

INSURANCE LITIGATION™

Reynolds

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Act requires that every workers' compensation contract contain a clause that the insurer shall be directly and primarily liable to the employee, a covered employee stands in the same position as an insured in a private insurance contract and a workers' compensation claim should be treated as a first-party direct coverage claim. By contrast with a third-party claim, in a first-party direct coverage case, the insured is not represented by the insurer. The insured can directly influence the insurer's claim evaluation process and may file an action to compel performance by the insurer or seek damages for failure of the insurer to perform. For these reasons, an insurer in a first-party coverage dispute does not owe a quasi-fiduciary duty to the insured. The *Brodeur* court summed up: "Having previously found that workers' compensation claims should be treated like first-party claims and that there is no fiduciary or quasi-fiduciary relationship between an insured and an insurer in a first-party context, we now explicitly hold that the insured and insurer in a workers' compensation context are not in either a fiduciary or quasi-fiduciary relationship."

Fraud. Petitioner claimed that the letter dated August 20, 1999, from Interstate's counsel, denying authorization for the medication and surgery, was a factual misrepresentation that constituted fraud. This allegation was based on regulations which state that if an insurer does not issue a written denial of a requested treatment along with certain supporting information within five business days, the request will be "deemed authoriz[ed]." The defendants countered that the letter was a legal opinion and so not subject to a fraud claim.

The court agreed with the defendants. The August 1999 letter did not contain a misrepresentation of fact because it merely stated that the defendants did not authorize certain medical treatment, which was true. The misrepresentation arose from the implication that the medication had not already been authorized—an incorrect representation of a matter of law. That misrepresentation, however, was an incorrect legal opinion, not a misrepresentation of fact. "Although eventually the ALJ determined that Respondents erroneously denied the [medication] treatment, the ALJ's decision did not retrospectively change Respondents' incorrect legal opinion into a misrepresentation of a fact. As a statement of Respondents' opinion on a matter of law, the denial

in the August 1999 letter is not actionable under the general rule that requires a misrepresentation of fact."

Contribution & Subrogation

Texas Supreme Court Prohibits Settling Liability Insurer from Compelling Co-Insurer's Proportionate Participation in the Settlement of a Third Party Claim, Even Though Nonsettling Insurer's Refusal to Participate in Settlement Was Unreasonable

Pro Rata Other Insurance Clauses in Insurers' Policies Preclude Contribution, and Insured's Inability to Recover from Nonsettling Insurer Precludes Either Contractual or Equitable Subrogation

Mid-Continent Insurance Company v. Liberty Mutual Insurance Company, __ S.W.3d __, 2007 WL 2965401 (Tex. October 12, 2007)

Case at a Glance

This case came to the Texas Supreme Court on certified questions from the Fifth Circuit concerning the rights of two primary liability insurers who are cooperating in the defense of their common insured when one of the insurers settles for an amount greater than either insurer's policy limit but less than their combined limit and then attempts to obtain reimbursement of a proportionate share of the settlement from the nonsettling insurer. The court's reasoning is subtle and would likely produce to a different result under slightly altered factual scenarios. The court's opinion therefore requires unusually extensive summarization and discussion. Readers who want a quick picture can safely read only the headlines and this "Case at a Glance" section.

The two liability insurers provided the same insured applicable primary insurance coverage under standard Comprehensive General Liability insurance contracts. Each of their primary policies had a \$1 million coverage limit and contained identical other insurance clauses providing for equal or pro rata sharing if a loss is covered by other primary insurer.

One of the insurers also provided a \$10 million excess policy. Both insurers together and cooperatively assumed the defense of the suit against their common insured, and both of them admitted coverage.

The carrier issuing the excess policy evaluated the insured's liability at \$1.5 million and procured an offer to settle for that amount. The other liability insurer unreasonably undervalued the case against their common insured at not more than \$300,000, and agreed to contribute only its \$150,000 proportionate share to the settlement. The carrier with an excess policy (L-1) settled for \$1.5 million. It funded \$1.35 million; and the carrier without an excess policy (L-2) supplied \$150,000—one half of its estimate of their joint insured's probably loss. L-1 then sued the L-2 for reimbursement of \$600,000—L-2's proportionate share of \$750,000 less its \$150,000 contribution.

Now for the certified question, expressed as separate and shorter questions: Does L-1 have any cause of action—whether direct or by subrogation—to recover from L-2 which paid the substantially lower sum? In other words, does the insured that underpaid have an enforceable legal duty to reimburse the more settlement oriented and more reasonable insurer with respect to its payment of more than its proportionate share of the amount of a settlement? In effect, the certified question asks whether one liability insurer can control the legal duty of another with regard to settlement, under at least some circumstances. Or to put the question slightly differently: Can one carrier bind another to settlement?

The Texas Supreme Court answered *No!* to this complex question (here formulated as several related questions). The court reasoned that pro rata other insurance clauses in the policies precluded reimbursement under an equitable contribution theory, and the insured's inability to recover from L-2 precluded recovery under a subrogation theory. The fact that the settlement fully compensated the insured precluded contractual subrogation, and the insured's failure to make a policy limits settlement demand precluded equitable subrogation.

Summary of Case

Facts. The underlying claim arose out of a head-on automobile collision on roads that had been narrowed for a Texas highway construction project.

The collision occurred when a driver crossed into the on-coming traffic and collided with a car occupied by the underlying claimants—all members of the same family. They sued the driver that hit them; Kinsel Industries, the general contractor on the project ("GenC"); Crabtree Barricades, the GenC's subcontractor responsible for signs and dividers ("Sub"); and the State of Texas.

GenC was the named insured under a Liberty Mutual Insurance Company (Liberty) Comprehensive General Liability (CGL) policy with \$1 million limits. Liberty also provided GenC with a \$10m excess liability policy. GenC also was covered as an additional insured under another \$1 million CGL policy issued by Mid-Continent Insurance Company ("M-C") CGL to Sub. Thus, GenC was a covered insured under two separate CGL policies, so it had a total of \$2 million in primary liability coverage. As usual, the two insurers had no contract between them that applied following an accident, even though both of them acknowledged coverage and provided defenses.

The other insurance clauses in the Liberty and M-C policies were identical. Both insurers were to provide indemnity payments in equal shares or they each were to provide pro-rata sharing of indemnity, depending on the circumstances. Under the circumstances of this case, the sharing would be pro-rata. These two primary policies also each contained a subrogation clause, and a version of the standard "no action" and "voluntary payments" clauses prohibiting settlements without the insurer's consent.

In addition to agreeing about there being coverage for both defense and indemnity, the insurers also agreed that the total verdict for the injured family against all defendants would be around \$2-\$3 million. They disagreed, however, as to the value of the claim against GenC. Initially, both of them thought that it had 10-15% percent of the total fault, but Liberty increased this estimated amount of GenC's fault to 60% as the case evolved, while M-C did not. For this reason, M-C refused to increase its contribution over the original percentage. After repeated refusals by M-C to increase its contribution to a settlement, Liberty Mutual agreed at a mediation to settle on behalf of GenC for \$1.5 million (sixty percent of a \$2.5 million anticipated verdict). Liberty demanded M-C contribute half, but M-C continued to calculate the settlement value of the case against GenC at \$300,000

and agreed to pay only \$150,000. Liberty, therefore, funded the remaining \$1.35 million, paying \$350,000 more than its \$1 million CGL policy limit. Liberty reserved its right to seek recovery against M-C for its portion of the settlement. Sometime later, before trial, M-C settled the family's claim against Sub for \$300,000, leaving unused policy limits of \$550,000.

Procedural History. Liberty sued M-C in Texas state court; M-C removed the case to federal court on diversity grounds. Following a bench trial that resulted in a reported opinion, *Liberty Mutual Insurance Company v. Mid-Continent*, 266 F.Supp.2d 533 (N.D. Tex. 2003), the district judge determined that through subrogation Liberty was entitled to recover \$550,000—the amount remaining on M-C's policy limits after deducting the \$150,000 M-C contributed to the settlement on behalf of GenC and the \$300,000 paid to settle the claim against Sub. The court acknowledged that \$550,000 together with M-C's \$150,000 contribution fell \$50,000 short of M-C's \$750,000 proportionate share, but found no justification for increasing M-C's total liability beyond its \$1 million policy limit.

The district court reasoned from the following premises. First, each of the two insurers owed a duty (to whom, the insured, each other, or both, the district court does not say) to act reasonably when exercising its rights under its CGL policy. The court relied on *General Agents Insurance Company [GAINSCO] v. Home Insurance Company of Illinois*, 21 S.W.3d 419 (Tex. App.—San Antonio 2000, pet. dismissed by agr.) for this first premise. Second, M-C was recalcitrant, rigid and “objectively unreasonable” in determining GenC's share of liability. Third, Liberty was reasonable in engineering and accepting the settlement offer from the members of the injured family. Fourth, not only was Liberty reasonable in valuing the plaintiff's claim, it was reasonable in avoiding the “real potential of joint and several liability.”

M-C appealed. The Fifth Circuit certified three questions of law to the Texas Supreme Court, which answered only the first one, since a negative answer to the first question rendered the other two irrelevant, given the surrounding facts. The basic theme of the first certified question was whether an insurer in the position of Liberty had a cause of action against an insurer in the position of M-C. Built into this question are several others. If there is any

actionable duty which M-C has violated, what is the foundation of that duty? Is it owed directly by M-C to Liberty? Or is it passed on from GenC to Liberty by subrogation?

Arguments of Liberty. Liberty maintained that a carrier in its situation was entitled to reimbursement based on both contractual subrogation and equitable or common law subrogation. Thus, Liberty contended that it was subrogated to the common-law/equitable right of GenC that M-C “act reasonably when handling an insured's defense—including reasonable negotiation and participation in settlement.” As the court observed, and as will be discussed presently, this last argument would require that Texas law be significantly expanded—indeed, changed.

Arguments of Mid-Continent. M-C asserted that it breached no duties to GenC which Liberty might use as the foundation of a subrogation claim. It also argued that it owed no legal duties directly to Liberty upon which a contribution claim might be based. In the latter context, it suggested that the rules articulated by the San Antonio Court of Appeals in the *GAINSCO* were contrary to Texas law and should be rejected.

M-C on Subrogation. M-C acknowledged coverage and provided a defense to GenC. Consequently, it breached no contract it had with its insured, so there can be no foundation for Liberty's claim of contract-based subrogation. In addition, according to M-C, the only common law duty it might have owed GenC while defending it was the duty to accept a reasonable settlement offer within policy limits or else be liable for any excess judgment. In Texas, this is called the “Rule in *Stowers*,” or something like that. *G. A. Stowers Furniture Co. v. American Indemnity Company*, 15 S.W.2d 544, 547 (Tex. Comm'n App., 1929, holding approved). Since the underlying plaintiffs never offered to settle within policy limits and there was no excess judgment, Mid-Continent asserted GenC had no *Stowers* claim to which Liberty could subrogate under a common law or equitable subrogation theory.

M-C on Direct Action. Relying on previous Texas Supreme Court cases, and their exposition of Texas law, M-C invoked the following principles. First, a direct *contribution* action does not exist between co-insurers when their policies contain other insurance clauses. Second, the Texas Supreme Court has declined to recognize a direct action between an

excess liability insurer and a primary liability insurer." And, third, "the lack of litigation in Texas between co-primary insurers disconfirms any need to create a right of *reimbursement* between them."

Texas Supreme Court's Decision: The Texas high court accepted both of M-C's arguments against reimbursement: (1) There is no direct right of contribution between co-primary insurers whose policies contain other insurance clauses; and (2) GenC has no rights against M-C to which Liberty may be subrogated. The court also disapproved of the reasoning in the *GAINSCO* case "to the extent it would provide recovery to an overpaying co-primary insurer in the context presented [in this case]."

Court's Analysis: Contribution. According to the supreme court, it looks like Liberty is arguing for "right of contribution," although it does not use that language. The court infers this conclusion from Liberty's reliance on the *GAINSCO* case. The court even wonders if Liberty is not trying to create and use a direct action for reimbursement based on a right of contribution. The court rejects this tactic based upon an analysis of the idea of legal contribution. Under Texas law, if two insurers each bind themselves to pay the entire insured loss, but only one does do, that one has a right of payment from the one which does not pay. The same rule applies if more than two insurers make this agreement, but only one pays. And there are many more combinations. *Trader & General Insurance Company v. Hicks Rubber Company*, 169 S.W.2d 142, 148 (Tex. 1943). This right of action is one of contribution.

Here are the elements of an action for contribution: (1) Two or more insurers share a common obligation. (2) The insurer seeking contribution made a compulsory payment or something like that. (3) The compulsory payment was greater than its "fair share of the common obligation or burden." *Employers Casualty Company v. Transport Insurance Company*, 444 S.W.2d 606, 609 (Tex. 1969). However, the court has also recognized that "this direct claim for contribution between co-insurers disappears when the insurance policies contain 'other insurance' or 'pro rata' clauses." *Hicks Rubber*, *supra*, at 148. Pro rata clauses, unlike equal contribution clauses, preclude a direct claim for contribution because the insurers do not share a common obligation so Element-(1) of contribution is not met. "[E]ach co-insurer

contractually agreed with the insured to pay only its [own] pro rata share of a covered loss; the co-insurers did not contractually agree to pay each other's pro rata share." Further, if one of the insurers pays an amount in excess of its pro rata requirement, it has paid voluntarily, i.e., without a legal obligation to do so, and—of course—such payments cannot be the foundation of subrogation. The court acknowledged that its reasoning is inconsistent with the reasoning in the *GAINSCO* case. The court "disagree[d] with *General Agents [GAINSCO]* to the extent it creates [or sought to create] a common law duty between co-primary insurers to reasonably exercise rights under an insurance policy."

Court's Analysis: Subrogation. Liberty alternatively asserted a right to reimbursement based on one of two doctrines of subrogation: contractual or equitable (aka common law). Contractual (or conventional) subrogation is created by an agreement or contract that grants the right to pursue reimbursement from a third party in exchange for payment of a loss, while equitable (or legal) subrogation does not depend on contract but arises in every instance in which one person, not acting voluntarily, has paid a debt for which another was primarily liable and which in equity should have been paid by the latter. In either case, the insurer stands in the shoes of the insured, obtaining only those rights held by the insured against a third party, subject to any defenses held by the third party against the insured. The critical question therefore was whether GenC possessed any rights against M-C to which Liberty could subrogate.

Significantly, the supreme court had earlier said that "when several insurance policies covering the same loss contain pro rata clauses, none of the co-insurers has a right to contribution from the others, 'nor will the payment of the whole loss by any of them discharge the liability of the others.'" *Hicks*, *supra*, at 148. Of course, it is the last clause that matters. It says that non-paying insurers are still liable *to the insured* for what they were obligated to pay but didn't. If that is true, then the paying insurer should be subrogated to the insured's rights.

There is a subtlety, however, that must be invoked. "Having a right [to seek recovery on the legal theory of] subrogation. . . is distinct from the ability to recovery under that right." For example, if a contract of insurance contains a subrogation clause, then the

party-insurer has a right of subrogation, but having that right does not dictate “when the insurer is actually entitled to subrogation or how much is should receive.” Here, the court “determine[d] that the facts [of this case] preclude recovery because Liberty Mutual cannot meet the elements of subrogation.”

With respect to contractual subrogation, Liberty argued that it was subrogated to the contractual right of GenC to enforce language in M-C’s policy imposing a duty upon M-C to defend and indemnify and to pay a pro rata share of settlement. The court agreed that the co-insurers’ contractual duties to GenC were specified in the CGL policies and included a several and independent duty to pay a pro rata share of a covered loss up to their respective policy limits. But the refused to view the independent of the purpose of a pro rata clause, nor without consideration of the rules of indemnification. The court explained that where two different policies provide coverage for a loss, the pro rata clause does not create an exception to the principle of indemnity, but rather implements that principle by eliminating the potential for double recovery by the insured. Thus, GenC had no right, after being fully indemnified, to enforce M-C’s duty to pay its pro rata share of a loss. This was true even though M-C had violated a duty it owed the insured, to wit: to settle cases against it on a reasonable basis. In other words, the insured’s contract rights may have been violated by the underpaying insurer, but that insurer did not inflict any injury or damages on the insured, because the other insurer had stepped in and paid the whole sum.

Common law (aka, equitable) subrogation did not even get off the ground under Texas law in a case like this. The only time an insured has an enforceable legal right to reasonable litigation-focused conduct by a liability carrier having a legal obligation to defend it is when the defending insurer has an opportunity to “protect the insured by accepting a reasonable settlement offer [or demand] within policy limits.” In other words “*Stowers* is the only common law tort duty in the context of third party insurers responding to settlement demands.” The plaintiff’s nonnegotiable but reasonable (ex hypothesi) demand in the underlying case was \$1.5m, a sum which was not within the limits of the Mid-Continent policy. Thus, neither GenC nor Liberty suing as GenC’s subrogee was able to allege the elements of a *Stowers* cause of

action.

Obviously, the situation here is quite different from a situation in which a primary carrier fails to pay a demand within policy limits, the plaintiff obtains a judgment in excess of policy limits, and an excess carrier has to indemnify the insured. In a case fitting this description, the insured would have sustained a loss and would have a tort case against the primary insurer under the *Stowers* Doctrine; the excess carrier would have paid the insured’s loss, and would take the legal rights generated by that loss. *American Centennial Insurance Company v. Canal Insurance Company*, 843 S.W.2d 480, 482 (Tex. 1992).

Finally, although the certified question from the Fifth Circuit specifies that M-C was not reasonable in its evaluation of the exposure of GenC, the Texas Supreme Court focuses on something else. “A reasonable primary insurer, which did not improperly handle the claim,” in the supreme court’s view, “would not pay more than its primary limits.” But this is precisely what Liberty did; it paid \$350,000 above its primary policy. Hence, Liberty seems to have been motivated by concern for its excess insurance policy. Protecting Liberty’s excess policy is not M-C’s problem.

Concurring Opinion. The one concurring Justice agreed with the court opinion, but wanted to add some further thoughts. He emphasized five points.

First, legal questions in “high-stakes” insurance cases “can be fiendishly difficult.” [There is little doubt but what this last phrase will become common place in discussions of the problems treated in this case and in law review “Notes” and “Comments” by law students. Judge Willett is to be saluted.]

Second, the way to deal with this problem is to focus on the facts of the underlying case, as well as the facts of the follow-up insurance case. The complexity of the facts requires that the legal rules be narrow. Broader rules would lead to very difficult fact trials and hence to highly complex appeals. Otherwise juries would have to consider the following questions in cases like this:

- the range of damages the jury in the underlying case might have awarded in the underlying case (including a large number of factors),
- the expected value of the judgment in the

underlying case,

- the implications of the *Stowers* Doctrine, e.g., what would have been a reasonable settlement offer within policy limits, and
- how a reasonable insurance company would have handled all the problems in the underlying case from beginning to end.

Without serious dangers to insureds, this complexity should be avoided. For one thing, imagine trying to explain something “fiendishly difficult” to a jury. For another, insurers, which are substantially sophisticated financially and legally speaking, can take care of themselves. Of course, the situation is quite different in the *Canal* case situation discussed above, in a situation where the primary carrier wrongfully denied coverage, in a situation where a defending insurer refused to pay its prorated share of a judgment, or perhaps even where a primary carrier refused to pay anything toward indemnity at all.

Third, liability insurer’s contractual and common-law duty, or at least its principal duty, runs to its (relevant) insured. Taking a “hard line” in settlement negotiations for its insured does not breach any of the following duties it has to its insured: “to defend, to exercise good faith, to settle within policy limits, or any other contractual or common-law duty an insurer might owe its insured.”

Fourth, excess liability carriers tend to be more interested in multiple primary carriers settling within their policy limits than the primary carriers may themselves be, since it has exposure above the primary carriers. Thus the motivating factor influencing the excess carrier may not be the protection of the insured.

Fifth, “[i]nsurance companies are not eleemosynary[, i.e., charitable] institutions, and where, as here, the insured is protected throughout the litigation process, insurers are entitled to exercise their business judgment in deciding whether to settle a claim and for how much.” In situation of insured protection just sketched, courts have to reason “to prohibit insurance companies from engaging in sharp negotiations with each other.” Insurers do not owe each other any duty to protect one another’s business interest, and permitted negotiation tactics not already illegal is topic “best left to the business world.”

Comment

There are three independent major fundamental premises—and hence three different arguments—in the majority opinion regarding subrogation. The *first* one is that defending liability insurers do not owe their insureds that they are defending a duty to settle cases (or even try to settle them) within policy limits in the absence of a demand for such a settlement from a plaintiff. Even then, they don’t owe a duty to settle such a demand, unless the offer is reasonable under the circumstances. Obviously, if a defending liability insurer does not owe its insured any such duty, it does not owe it to any other liability insurer involved, or having exposure, in the case.

The *second* premise is that when one liability insurer (L-1) settles while the other one refuses to settle (L-2), but the insured defendant is all at once relieved of any liability to the plaintiff by the actions of L-1, then the insured has never suffered loss or damages and so there can be no exercisable and specific right of subrogation accruing to L-1 against L-2, although it might have a right of subrogation against some party outside the settled lawsuit for the injury it has caused the insured.

The *third* premise rests on the voluntary-ness element in the right of subrogation. A person or entity that pays has no right of subrogation if its payment is entirely voluntary. A person has a right of subrogation only if its payment rested upon a legal obligation, or, at least in the case of insurers, what it reasonably thought was a legal obligation. Thus, those discussing and/or teaching subrogation ought to stop using the Good Samaritan story as a vivid instructional device in the context of explaining subrogation.

The three arguments or premises under discussion in the previous paragraphs are independent of one another. Thus, if any one of them is sound, the supreme court’s decision in the *Mid-Continent* case regarding subrogation is unassailable. Nevertheless, at least one of them must be sound.

It seems to me that each of these arguments has at least one flaw. The first one states the law correctly, but the law ought to be changed. The second one—even if legally correct as a technical matter—can be easily avoided, as a practical matter, at least in principle. The third one constitutes a misapplication of the voluntary-ness element of subrogation, even as the court explained that element.

First Argument. If the first argument is accepted, defending liability insurers can expose their insureds to dangers simply by being unreasonable. Would the world not be better off if the law took defending liability carriers to have a duty to the insureds they are defending to try and achieve reasonable settlements within policy limits? This would make the unreasonable insurer liable for damages exceeding its policy limits if it unreasonably failed to at least try and settle on behalf of a liable insured.

One danger in this situation, of course, is that defended insureds and some plaintiffs would conspire to avoid settling so that the recalcitrant defending carrier could be nailed. However, these problems can be avoided, most of the time. Furthermore, such plotting would be a violation of the cooperation clause on the part of the defended insured, and that would complicate so much for the conspirators that many, if not most of them, would refrain. Another danger is that some plaintiff's lawyers would try to provoke defending insurers to fail to initiate settlement discussions and then argued that the insurer was totally responsible for the failure of the parties to try and settle. This too can be overcome. The insurer can simply ignore the footwork of plaintiff's counsel, or it can document and hence prove his dishonorable conduct.

Second Argument. There are a number of ways this argument can be neutralized by practical conduct. Some of these methods have difficulties, but others do not.

At least in theory, the problem that L-1 experienced could be avoided, at least in theory, by treating its payment over and above the equal or pro rata share as a loan which would be considered repayable only if a subrogation case was won by L-1 and then only the extent of the win. The use of "loan receipts" is an old and established custom—or, at least, device—under at least some circumstances. This would technically leave the insured with a loss, so that subrogation would be at least possible. Of course, there might be litigation about the reality of the loan, and L-2 would claim that it was phony and/or that L-1 was really a volunteer. Still, this is a dangerous and uncertain situation, so the Liberty problem could (at least) often be avoided.

The problem could also be avoided by the use of assignments. L-1 would pay its pro rata share of the loss pursuant to its contract of insurance. The insured

would demand that L-2 pay the rest. The insured, L-1, and the plaintiff would wait an agreed upon and short interval. L-1 would pay the rest of the loss in exchange for an assignment of any right to recovery from L-2. Given the way the court sees Texas law, the assignment would have to go from the insured defendant to the plaintiff and from the plaintiff to L-1. Some might doubt the soundness of this approach since it is easily regardable as too clever, or questionably over clever.

The problem could also be avoided by submitting through the submission of a series of *Stowers* demands. The first demand or the first two demands might exhaust the primary policy of L-1. Now suppose that there are two demands left. The policy of L-2 would be the only primary policy left, so the *Stowers* demands remaining would be (in effect) directed to it. This is a relatively common practice already, so there is no reason to this it would be subject to challenge.

Of course, there are yet other ways to accomplish defeating the court's view. Consequently, in the end, the subrogation doctrine formulated here is simply creating a new set of preferred settlement tactics. Clever adjusters and attorneys will love the new day.

Third Argument. The third argument is that L-1 over payment was voluntary and so there is no right of subrogation. The court's opinion states that if a carrier pays more than its pro rata share of a settlement, its payment was voluntary, so there can be no subrogation. This universalistic premise cannot be true, given what else the majority opinion says about the voluntary-ness requirement of subrogation for liability insurers. "In the context of equitable subrogation, Texas courts have been liberal in their determinations that payments were made involuntarily." Here the court is citing *Keck, Mabin & Cate v. National Unions*, 20 S.W3d 692, 702 (Tex. 2000). [Alas, it is not clear to whom or to what the second occurrence of "its" refers.]

But if the universalistic premise just repeated is taken to be iron clad by the Texas Supreme Court, that court is being anything but liberal when thinking about voluntary-ness in relation to liability insurers settling tort cases. This is logically inconsistent with the idea that payments by insurers will not be regarded as voluntary if its payment of a third-party claim is done in good faith and under a "reasonable belief that the payment is necessary to its protection."

Concurring Opinion. Justice Willett argues that hard and sharp negotiation tactics are appropriate for liability carriers, since they are businesses and not charities and are therefore entitled to make business decisions. This view, as stated, involves a problem. To be sure, insurers are in business; they are business entities. However, what they sell is care and protection. For this reason, if no other, there is law in Texas that insurers must treat the interests of their insureds as equal to their own. This makes insurers different types of business than most others. To be sure, insurers are not under Texas law the fiduciaries of their insureds. For this reason, insurers need to place the interests of the insured ahead of their own. This is true even of liability carriers that are defending their insureds pursuant to the insurance contract. However, insurers have a duty under Texas law to treat the interests of their insureds as at least equal to their own. In contrast, most businesses that are in "arm's length transactions" may treat their own interests as being ahead of those of the other parties involved. This difference is not recognized in Justice Willett's opinion, and so may be regarded as having been ignored. One wonders if this distortion is a good idea.
// Quinn

Property Owner's Contractual Obligation to Indemnify Management Company Did Not Preclude Property Owner's Liability Insurer from Obtaining Contractual Indemnity from Management Company's Liability Insurer

Indemnity Agreement "Explicitly" Require Indemnitor to Indemnify for Indemnitee's Own "Active" Negligence and Thus Did Not Apply

Edmondson Property Management v. Kwock, ___ Cal.App.4th ___, ___ Cal.Rptr.3d ___, 2007 WL 3036735 (5th Dist., Oct. 18, 2007)

Case at a Glance

Courts will enforce an indemnity agreement and cut off the indemnitor's liability insurer's contribution rights against the indemnitee's liability insurer if the indemnity agreement explicitly and unequivocally applies to the conduct alleged or claim made and intent of the parties to the indemnity agreement was to make the insurance obtained by the indemnitor

primary.

A property owner's agreement to indemnify its property management company did not apply to the management company's "active" negligence and thus did not cut off the owner's liability insurer's right to seek contribution from the management company's liability insurer for the cost of indemnifying the management company, which was an additional insured under the owner's policy. The management company was actively negligent in causing injuries a 7-year-old child suffered when she fell off the roof of a storage shed, because the management company had notice prior to the fall that children generally, and the injured child specifically, had been playing on the shed roof, but failed to take immediate preventive action.

Summary of Decision

The *Kwock* case examines how an indemnity agreement in a contract between an apartment building owner and a property management company hired to manage the building affects the respective rights of the liability insurers for the owner and the management company to seek contribution and indemnity. The personal injury action underlying the dispute between the insurers was filed against both the owner and the management company on behalf of a seven-year-old child who fell off the roof of the apartment building's storage shed. The owner's liability insurer defended both the owner and the management company, with the management company's insurer paying half of the management company's defense costs.

The management company filed a cross-complaint in the personal injury action against the owner for contribution, indemnification, subrogation, and declaratory relief based on indemnity agreement, which obligated the owner to indemnify the management company "any and all costs, expenses, attorney's fees, suits, liabilities, damages from or connected with the management of the property by [the management company], or the performance or exercise of any of the duties, obligations, powers, or authorities herein or hereafter granted to [the management company]" and further provided that the owner would not hold the management company "liable for any error of [judgment], or for any mistake of fact or law, or for

nything which [the management company] may do or refrain from doing hereinafter, except in cases of willful misconduct or gross negligence." The agreement required the owner to carry liability insurance naming the management company as an additional insured. As an affirmative defense to the management company's cross-complaint, the owner asserted that the indemnity agreement did not require it to indemnify the management company for the management company's own negligence.

The owner's insurer negotiated and funded a \$550,000 settlement of the personal injury action. The settlement agreement apportioned \$50,000 to the owner's liability and \$500,000 to the management company's liability. Although the agreement released both the owner and the management company from liability to the injured child, it did not resolve the management company's cross-complaint.

Following the settlement, the owner's insurer sued the management company's insurer for subrogation, contribution, and indemnity for the amount paid to settle the personal injury action. The management company's insurer filed a cross-complaint seeking equitable subrogation and indemnification for the amounts it expended in defense of the personal injury action. Because the settlement of the personal injury action precluded the management company from proving the damages element of the contribution, indemnification, subrogation causes of action in its cross-complaint against the owner in the personal injury action, the court granted the owner's motion for summary adjudication on those causes of action and consolidated the remaining declaratory relief cause of action with the management company's insurer's cross-complaint against the owner's insurers.

Following a bench trial, the trial court ruled (1) that the indemnity provision in the property management agreement obligated the owner to indemnify for the management company's own negligence only if that negligence was "passive" rather than "active"; (2) because the management company knew the child had played unsupervised on the roof of the shed and had not acted to prevent the fall, its alleged negligence was active, not passive, and the indemnity provision did not apply; (3) both the owner's policy and the management company's policy bore the same level of liability; and (4) each was liable for 50 percent of the settlement paid (rejecting

the apportionment of the settlement agreement).

The California Court of Appeal, Fifth District, affirmed. As a general rule, when multiple insurance carriers "equally and concurrently" insure the same insured and cover the same risk, each insurer may assert a claim against a coinsurer for equitable contribution when it has undertaken the defense or paid a liability on behalf of the insured. This is so even if insurers' policies contain "other insurance" clauses making coverage "excess" of other applicable insurance. The issue before the court of appeal was whether the indemnity agreement between the owner and the management company rendered the coverage provided by their respective liability insurers unequal and nonconcurrent and thus cut off the indemnitor owner's liability insurer's contribution and indemnity rights against the indemnitee management company's liability insurer. After surveying the case law, the court determined an indemnitee's liability insurance is excess over the indemnitor's liability insurance if two questions can be answered in the affirmative: (1) Does the indemnity agreement apply to the conduct and claims for which the indemnitee is liable; and (2) Do the parties to the indemnity agreement intend to make the indemnitor's insurance primary and the indemnitee's insurance excess? The court answered "no" to the first question and therefore did not address the second question. In addressing the scope of the indemnity agreement between the owner and the management company, the court recognized that an indemnity agreement may provide indemnification against the indemnitee's own negligence but held that such an agreement must be "express and unequivocal." Unless an indemnity agreement explicitly covers the indemnitee's "active" negligence (although it need not use the word "active" to do so), courts will treat it as a "general" indemnity clause that applies only to the indemnitee's "passive" negligence. "In other words, the insurance company seeking to defeat a claim of equitable contribution must prove that the indemnification agreement would bar any recovery between the insureds before it can successfully claim equitable contribution would negate the negotiated contract between the insureds." The court found the management company's insurer failed to carry this burden because it could not be determined "with certainty" from the language of the indemnity agreement whether the

unless, as discussed in Insurance Claims & Disputes, § 6:2, the actual mutual intent of the contracting

parties can be ascertained and that mutual intent mandates a different result.

18. *Simpson v. Infinity Select Ins. Co.*, 269 Ga. App. 679, 605 S.E.2d 39, 42 (2004), cert. denied, (Jan. 10, 2005) (Court rejected affidavits of expert witnesses and held that policy unambiguously did not afford coverage because "the policy should be read as a layman would read it and not as it might be analyzed by an insurance expert or an attorney"). Compare *Commercial Union Ins Co v. Seven Provinces Ins. Co., Ltd.*, 217 F.3d 33, 38-39 (1st Cir. 2000) (Massachusetts law) (Expert testimony allowed to aid in the interpretation of language used in a reinsurance policy. In that case, however, issue was what a technical insurance term meant that could only have been used in a technical sense).