently pursue the allocation of defence costs from the other insurers after everything had been resolved.

In essence, the Court of Appeal rejected the all sums approach, finding that, first, the application judge's disposition placed a disproportionate and unreasonable burden on the selected insurer which would end up financing the entire defence then to go through the difficult task of pursuing allocation from the other insurers based on equitable contribution.

Second, the Court of Appeal found that the application judge did not fully take in account that the scope of responsibility contemplated under these insurers' policies was time-limited in nature - the insurers had agreed to provide indemnity for a discrete amount of time prescribed by each policy period.

As described by the Court of Appeal, "In the B.C. Users' Action, the representative plaintiff alleges that he was first prescribed OxyContin in or around 2003. By that time, AIG, RSA, and Liberty's coverage periods had expired. Requiring them to defend this claim, as the respondents have opted to do, improperly increases the scope of responsibility contemplated under these insurers' policies which were time-limited in nature."

This is addressed in the policies which state that the coverage grant is for "…all sums which the insured shall be legally obligated to pay as damages because of … bodily injury or … property damage to which this policy applies". The Court of Appeal agreed that each of the

insurers had agreed to provide indemnity for a discrete policy period which was consecutive. There was no concurrent coverage: "[t]he Primary Insurers were not insuring the same risk. Rather, they each agreed to cover risks within certain time parameters. Each insurer covered a successive period of time that captured a different risk profile. No insurer agreed to cover risks falling outside their prescribed time period." As such, it was logical to similarly divide the obligation to defend among the insurers. Because the insurance coverages were consecutive rather than concurrent each insurer was only proportionately responsible on a pro rata basis for the amount of time that they insured the risk.

Essentially, the Court of Appeal looked at the situation and acknowledged that the Insureds' insurers over the 20 year span were delineated into specific policy periods and therefore, it was logical to divide proportionally the 20 year span between each of them.

In coming to this decision, the Court of Appeal distinguished the cases the application judge had relied upon where there were covered and uncovered claims, where insurers' coverage overlapped for the same policy period (i.e. concurrent coverage), and from cases where there were mixed claims giving rise to multiple theories of liability.

Deductibles and Self-Insured Retentions (SIRs)

Having decided the insured could select an insurer to defend, the application of deductibles/SIRs also had to be considered. The application judge decided that a Primary Insurer's duty to defend and contribute defence costs would be triggered once its insured had exhausted the SIR/deductible under its single primary policy. She reasoned that the ongoing defence cost contributions of the insurer with the exhausted SIR could be applied toward the exhaustion of the other insurers' SIRs/deductibles. To her, it did not matter who had extended the funds, only that defence costs had been incurred and funds had been extended. The Court of Appeal rejected this approach noting that a SIR depends on the legal obligations to pay, among other things, defence costs and that the language of the policies in issue on SIR obligations differed.

It decided that as the defence costs were to be equally divided in proportion to the amount of time that the insurer was on risk, so too the pro rata time-on-risk formula applied to the exhaustion of the SIRs. "So by way of example, Aviva acknowledges that its SIRs in its policies with [Shoppers Drug Mart] have been exhausted. Accordingly, it is obliged to pay [Shoppers Drug Mart's] defence costs…In light of the allocation amongst the Primary Insurers, Aviva's exposure is limited to 60% of [the insured's - Shoppers Drug Mart's] defence costs. As the SIR may not yet have been exhausted under the one Liberty policy (one of Shoppers Drug Mart's other Primary Insurers), [Shoppers Drug Mart] is responsible for the remaining 40% until that determination has been made and until Zurich's SIRs have been exhausted [Zurich was the other Primary Insurer]."

Pre-tender Defence Costs

This issue arose because Loblaw had incurred defence costs prior to providing notice of a claim to the insurer. The Court of Appeal determined this with reference to provisions of Ontario law and rules of practice that provide for discretionary relief from forfeiture. For the purposes of this article, it is noteworthy that the Court's decision to decline relief from forfeiture was based on the principle

that the duty to defend only arises on demand or notice: “Otherwise the insurer may have no knowledge of the claim it is obligated to defend or opportunity to exercise its contractual rights respecting this defence or other policy conditions and exclusions.” Although this was a case regarding contributions between insurers, the same principle applied.

Finally, the court considered issues of litigation privilege and/or solicitor-client privilege as between the insurers and the insured and as between insurers, only some of which had signed a Defence Reporting Agreement (“DRA”) and a myriad of other unique challenges presented by the circumstances the underlying Class Actions. With a number of noteworthy caveats, the Court of Appeal agreed that the application judge had properly concluded that the DRA struck the right balance between the rights of the insured and the insurers. We commend this to you as informative reading for another day…

Should you have any questions about this topic, please contact the authors of this article, Brendan Scott and James Norton, Lawyers at Zuber & Company LLP.