Chapter 2:
ALLOCATION OF SETTLEMENT PAYMENTS AMONG SELF-INSURED POLICYHOLDERS, INSURANCE CARRIERS, AND OTHERS HAVING “INTERESTS” IN CONSTRUCTION INDUSTRY LIABILITY CLAIMS
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As an owner or general contractor, you are pleased with the progress of the work on your latest construction project. The project is on time and under budget when, suddenly, a serious accident occurs, resulting in substantial and permanent physical injuries to two employees of your subcontractor. Because the workers’ compensation laws of the local jurisdiction do not bar claims brought by your subcontractor’s employees, you face the uncertain prospects of defending a significant personal injury lawsuit involving a multi-million-dollar damages claim. Fortunately, your contract manager included a broad indemnity clause in the underlying contract that obligates your subcontractor to reimburse the cost of defending and settling the tort case if the subcontractor is in any way at fault. Given the risks of a substantial liability award, you decide to negotiate a reasonable settlement and expect the subcontractor’s indemnity contribution to cover the deductible or self-insured retention in your own liability policy. Your carrier agrees that the settlement offer you propose is reasonable but disagrees with your position that any portion of the proceeds of the indemnity claim against your subcontractor can be used to satisfy the policy retention before the carrier is fully reimbursed for the settlement contribution it makes. How should this dispute be resolved?

Increasingly, owners, contractors, and subcontractors engaged in construction work are faced with scenarios similar to the hypothetical outlined above. Unfortunately, there is a paucity of compelling authority addressing how settlement payments made to resolve such claims should be allocated among the multiple, competing interests that may claim “subrogation” rights in the third-party, indemnity claims. This chapter reviews the leading cases on this subject and discusses the various concepts that may be applied in determining the outcome of subrogation allocation disputes. Ultimately, careful analysis of insurance policy terms, of the law governing allocation and subrogation issues, and of the practicalities of the situation is essential in resolving construction-related claims to minimize the policyholder’s exposure to large, out-of-pocket losses.

§ 2.02 CLAIMS SETTLEMENT ALLOCATIONS: AN OVERVIEW AND GLOSSARY OF INSURANCE TERMS

[A] Construction Risk Management

Insurance carriers offer a number of products, including builder’s risk, “wrap-up” programs, and other forms of project-specific coverage designed to insure against construction-related accidents and claims. However, such coverage may be difficult or expensive to obtain, the cost of coverage may not be budgeted as part of the overall project, or the project may not be large enough to warrant a specific insurance coverage program. In such circumstances, project owners and contractors often rely on standard forms of liability coverage, especially when engaged in repetitive maintenance or other construction-related activities that may extend for several years at a single site or at several different locations. In such cases and in certain high-risk industries, such as oil and gas exploration, refinery construction and maintenance, chemical manufacturing, and other similar operations, it may be difficult, if not impossible, to obtain “first
dollar” insurance coverage for construction or maintenance-related property damage and personal injury claims. Accordingly, companies engaged in such work, often obtain policies that include large self-insured retentions or deductibles that in some cases may even offset the policy limits of the applicable, “primary” coverage.

Regardless of the type of construction or maintenance activity involved, project owners and general contractors typically require their subcontractors to provide indemnity for construction-related damages and claims. Usually, the contract indemnity clause includes or is accompanied by a separate insurance clause that requires the contractor or subcontractor to insure its indemnity obligation and also to name the indemnitee as an “additional insured” on the liability policy. For example, a project owner may insist that its contractor or subcontractor provide indemnity for personal injury claims by any employees of the subcontractor who are injured on the job and whose tort remedies against the owner may not be limited to workers’ compensation benefits.

Project owners or general contractors faced with the sometimes catastrophic losses that occur during the course of (or after completion of) the project often pursue claims against other parties for negligence, design flaws, and workmanship errors that caused the loss. If liability is clear, it may be in the interest of all the parties to reach a rational compromise and settlement that appropriately allocates the liability and damages in accordance with the parties’ relative fault. Unfortunately, efforts to settle such claims can be hampered by disputes among the various carriers that may have issued multiple insurance policies potentially covering the loss.1 Large self-insured retentions and deductibles in such policies may further complicate the settlement process if it is not clear who bears responsibility for satisfying the deductible or self-insured obligation.

[B] Overview of the Allocation Issue

In the typical case, a subcontractor’s employee who is injured on the premises pursues a claim against the general contractor or the project owner who is partially self-insured. The defendant needs to know how any recoveries from other, possibly responsible parties, including the subcontractor who has agreed to indemnify and obtain insurance against such claims, will be allocated. For example, if the amount of the claim exceeds the self-insured retention (SIR) or deductible in the owner’s liability policy, will indemnity payments received from the subcontractor or the subcontractor’s insurer be allocated first to reimburse the owner’s insurance carrier or to reimburse the loss incurred by the owner in satisfying the applicable SIR? In other words, does the insurance carrier who has paid a portion of the applicable settlement and accordingly is subrogated to the insured’s right to any recovery from third parties have “first priority” in any recovery, or should the recovery be allocated in whole or in part to the policyholder’s own loss?

1 Construction-related insurance coverage disputes are not uncommon, but discussion of such disputes is beyond the scope of this chapter. See generally, S. Turner, Insurance Coverage of Construction Disputes, 2nd ed. (1999). Even absent a specific, project-related policy, policy owners and contractors should not overlook the coverage that may potentially be available for construction claims under many standard commercial general liability (CGL) policies. See 1999 Wiley Construction Law Update, § 3.01—.03 (N. Sweeney, ed. 1999).
As noted by one commentator, a policy “deductible” may be “fairly construed” as allocating a specific portion of every loss to the policyholder and hence as implicitly allowing the insurance carrier to claim first priority in any recovery from the indemnitee or other third party.\(^2\) However, in the typical policy, a “deductible provision is not an agreement about bearing net loss after recoupment from other sources.”\(^3\) As a result, it is not surprising that “[t]he arguments for preferring one over another of the rules of allocation are rather inconclusive in principle, and they are unsettled in the precedents.”\(^4\) Unfortunately, given the size of some construction-related losses and the large SIRs in policies that may share a portion of the loss, there may be an increasing “tendency” to resolve unclear allocation disputes through litigation. As a result, it is important for construction risk managers and construction counsel to be aware of and carefully consider subrogation-allocation issues in attempting to resolve construction claims amicably, while minimizing the loss exposure of their clients.

Before addressing the few cases that have considered and attempted to resolve such issues, it is important to become familiar with a general glossary of the terms and concepts that usually apply. Similarly, in analyzing the allocation issue, it is important to consider the applicable law governing subrogation and allocation in general to determine whether these same general concepts should apply in a construction accident case. For instance, in jurisdictions that recognize the “complete compensation” rule, an insurance carrier’s effort to claim priority to indemnity payments received from third parties may be inconsistent with public policy if the insured otherwise has an unreimbursed, out-of-pocket loss. Similarly, in those jurisdictions that allow a policyholder to settle its primary liability by obtaining a “credit” against the policy SIR from the claimant, leaving the claimant free to proceed with a claim for an “excess” recovery against the insurer, counsel should consider whether a specific allocation agreement made jointly with the third party responsible for the loss also might be enforceable. Finally, where, as is typical in most policies, subrogation and retention clauses do not expressly address allocation of settlement payments received from third parties, policyholders should consider negotiating an appropriate compromise allocation arrangement with their carriers; as effectively suggested by Professor Keeton.

[C] Glossary of Terms and Concepts

[1] Subrogation

The doctrine of subrogation has its roots in equity. “The right of subrogation rests not upon a contract, but upon the principles of natural justice. The principle of subrogation will be applied or not, according to the dictates of equity and good conscience, and to considerations of public policy, resting, as it does, upon the maxim that no one should be enriched by another’s loss.”\(^5\) Principles of equitable subrogation permit an insurer that has paid an insured’s loss to recover the amount paid from the party responsible for the loss. Subrogation allows the insured

\(^2\) R. Keeton and A. Widiss, Insurance Law, § 3.10(b)(4) at 240 (1988).
\(^3\) Id.
\(^4\) Id. (noting that there is a “tendency” in the few decisions addressing the issue to reach a “compromise,” which may reflect a “similar tendency for insurers and their insureds to settle these issues on a compromise basis rather than pressing for an adjudication”).
to be made whole, but not more than whole by preventing an insured from obtaining a double recovery. Instead, the doctrine requires a wrongdoer to appropriately reimburse the insured party’s carrier for any indemnity payments made as a result of the wrongdoer’s conduct.

Contractual subrogation, also known as conventional subrogation, arises under a contract of insurance. In the typical construction case, the insurer has a specific contractual right of subrogation that it may involve in pursuing claims against third parties responsible for the loss. Nevertheless, in some jurisdictions, subrogation remains basically equitable in character, and contractual terms that alter basic equitable principles in the distribution of subrogation recoveries are given no effect.6 Other jurisdictions permit the insured and insurer to modify the traditional, equitable concepts of subrogation.7

Insurance policies contain various forms of subrogation clauses. A typical subrogation clause may read as follows:

In consideration of and to the extent of said payment the undersigned hereby subrogates said insurance company to all of the rights, claims and interests which the undersigned may have against any person or corporation liable for the loss mentioned above, and authorizes the said insurance company to sue, compromise or settle in the undersigned’s name or otherwise all such claims . . .

Such a clause does not allocate priority of recoveries from third parties between the insurer and its insured; but other forms of subrogation clauses, including especially clauses in health insurance policies, give specific, “first priority” in any third-party recovery to the insurer. As discussed more fully below, these clauses have generated considerable controversy in jurisdictions that ordinarily allocate priority in any recoveries from third parties or their insurers to the policyholder with an unreimbursed loss.


In the construction setting, an owner or general contractor typically requires a subcontractor to name the owner or general contractor as an “additional insured” on a policy obtained and paid for by the subcontractor, who is the “named insured.” A mere “certificate of insurance” does not suffice to confer additional insured status. An entity named as additional insured usually has the same legal rights and remedies as the named insured, including the right to pursue a contractual coverage claim against the insurance company. However, the extent of coverage provided may be limited by the policy provisions. Carriers often argue that additional insureds are covered only to the extent of their vicarious liability for the negligence of the primary insured and that no coverage is available for the independent negligence of the additional insured. However, unless the additional insured clause limits coverage to the named

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7 See § 2.03[B], infra.
insured’s indemnity obligation, the majority of courts hold that an additional insured enjoys “full” coverage for its own construction-related negligence.8

Subrogation interests between the named insured, an additional insured, and their insurer typically are subject to the “antisubrogation rule,” which prohibits an insurer from claiming subrogation against its own insured, including an “additional insured.” The purposes of this rule are twofold: First, the insurer should not be permitted to pass along the loss to its insured and therefore avoid the very coverage the insured purchased from the insurer. Second, the insurer should not be put in the position where a conflict of interest might develop and the insurer would manage the litigation in such a way as to reduce its liability; i.e., permitting subrogation in such circumstances might “affect the insurer’s incentive to provide a vigorous defense for its insured.”9 However, an insurer of a third-party plaintiff can sue a third-party defendant for subrogation, even though the plaintiff and the defendant are “co-insured” under another policy.10

[3] Other Insurance Clauses

An “other insurance” clause in an insurance policy describes how the policy will respond when there is other insurance coverage available to the insured for the described loss.11 Other insurance clauses provide a means of allocating or sharing a loss insured by different policies without permitting the policyholder to obtain a windfall, double recovery. Generally, to be considered “other insurance,” the competing policies must insure the same policyholder for the same risk and hence qualify as concurrent policies.

These clauses generally come in three varieties: “primary,” “excess,” and “escape.” A “primary” clause confirms that the policy will be primary insurance and that other insurance will be excess. An “excess” clause provides that the policy will be excess above any other primary policy applicable to the loss, and an “escape” clause purports to allocate losses to all other policies before the policy with the escape clause must pay. When faced with two or more “mutually repugnant” escape or excess clauses in concurrent policies, courts allocate the duties to defend and indemnify among the various carriers either on a pro rata basis depending on respective policy limits or on a basis of equal shares until the limits of one of the policies are exhausted.


A self-insured retention generally specifies the amount of financial risk that the insured assumes or “retains” before actual liability insurance protection becomes payable. The liability retained by a self-insured policyholder may include damages, defense costs, or both. There are some practical and legal distinctions between SIR and deductible clauses; but, as discussed in this chapter, the terms are functionally equivalent because both types of clauses require the policyholder to pay a specified portion of the loss. Thus, a deductible “alter[s] the point at which

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8 McIntosh v. Scottsdale Ins. Co., 992 F.2d 251 (10th Cir. 1993).
the insurer’s obligation to pay ripen[s] . . . [and] where an individual purchases liability insurance for all potential damages in excess of [a retained amount] the individual remains ‘self-insured’ for the [retained amount], which is in essence a ‘deductible’ although the policy does not refer to it as a deductible.”

Few SIR or “other insurance” provisions address the issue of whether an SIR should be treated as if it were “other insurance” for purposes of allocating payments received from the insurers of third parties. While the authorities on this point are not uniform, absent express statutory enactments to the contrary, most courts have ruled that self-insurance does not constitute other, “valid and collectible” insurance that is “available” to the insured for purposes of application of an “other insurance” clause. In Citgo, after settling personal injury lawsuits by employees of its contractor for approximately $7,000,000, the refinery owner filed an indemnity claim against the contractor and its insurer, claiming in part that by virtue of the “additional insured” clause in the contract, the refinery was entitled to be reimbursed by CGL for up to $5,000,000 of the settlement costs by the contractor’s insurance. Both Citgo and its contractor were self-insured for the full limits of their primary policies. The trial court agreed with Citgo’s position; however, a substantial judgment in favor of Citgo and its excess insurers was reversed on appeal. The court of appeals ruled that Citgo’s $3,000,000 primary CGL policy, which contained an offsetting $3,000,000 deductible, was self-insurance and not other “valid and collectible” insurance within the meaning of the “escape,” other insurance clause in the contractor’s policy. However, the court ordered Citgo and its self-insured contractor to share the settlement liability on a pro rata basis (five-eighths allocated to the contractor based on policy limits) until the limits of the owner’s $3,000,000 primary policy were exhausted. The court ruled that the owner’s excess carriers must pay the remainder of the approximately $4,000,000 in settlement costs.

The outcome of an “other insurance” allocation dispute may differ when a state legislature permits a policyholder to satisfy its obligations under motor vehicle financial responsibility or workers’ compensation laws by obtaining a formal certificate qualifying as a self-insurer. For example, in Pennsylvania, a “self-insurer . . . is required [by statute] to provide the equivalent of uninsured motorist coverage . . . [and] will be treated under the law as though it had in place a policy of insurance. . . . [A]ccordingly [the self-insurer] must be required to pay before another, applicable policy.” Generally, however, a policyholder that self-insures some or

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13 Citgo Petroleum Corp. v. Yeargin, Inc., 690 So.2d 154, 158, 169-70 (La. App. 3d Cir. 1997). See generally Annot., supra, 46 A.L.R.4th at 710 (“self-insurance against liability has generally been held not to be ‘other insurance’ within the meaning of a liability insurance policy . . .”).
14 Brissett v. Southeastern Penn. Transp. Auth., 355 Pa. Super. 508, 513, 513 A.2d 1037, 1040 (Pa. Super. 1986). See also 77 P.S. at 944, § 401 (for purposes of workers’ compensation benefits, an “insurer” is defined as including the “insurance carrier which has insured the employer’s liability under this act, or the employer in cases of self-insurance”).
all of its loss should not be treated as having provided “insurance” within the meaning of an “other insurance” clause in an applicable policy.\textsuperscript{15} 

The characterization of an SIR as tantamount to real “insurance” could significantly impact the insured’s expectations regarding the allocation of settlement payments received from third parties. If self-insurance were equivalent to valid and collectible insurance, primary and excess carriers may attempt to invoke their “other insurance” clauses to claim a significant share of any recovery from a third party. If a partially self-insured policyholder cannot obtain reimbursement of a significant SIR contribution from other carriers or from third parties, the result could be devastating to the insured’s financial bottom line.

\section*{§ 2.03 ALLOCATION OF PAYMENTS RECEIVED ON “SUBROGATED” CLAIMS} 

\textbf{[A] The “Complete Compensation” Rule} 

The “complete compensation” (or “make-whole”) rule holds that an insurer should not be able to exercise its subrogation rights until its policyholder has been fully compensated for its own loss. The principle behind the rule is that the compensation of the policyholder is the most important goal of insurance law.\textsuperscript{16} As noted by the Nebraska Supreme Court:

\begin{quote}
Research indicates that nearly every appellate court that has considered the question has recognized that \textit{unless an insurance policy contains a provision to the contrary, an insurer’s right to recover under a subrogation clause of an insurance policy requires that the insured must have been fully compensated for the loss covered by the policy}.\textsuperscript{17}
\end{quote}

The \textit{Frohlich} court supported this statement with cites from ten states, two federal circuits, and two of the leading commentaries on insurance law.\textsuperscript{18}

Insurance carriers have attempted to avoid the “complete compensation rule” by modifying the standard form of subrogation clause to provide specifically that the carrier may claim priority in obtaining reimbursement from third parties even before the policyholder is fully compensated for the loss. For instance, in \textit{Blue Cross and Blue Shield of Massachusetts, Inc. v.}
Trull, a medical insurer sought to recover the insurance proceeds the Trulls had received from their automobile insurance policy, and also claimed priority to funds they might receive in the future from claims pending against other parties. The applicable subrogation clause provided specifically that the carrier’s “right to repayment comes first even if you are not paid for all of your claims against the other person.” The court noted that the issue of whether the carrier or the policyholder should be afforded priority in recovering the proceeds of third-party claims was a matter of first impression in Massachusetts, ruling as follows:

[T]he subrogation clause at issue is binding on the Trulls only where their recovery from third parties fully compensates them for all damages incurred as a result of the accident. In addition, the court declares that, to the extent the subrogation clause asserts that the insurer’s right to repayment comes first even where the insured does not recover for all of its claim and/or even where the payment received by the insured is described as payment for other than health care expenses, it is void as against public policy.

The court noted that the nature of subrogation lies in equity and used three equitable principles to support its ruling: (1) subrogation “is not to be applied if the result is injury or prejudice to the person whose rights are sought to be used by another”; (2) “[t]he object of subrogation is to prevent injustice and one who seeks equity must do equity”; and (3) “subrogation is intended to prevent an injured party from recovering twice for the same damages.”

Neither the holding of Trull nor the equitable principles supporting it are limited to medical benefits insurance. However, some cases suggest that the public policy principles applied in Trull may not govern property damage claims; and in some contexts, statutory provisions may determine the outcome of subrogation disputes. For instance, in Santos v.

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20 Blue Cross had paid more than $280,000 in medical benefits to the Trulls, and their automobile carrier had paid $200,000 to settle “guest passenger” claims of two injured and one deceased family member. The insurance recovery was not allocated to any “particular expenses or damages” incurred by the Trulls. Id. at *1. The Trull case is a classic example of the typical subrogation dispute in which a carrier pays medical benefits to its injured and then seeks reimbursement from payments the insured receives from a third party responsible for the injuries.
21 Id. at *1.
22 Id. at *3 (emphasis added).
23 Id.
24 The Trull court did not distinguish between equitable subrogation allowed by law and conventional subrogation in accordance with specific contract provisions. As noted above, the Trulls’ insurance policy contained a specific subrogation clause granting priority to the carrier, but the court used equitable principles to explain its rationale for refusing to enforce the clause. See also Frost v. Porter Leasing Corp., 436 N.E.2d 387 (Mass. 1982) (noting that the principles that underlie subrogation would not be served by extending an implied right of subrogation to personal injury insurance).
25 Cf. Frost v. Porter Leasing Corp., 436 N.E.2d 387, 388-90 (Mass. 1982) (while equitable rights of subrogation may be implied in cases involving property damage loss, where the amount of any “excess compensation from the combination of insurance proceeds and tort recovery can be determined with certainty,” implied rights of subrogation may not be extended “into a field of insurance for personal injuries, absent an express contract.”
**ALLOCATION OF SETTLEMENT PAYMENTS**  

§ 2.03[A]

*Lumbermens Mutual Casualty Co.*,²⁶ two policyholders who had been reimbursed for less than the full amount of their loss pursuant to the “underinsurance” provisions of their automobile policies brought a declaratory judgment action concerning, among other issues, the insurer’s right to be subrogated to amounts collected from third-party tortfeasors. The policyholders argued that Lumbermens should not be entitled to recover any money from third parties until the policyholders’ damages had been fully reimbursed.²⁷

The policyholders argued in part that the Supreme Judicial Court should overturn its prior decision in *Bertassi v. Allstate Insurance Co.*,²⁸ in which the court had allowed a carrier to claim subrogation priority before the policyholder was fully reimbursed: “[W]hen the plaintiff recovered an additional $20,000 from the other alleged tortfeasors, that $20,000 was recovered for [the insurer’s] benefit,” even though the plaintiff had not been compensated to the full extent of his loss.²⁹ While the Santos court refused to overturn *Bertassi*, the court limited its ruling, noting that a motorist with an unreimbursed loss is “‘entitled to be compensated to the extent of the applicable automobile insurance [covering the tortfeasor], plus, at a minimum, an amount equal to the limit of his underinsurance coverage.’”³⁰ As a result, the *Santos* court allowed the carrier to enforce its subrogation rights with respect to the policyholders’ recovery from “nonmotorist tortfeasors,” but also apparently allowed the policyholders to retain settlement proceeds actually recovered from the insurance carrier of the other “motorist.”

*Bartassi* and *Santos* probably should be limited to their facts because of the “underinsured” motorists’ statutory concepts regulating coverage:

[W]e do not think that enforcement of the subrogation provision leads to an unconscionable result or violates public policy. . . . *We would be hard-pressed to declare as violative of public policy a provision which, at least with respect to mandatory underinsurance, has been explicitly sanctioned by the Legislature. See* G.L. c. 175, § 113L(4).³¹

In *Trull*, which did not involve underinsurance benefits, the court did not cite either *Santos* or *Bartassi* in holding that a subrogation clause giving priority to a carrier before the policyholder is fully reimbursed is void as against public policy.

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²⁷ Id. at 991.
²⁹ Id. at 949. The policy contained standard subrogation language that did not specifically grant priority to the carrier.
³⁰ *Santos*, 556 N.E.2d at 991.
³¹ Id. at 992 (emphasis added).
[B] Contractual Modification of the Complete Compensation Rule

Several jurisdictions allow an insurer to contract around the complete compensation rule. For instance, in *Sapiano v. Williamsburg National Ins. Co.*[^32] the policyholder’s vehicle, worth more than $20,000, was insured under a policy providing only $0,000 in collision coverage. The insurer paid the maximum policy limits, less a $500 deductible. The third party’s insurer tendered its liability limits of $10,000 to settle the plaintiff’s property damage claim. The insured plaintiff claimed he was entitled to retain $5,500 of the settlement to reimburse the shortfall between the value of his vehicle ($20,000) and the amount received from his carrier ($14,500); however, the carrier asserted a right to the entire $10,000 settlement pursuant to the subrogation clause in the policy. The trial court concluded that the plaintiff had first priority to the $10,000 offered in settlement and that the subrogated insurer could recover only after the insured was fully compensated for the fair market value of his vehicle. The appellate court affirmed, concluding that the rule reimbursing the insured first “‘has the greatest support . . . among the more recent judicial precedents. The application of this rule maximizes the prospect of “making the insured whole,” which is consonant with the equitable origins of the subrogation doctrine.’”[^33]

In *Sapiano*, the insurer argued that California’s “well-settled” complete compensation rule did not apply because it governed only equitable and not conventional subrogation allowed by contract. The court disagreed, writing that the policy’s subrogation “provisions . . . add nothing to the rights of subrogation arising by law.”[^34] However, the subrogation clause at issue did not have “top to bottom” language affording specific priority to the carrier. Instead, the contract provided only “in general terms that the rights to recover damages from another ‘are transferred to [the insurer]’. Although it substitutes plain language (‘transferred’) for legalistic jargon (‘subrogated’) [the clause] is no more specific or explicit than language used in older policies stating that the insurer ‘shall be subrogated’ to the insured’s rights against another.”[^35] The *Sapiano* court suggested that a different outcome might be warranted if the parties had agreed “explicitly . . . in their contract that the insurer has a priority regardless whether the insured is first made whole.”[^36]

There is a split or authority between courts that have agreed wan the dicta in *Sapiano*[^37] and courts that have agreed with *Trull* by refusing to allow insurers to contract around the

[^33]: 33 Cal. Rptr. 2d at 661 (quoting Keeton, *supra*, § 3.10 at 236).
[^34]: *Id*. at 661.
[^35]: *Id*. at 662.
[^36]: *Id* at 661, citing Samura v. Kaiser Found. Health Plan, 22 Cal. Rptr. 2d 20 (Cal. Ct. App. 1993) (emphasis added). *Sapiano* also quoted Keeton, *supra*, § 3.10 at 236 for the proposition that “‘ordinarily there is no barrier to the use of explicit subrogation terms that provide either for proration or for a disposition of recoveries from third parties that is even more favorable to the insurer’s interests.’” 33 Cal. Rptr. 2d at 662..
[^37]: See, e.g., Shelter Ins. Co. v. Frohlich, *supra*, 498 N.W.2d at 75 (“if a contract provides for subrogation on payment of less than the full amount of a debt or loss, partial payment of a debt or loss may be the basis for subrogation”); Wine v. Globe AmCas Co., 917 S.W.2d 558, 565 (Ky. 1996) (“subrogation rights may be modified by contract”); Culver v. Insurance Co. of N. Am., 559 A.2d 400, 402 (N.J. 1989) (“such [equitable] subrogation principles . . . could be altered by contract”); Ervin v. Garner, 267 N.E.2d 769 (Ohio 1971) (enforcing a subrogation agreement which clearly granted the insurer priority to any recovery from the tortfeasor).
complete compensation rule. For example, in *Franklin v. Healthsource of Arkansas*, the court refused to enforce a subrogation agreement that contained language purporting to assign any recovery from other insurance to the subrogated carrier:

**ASSIGNMENT OF BENEFITS**

I HEREBY ASSIGN TO HEALTHSOURCE ANY AND ALL BENEFITS PAYABLE BY ANY INSURANCE, INCLUDING BUT NOT LIMITED TO LIABILITY INSURANCE AND UNINSURED MOTORIST INSURANCE RELATING TO MY ACCIDENT/INJURY ON 3-31-94, TO THE EXTENT NECESSARY TO COVER ALL SERVICES RENDERED BY AND BENEFIT PROVIDED BY HEALTH-SOURCE. I DO THIS WITH FULL UNDERSTANDING OF HEALTHSOURCE’S CONTRACTUAL RIGHTS OF RECOVERY/SUBROGATION AND COORDINATION OF BENEFITS. I AUTHORIZE HEALTHSOURCE TO RELEASE INFORMATION NECESSARY TO PURSUE THIS CASE.

The court’s rationale was based on principles of equity, refusing to draw any distinction between equitable subrogation concepts and cases involving contractual or conventional subrogation, noting that in either case, the policyholder’s right to complete compensation should take precedence over the carrier’s right to subrogation.

Similarly, in *Powell v. Blue Cross & Blue Shield*, the Alabama Supreme Court refused to enforce a top-down subrogation clause, holding that “a prerequisite to the right of subrogation is the full compensation of the insured. In effect, an attempt to contract away this prerequisite . . . would defeat the right itself.” The following language from the *Powell* case is instructive:

The very heart of the bargain when the insured purchases insurance is that if there is a loss he or she will be made whole. The cases that originally applied subrogation to insurance contracts did so on behalf of the insurer only after the insured had been fully compensated. These cases never envisioned the use of subrogation as a device to fully reimburse the insurer at the expense of leaving the insured less than fully compensated for his loss.

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38 942 S.W.2d 837 (Ark. 1997).
39 Id. at 84.
40 581 So. 2d 772 (Ala. 1990).
41 Id. at 777.
42 Id.
The Georgia Supreme Court recently concluded that the reasoning in *Powell* was “compelling” and adopted it in striking down a subrogation clause requiring the policyholder to reimburse the carrier from the proceeds of claims against third parties “‘[e]ven if the total amount you collect is less than your actual losses.’” Relying in part on the provisions of a recently enacted statute, the court decided that the principle of “complete compensation is, and was . . . the public policy of this State” and could not be circumvented by a contract provision allowing “the insurer, at the expense of the insured, to avoid the risk for which the insurer has been paid by requiring the insured to reimburse the insurer whether or not the insured was completely compensated for the covered loss.

The complete compensation cases usually arise in the personal injury context and, like *Davis*, sometimes are supported by statutory enactments. However, it does not necessarily follow that the concept cannot be applied just as broadly in the context of property damage or other losses arising out of construction accident claims. When a construction accident causes personal injuries, the contractor or premises owner often compensates the victims through workers’ compensation or tort settlements. The typical recovery dispute then revolves around the language of the indemnity or insurance clauses in the construction contract or subcontract. In such cases, if the public policy of the state favors “complete compensation,” then a strong argument exists that even a clear clause purporting to give the insurance carrier priority in recovery may not be enforced so long as the insured has a provable, unreimbursed loss. Nevertheless, as discussed in the next section, this outcome is by no means certain, especially where a portion of the insured’s unreimbursed loss is attributable to a self-insured retention or policy deductible.

[C] “Off-the-Top” Subrogation in Construction Industry Claims

While the “complete compensation rule” favors the policyholder, courts have reached somewhat different results in dealing with “competing” subrogation clauses in primary and excess liability policies that have contributed to the loss. In such cases, when the umbrella or excess policy (or in one case a primary policy) includes a “Retention” provision or SIR, courts have concluded that as a general rule, subrogation recoveries should be allocated among multiple claimants by reimbursing the top “level” (excess) policy first. Two of the leading cases that address this issue in the context of construction-related claims are *Century Indemnity Co. v.*

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44 The statute provides in relevant part that a “benefit provider” (insurer or other payor) who has paid medical or disability benefits may be reimbursed from the proceeds of a claim against a third party only if the injured party’s recovery “exceeds the sum of all economic and noneconomic losses incurred as a result of the injury. . . .” O.C.G.A. § 33-24-56.1(b). Where the medical benefits are paid by an “ERISA-governed benefit plan,” some courts have ruled that such anti-subrogation statutes are preempted by federal law. Cagle v. Flick, 3 E Supp. 2d 982 (N.D. Ind. 1998). But cf. Sanders v. Scheideler, 816 E Supp. 1338, 1346-47 (W.D. Wis. 1993) (where plan is silent as to subrogation priority, the “make whole doctrine” should be applied as the “default priority rule” applicable under federal common law), aff’d, 25 F.3d 1053 (7th Cir. 1994) (unpublished).
45 271 Ga. at 510.
The subrogation language considered in these cases reads as follows:

Inasmuch as this policy is “excess coverage,” the insured’s right of recovery against any person . . . cannot be exclusively subrogated to the [Insurance] Company.

It is therefore agreed that in case of any payment hereunder, the Company will act in concert with all other interests (including the Insured) concerned, in the exercise of such rights of recovery. The apportioning of any amounts recovered . . . shall follow the principle that any interests (including the Insured) that shall have paid an amount over and above any payment hereunder, shall be first reimbursed up to the amount paid by them; the [Insurance] Company is then to be reimbursed up to the amount paid hereunder; lastly, the interests (including the Insured) of whom this coverage is in excess are entitled to claim the residue, if any.

This wording is inherently ambiguous and seems internally inconsistent, especially when considered in relation to an insured’s unreimbursed loss. Thus, the clause permits the insured (or other “interests”) to recover any amount “over and above any payment hereunder” before the carrier recovers its payment. However, the last phrase of the clause appears to provide that if the policy is excess coverage, then the insured or others who make payments that are within lower levels (layers) of coverage may be not entitled to claim priority in recovering from third parties. Instead, they may only recover the “residue” after the excess carrier is fully reimbursed. The terms “interests” and “over and above,” as used in this clause, are not defined. For example, if...
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the insured has an unreimbursed loss, is such a loss “over and above” the policy limits (or “payment hereunder”), or is the coverage “excess” to the insured’s payment? Does it make any difference if the insured’s loss is caused by underinsurance because the policy limits have been exceeded or because there is no coverage provided for the insured’s loss within a policy retention? A retention or deductible provision might be construed as obligating the insured to bear an agreed portion of any loss; however, as noted above, a typical deductible or SIR provision does not contain language specifying how recoveries from third parties should be shared.50 Certainly, the subrogation clauses construed in Century Indemnity and Vesta are completely silent about the relative priorities to any recovery when the insured has incurred an unreimbursed loss within its SIR.

Century Indemnity is a paradigm case in which a subcontractor’s employee was killed as a result of a construction accident, leading to claims and cross-claims involving the subcontractor and general contractor, who was supposed to be named as an “additional insured” on the subcontractor’s insurance policy. However, while the subcontractor had obtained $500,000 in coverage to insure its liability to indemnify the general contractor for claims by the subcontractor’s employees, the policy in question did not name the general contractor as an “additional insured.”

The wrongful death claim by the heirs of the deceased employee settled for $1,100,000, with $500,000 (policy limits) contributed by London, the general contractor’s primary carrier, and approximately $600,000 contributed by Century, the general contractor’s excess carrier. The trial judge decided that $500,000 was recoverable from the subcontractor’s insurance carrier. The court classified this recovery as an “indemnification fund” (rather than primary insurance) and decided that it should be allocated entirely to reimburse the $600,000 settlement contribution from the general contractor’s excess carrier, Century. The appellate court agreed. Noting that when it paid its policy limits, London became subrogated to its insured’s rights, the court decided that “London, as . . . subrogee, had no greater rights than [the insured] itself and thus was bound by the [subrogation] agreement that London’s insured . . . had made with Century.”51 Similarly, the appellate court also ruled that London was bound by the retention clause in the excess policy:

[The insured] had agreed that it would absorb the first $500,000 of any loss, and until it did, Century’s excess coverage would not be applicable. Therefore, if the $500,000 [indemnification fund] . . . were paid to London in fact, the result would be that London would not suffer the $500,000 loss that had to be exceeded in order to trigger the applicability of Century’s excess coverage. . . . London was one of two subrogees, and was below Century in the order of preference because of the loss [its insured] agreed to absorb (the

recoveries are distributed.” Id. The opinion is silent as to the relative priorities to any recovery between the policyholder itself and the excess carriers.

50 See note 3 and accompanying text, supra.
51 Id. at 398.
first $500,000), as well as the order of preference given by Century’s “top to bottom” subrogation clause.52

The court noted that the “same result would have been reached if [the subcontractor] . . . had named [the general contractor] as an additional insured,” i.e., London would have paid $500,000, the subcontractor’s insurer $500,000, and Century $100,000 to settle the wrongful death case.53 In addition, without citing the “complete compensation” rule, the court noted that London still would not have been entitled to any recovery from the “indemnification fund” even if there had not been any excess coverage: “London would not be entitled to take the [indemnification fund], suffer a net loss of zero, and leave its insured to pay a net loss of over $600,000.”54

In Vesta, supra, the fifth circuit considered a similar construction-related personal injury case involving a subrogation clause virtually identical to the “top to bottom” clause in Century Indemnity. However, only one “layer” of insurance coverage was involved—a “Primary Integrated Risk Program” with Vesta as lead underwriter. The program contained limits of $35,000,000 for “the ultimate net loss in excess of the greater of: (A) the amount recoverable under Underlying Insurances, or (B) a self-insured retention of $5,000,000, . . . (hereinafter called the “underlying limits”). . . . .”55 In settling with the injured employee of a subcontractor, Amoco (the insured) paid $2,715,000, and the insurers for Amoco’s subcontractor (the plaintiff’s employer) paid $3,500,000 pursuant to the subcontractor’s “contractual liability” coverage that insured its obligation to indemnify Amoco against such claims. Amoco’s insurer, Vesta, paid 65.7 percent of the loss in excess of the $5,000,000 SIR, which was the percentage amount attributable to Amoco’s interest in the facility where the injury occurred. Vesta’s payment allowed Amoco to retain $798,255 of the indemnity payment from its subcontractor’s insurers. Amoco agreed to treat the Vesta payment as a “loan,” subject to the outcome of a declaratory judgment action establishing the respective priorities of Amoco and Vesta to the $3,500,000 indemnification payment made by the subcontractor’s insurers.

The trial court ruled in favor of Amoco. On appeal, the fifth circuit reversed, drawing a distinction between payments received from other insurance and payments received for contractual indemnity. The court noted that the policy defined the terminology “ultimate net loss,” as used in the applicable retention clause, “to include the total sum that Amoco or any company as its insurer became obligated to pay because of . . . personal injury claims.”56 However, the court ruled that the contractual indemnification clause did not make the “indemnifying party an ‘insurer’ of the other party,” concluding that “one party to a contract for

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52 Id.
53 Id. at 399. Thus, the court assumed (perhaps erroneously) that the “additional insured” coverage provided by the subcontractor’s insurer would be treated as primary, “other insurance” and that the $500,000 limits of both primary policies would have to be exhausted before Century’s excess policy could be triggered, resulting in the same outcome allocating $100,000 of the loss to Century. A previous ruling on this point had been reversed and remanded in an earlier appeal. See 16 Cal. Rptr. 2d at 395-96. See also discussion at § 2.02[C][3], supra.
54 Id. at 398.
55 986 F.2d 981, 984 (5th Cir. 1993).
56 Id. at 985 (emphasis added).
services is not an ‘insurer’ of the other party to the contract solely because the first party indemnifies the second party pursuant to an indemnity clause in that contract.” Accordingly, the court decided that the indemnification payment could not be considered to be part of the “ultimate net loss” that would apply against Amoco’s SIR and ruled that the applicable subrogation clause apportioned amounts recovered from third parties in the following sequence:

1. any party that has already paid more than its designated share shall first be reimbursed up to the excess amount paid;
2. Vesta is then to be reimbursed out of any balance then remaining up to the amount it paid; and
3. lastly Amoco is entitled to claim any residue.58

The court treated the full amount of the SIR as the policyholder’s “designated share,” ruling that because the policyholder had not exhausted its $5,000,000 SIR, the carrier had priority to any settlement contribution received from the policyholder’s indemnitor. Accordingly, the court awarded Vesta the full amount of its “loan,” as well as prejudgment interest.

The most recent Texas case on the subject cited both Vesta, supra, and Highlands Ins. Co., supra, and ruled with very little discussion that the subrogation provision in the excess liability carrier’s policy (which it did not quote) “provides that the last paid-in monies be the first paid out.”59 Because the subrogation clause in the primary carrier’s policy did not address the priority of payment, the court concluded that the excess carrier was entitled to claim the entire amount of the proceeds received in settling cross-claims against third parties, less the amount of $7,500, which the trial court had allowed the policyholder to retain in reimbursement of the deductible in the primary policy. The primary carrier received nothing. While the excess carrier apparently claimed the full amount of the third-party recovery,60 the appellate court, without any discussion, allowed the policyholder to retain the $7,500 deductible payment. The confusion in this area is further heightened by the conclusion of the dissenting judge, who wrote, without citing Century Indemnity, supra, that he found “no case law applying ‘last in, first out’ as between primary carriers and excess carriers,” noting that he would have awarded “$60,000 only” to the excess carrier.61

The cases discussed above address multiple “layers” of insurance coverage; but the Vesta court effectively treated the policyholder’s self-insured retention as equivalent to a primary coverage layer, noting that the policy defined the SIR as “underlying limits.” However, as noted

57 Id. at 985-86.
58 Id. at 986 (emphasis added).
60 The total amount received from third parties was $1,060,000. The trial court had allocated $7,500 of this recovery to the policyholder to reimburse its deductible and prorated the remainder of the recovery between the primary carrier and the excess carrier. Invoking its “last paid-in . . . first paid out” subrogation clause, id. at 435, the excess carrier argued that it was entitled to the “full third-party recovery of $1,060,000.” Id. at 433.
61 Id. at 435. The dissenting judge did not state whether he believed the amount allocated to the deductible should be retained by the policyholder or reallocated to the primary carrier.
above, most cases addressing self-insurance hold that, like a deductible, a self-insured retention does not count as “other insurance” in allocating recoveries among multiple carriers.”

[D] Subrogation Recoveries from “Other Insurance”

The cases discussed above do not address a provision specifically permitting the insured to apply “other insurance” to satisfy its SIR obligation. On the other hand, in Vesta, the court construed the terminology “ultimate net loss” as allowing Amoco to satisfy its SIR by other insurance. Thus, the court rejected the insured’s argument that it could “protect itself from payments within its SIR” by contract, holding that a contractual indemnity payment was not the equivalent of payment of actual insurance proceeds. Moreover, because the indemnity clause expressly provided for indemnification of Amoco and its insurers, the court stated that “Vesta [the insurer] could have proceeded directly against [the subcontractor] for indemnity without relying on the subrogation clause.”

The court noted that Amoco could have “separately insured[d] itself for any or all of its $5,000,000 self insurance retention . . . [but] failed to take advantage of this opportunity, opting instead to include only an indemnity clause in the contract . . . which itself recognized the potential rights of Amoco’s insurer’s in any indemnification.”

Unlike Amoco, the premises owner in Assurizioni Generali SpA v. Crown Central Petroleum Corp. had required its subcontractor to both indemnify and name the owner as an additional insured with respect to claims by the subcontractor’s employees for work-related injuries. The owner, Crown Central, paid $1,000,000 (its SIR); and its carrier, Cigna, paid $1,900,000 to settle personal injury claims by two employees of the subcontractor. After ruling that Crown Central was in fact an “additional named insured” under the policy issued by Generali to the subcontractor, the court addressed the issue of whether the $1,000,000 limits of the Generali policy should be allocated entirely to the settlement payment made by Crown Central or to the settlement payment made by Cigna.

First, the court considered whether or not Cigna could claim credit for the payment from Generali based on the wording of the excess other insurance clause in its policy, which provided that Cigna would pay only if the amount of the loss exceeded the sum of “total amount that all such [other] insurance would pay . . . [and] [t]he ‘retained limit’ shown in the Declarations.” Noting that “other insurance” clauses only apply “when two policies provide concurrent coverage,” the court decided that the Generali policy, as a primary policy, was not “concurrent” with the Cigna policy because the two policies insured “different layers of risk” —the primary policy only provided coverage within Crown Central’s $1,000,000 SIR and the Cigna policy

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62 See discussion at § 2.02[C][4], supra.
63 986 F.2d at 987.
64 Id.
only covered losses in excess of $1,000,000. The court distinguished the Vesta decision because it did not involve “other insurance.”

Turning to the subrogation clause, the court noted that the language of the policy gave Cigna a right of subrogation to “recover ‘all or part of any payment we [Cigna] have made under this policy.’” Again, because Cigna’s payment obligation was not triggered until after the $1,000,000 SIR was exhausted, the court decided that the recovery from Generali “is not a recovery of any payment Cigna made under its Policy?” The court distinguished Vesta and one other case in which a carrier had “dropped” down to pay before its coverage layer was reached because in those cases the carriers had “advanced money” before the retained limits of the applicable policies were satisfied. Accordingly, the carriers had “discharged part of the debt of another,” thereby entitling them to subrogation. Interestingly, the Crown Central court did not cite the language of the Vesta decision, suggesting that the outcome would have been different if Amoco had been an “additional insured” on its subcontractor’s policy. The Crown Central court may have failed to cite this language because the definition of “ultimate net loss” in the Cigna policy at issue, unlike the definition of the same terminology in the Vesta policy, made no reference to satisfying the “ultimate net loss” from other insurance coverage.

Both the Vesta and the Crown Central courts arguably exalted form over substance in dealing with SIRs and “other insurance.” While the outcomes of these cases can be reconciled to some degree based in part on the specific wording of the subrogation clauses and retention clauses at issue, it makes little sense to deprive the policyholder of a third party’s indemnity payment simply because it was made by a carrier obligated to insure the subcontractor’s contractual liability to indemnify the owner rather than by the same carrier under an omnibus or blanket “additional insured” clause. Similarly, insurance carriers might contend that it makes little sense to allow an owner to retain 100 percent of the proceeds of other insurance simply because the other carrier refused to pay and the policyholder paid first before its excess carrier paid any portion of the settlement. In either case, when a policyholder chooses to protect its obligation to satisfy an SIR, whether by indemnity or other insurance or a settlement with the

67 Id. At 6-9.
68 Other courts might disagree with the analysis. As discussed above, the Century Ind. court noted in dicta that the two primary “insurers” (of the owner as named insured on its own policy and of the owner as an additional insured on the policy obtained by the subcontractor) would be required to pay the loss before the excess policy could be triggered. See note 47 and accompanying text, supra.
69 Id. at 10 (emphasis in original).
70 Id.
71 The subrogation clause in Crown Central did not contain the type of “top to bottom” language construed in Vesta or any other language that gave the carrier any specific priority to recover funds received from other parties before the policyholder could be reimbursed. However, the Crown Central court did not distinguish Vesta on that ground.
72 Some policies, including presumably the Subcontractor’s policies in the Vesta case, require an “additional insured” endorsement to be added to the policy to extend coverage to another entity. However, because clauses requiring either an owner or a subcontractor to name the other party to the contract as an “additional insured” are common in construction contracts, many policies issued to construction contractors contain omnibus clauses providing that any party that requires the insured to name it as an “additional insured” automatically is classified as such under the policy. Apparently, such a clause was included in the subcontractor’s policy in the Crown Central case.
injured party, and absent specific language in the policy to the contrary, the policyholder should be allowed to retain the benefits of such protection in preference to the carrier.

[Structuring Settlement Agreements to Satisfy an SIR]

The foregoing cases address typical situations involving construction-related claims and indemnity where the parties have not included language that specifically defines the relationships between payments made by third parties, the self-insured policyholder, and the insurance carriers for the parties. For example, the outcome in Vesta, supra, might have been different if Amoco had used contract language that specifically obligated its contractor to provide indemnity or insurance to cover Amoco’s obligation to reimburse (or pay) its carrier any portion of the policy SIR. While the language in Vesta suggests that any payment that is not actually made by an insurance carrier could not be credited against Amoco’s SIR, several courts have allowed such “credits” in cases involving settlements partially funded by lower level carriers (or the self-insured policyholder) that left the excess carrier exposed to additional liability.

For instance, in Kelley Co., Inc. v. Central National Insurance Co., an excess liability policy required the insured to maintain $500,000 in primary insurance in addition to a $250,000 deductible beyond the primary insurance “level.” After an appellate court reversed a jury award allocating $1.15 million liability to the insured, remanding for a new trial on liability, the insured and its primary insurer settled with the tort claimant for $486,942 in cash, agreeing that the payment made satisfied the first $750,000 of liability against the insured. This settlement “credit” exhausted the primary coverage layer and the $250,000 deductible in the excess policy. The excess insurer then settled the remaining portion of the claim for $312,820 but refused to recognize the settlement credit and demanded that the insured pay the full amount of the $250,000 deductible in the excess policy. The insured argued that the $250,000 credit in the first partial settlement was full satisfaction of the deductible, while the excess insurer alleged that the insured was required to “actually pay” the deductible and had settled in bad faith. The court found that the insured “essentially became self-insured for the amount of the deductible, and thus, is in the analogous position of a primary insurer and should be able to enter into a settlement agreement.” The court further found that the $750,000 settlement credit “exhausted” the deductible requirement, noting that the policy was silent as to whether actual payment was required.

The Kelley court distinguished United States Fire Ins. Co. v. Lay, which invalidated a settlement “credit” in a wrongful death action that released the primary insurer but not the excess

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73 Cf. Century Indemnity, supra. In Century Indemnity, the court gave priority to the excess carrier’s “top-down” subrogation clause vis-à-vis the subrogation claim of the primary carrier against an indemnitor, noting that it made no difference whether the source of the third party’s payment was contractual indemnity or insurance. In either case, the “subrogation clause of the [excess] contract should . . . be honored.” 16 Cal. Rptr. 2d at 399. The Century Indemnity court also stated, however, that the outcome would be the same (i.e., the primary carrier could not claim priority in subrogation) if the policyholder had incurred an unreimbursed loss in paying the settlement.
74 662 F. Supp. 1284 (E.D. Wis. 1987).
75 Id. at 1287.
76 577 F.2d 421 (7th Cir. 1978).
insurer from any further liability. In Lay, the Seventh Circuit held that the excess carrier was not liable for any part of the judgment rendered because the insured had not "sustain[ed] a loss in excess of the retained limit," as required by the language of the excess policy. The court commented that it could “conceive of good reasons for an excess carrier to be unwilling to accept liability unless the amount of the primary policy has actually been paid” because “settlement for less than the primary limit that imposed liability on the excess carrier would remove the incentive of the primary insurer to defend in good faith or to discharge its duty . . . to represent the interests of the excess carrier.” In distinguishing Lay, the Kelly court pointed out that “the Lay policy contained specific language requiring payment of the retained limit; the Central policy contains no language regarding how the deductible should be paid.”

The Kelly court characterized the settlement at issue as involving a “Loy type release.” Such a release enables a primary insurer to settle a claim for less than the primary limits, obtaining satisfaction up to the primary carrier’s policy limits, while permitting the claimant to continue to pursue claims seeking recovery from an excess insurer. Courts have tended to side either with the Loy or the Lay analysis, sometimes carefully analyzing the specific policy language, in determining whether or not primary limits may be exhausted without requiring actual payment of policy proceeds (or a deductible).

Zeig v. Massachusetts Bonding & Ins. Co. is perhaps the seminal case holding that full payment of primary policy limits is not required to trigger coverage under an excess policy. The Zeig court adopted a bright line approach to the issue, stating the following:

The defendant [excess insurer] argues that it was necessary for the plaintiff actually to collect the full amount of the [underlying] policies . . . in order to “exhaust” that insurance. Such a construction of the policy sued on seems unnecessarily stringent. It is doubtless true that the parties could impose such a condition precedent to liability upon the policy, if they chose to do so. But the defendant had no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in excess of the limits of those policies. To require an absolute collection of the primary insurance to its full limits would in many,

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77 Id. at 423.
78 662 F. Supp. at 1290.
79 Loy v. Bunderson, 320 N.W.2d 175 (Wis. 1982).
80 See Drake v. Ryan, 498 N.W.2d 29 (Minn. Ct. App. 1993), aff’d, 514 N.W.2d 785 (Minn. 1994) (refusing to follow Lay and approving a Loy-type release of claim against primary insurer with reservation of claim against excess liability carrier for damages exceeding limits of primary policy); Allstate Ins. Co. v. Riverside Ins. Co. of Am., 509 F. Supp. 43, 50 (E.D. Mich. 1981) (declining to follow Lay and holding that agreement in which primary insurer agreed to pay less than policy limit in full satisfaction of any claim against primary insurer was not against public policy of Michigan or in derogation of excess insurer’s rights). See also American Home Assurance Co. v. Commercial Union Assurance Co., 379 So. 2d 757 (La. Ct. App. 1979) (primary insurer’s settlement of claims for less than policy limits with reservation of right to claim amounts above primary coverage did not entitle excess insurer to recover from the primary insurer on theory of either subrogation or unjust enrichment).
81 23 E2d 665 (2d Cir. 1928).
if not most, cases involve delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable.\textsuperscript{82}

In Zeig, the court refused to interpret the word “payment,” as used in the excess policy, to require actual payment of cash proceeds, noting that the term “often is used as meaning the satisfaction of a claim by compromise, or in other ways. . . . Only such portion of the loss as exceeded, not the cash settlement, but the, limits of those policies, is covered by the excess policy.”\textsuperscript{83}

Tying it all together, the court in \textit{Rummel v. Lexington Ins. Co.}\textsuperscript{84} found actual payment of underlying limits and an SIR unnecessary in three scenarios: the insured’s insolvency, the primary insurer’s refusal to pay, and the first layer excess insurer’s settlement for less than policy limits. The underlying tort case involved a clerk at a Circle K convenience store who was acting in accordance with Circle K’s policy of confronting shoplifters. He attempted to prevent three men from stealing some merchandise when the men brutally attacked him, resulting in severe personal injuries. The clerk filed a lawsuit against Circle K seeking compensatory and punitive damages for his injuries. Within a year of the filing of the complaint, Circle K filed a petition before the U.S. Bankruptcy Court under Chapter 11 of the Bankruptcy Code. The bankruptcy court allowed the plaintiff to litigate his claims against Circle K by lifting the automatic stay. The jury returned a verdict awarding the plaintiff over $1,000,000 in compensatory damages and $10,700,000 in punitive damages.

Circle K had a primary policy from Columbia Casualty (Columbia) that insured the first $750,000 of losses above a $250,000 SIR. The next layer of coverage, issued by International Surplus Lines Insurance Company (ISLIC), insured Circle K for $5,000,000 in excess of the $250,000 SIR and the $750,000 Columbia coverage. Lexington Insurance Company, the third layer excess carrier, insured Circle K for $10,000,000 in excess of $6,000,000. Following entry of judgment, Circle K requested its carriers either to pay the judgment, settle with the plaintiff, or take over the defense and appeal. Only ISLIC honored this request, leading eventually to a settlement between the plaintiff, Circle K, and ISLIC. The settlement satisfied the judgment by granting the plaintiff a $500,000 unsecured general creditor claim that satisfied Circle K’s SIR; by paying the plaintiff $1,625,000 in cash and crediting the ISLIC policy as being satisfied up to its $5,000,000 limits; and by assigning to plaintiff Circle K’s claims against Columbia and

\textsuperscript{82} Id. at 666 (emphasis added). See also 6 Appleman, Insurance Law and Practice § 3913 at 498 (actual payment of policy limits is not required because “settlement under a primary policy of claims equaling the amount of the policy permits recovery on a secondary policy made applicable only where the primary insurance is exhausted in payment of claims”).


\textsuperscript{84} 945 P.2d 970 (N.M. 1997).
Lexington for the unreimbursed portion of the judgment (less the credits) and for bad faith and breach of contract.

The trial court agreed with Lexington’s arguments that the settlement was improperly collusive, that allocating most of the proceeds and credits to punitive damages not covered under the Lexington policy was improper, and that the Lexington policy could not be triggered until $6,000,000 in underlying coverage (including the SIR) was actually paid. On appeal, the New Mexico Supreme Court reversed. Concluding that actual payment in cash of the underlying limits was not a “condition precedent” to coverage, the court ruled that the possible “bad faith” of the primary carrier (Columbia) in refusing to pay did not relieve Lexington of its insurance obligation. In addition, citing Zeig, among other authorities, the court concluded that an “excess carrier has no rational interest in whether the primary policies are collected in full, so long as it is only required to pay the loss for which it would otherwise have been liable.”

The court also analyzed Lexington’s argument that allocating the settlement payments and credits to the punitive damages award was an unconscionable, collusive violation of Circle K’s contract with Lexington. The court determined that Lexington’s policy was silent on the allocation of compensatory and punitive damages and found nothing in the insurance policy or state public law requiring the underlying insurance to be applied first “to compensatory damages rather than punitive damages at the expense of the best interests of the insured.” The court remanded the case for trial on the merits of the bad faith claims asserted by both parties (Lexington’s allegations of collusion and the plaintiff’s allegations that Lexington acted in bad faith). The court noted, on the one hand, that Lexington “may have acted improvidently, if not in bad faith by refusing to keep abreast of the negotiations,” thereby having “abdicated any right to object to the final settlement,” and, on the other, that a settlement that is “the product of fraud or collusion would release [Lexington] from any obligation.”

*Rummel* supports the proposition that a carrier, including an excess carrier, cannot deny coverage or otherwise stand on the sidelines and thereby avoid liability in a structured settlement where coverage is found to be available. If the primary or lower level carrier and the partially self-insured policyholder face a substantial exposure, imaginative resolution of the dispute on a fair and rational basis that “shares the risk” among multiple parties should withstand scrutiny in most jurisdictions.

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85 *Id. at* 981.
86 *Id. at* 982.
87 *Id. at* 983-84.
§ 2.04 SUMMARY OF SUBROGATION AND SETTLEMENT ALLOCATION CONSIDERATIONS

The risk manager or construction practitioner should look first to the language of the policy to determine how payments from other insurance and third parties will be allocated to satisfy the applicable SIR. However, where, as in most policies, language clearly specifying the relative priorities is absent, ambiguous, or murky at best, an opportunity arises to apply a state’s complete compensation rule to reimburse the insured first, up to its out-of-pocket loss, and then to satisfy the remaining insurance layers above any retained amount or deductible. Careful scrutiny should be given to the language of the SIR and subrogation clauses in the primary and excess policies, which may be outcome determinative in some jurisdictions.

Further, the “other insurance” language in an excess policy may be subject to the interpretation given by the Crown Central court; namely, that “other insurance” clauses only apply when two policies provide “concurrent coverage.” Accordingly, an excess insurance policy insuring a different layer of risk from the primary policy containing the SIR would not be entitled to any priority in recovering proceeds from third parties or other insurance until the insured’s unreimbursed SIR loss is satisfied. This outcome is by no means certain, however, even in “complete compensation” jurisdictions, especially if the excess policy contains a clearly worded subrogation clause with a last paid-in, first reimbursed provision. However, even if a clear “top-down” subrogation provision is in place, an insured may argue that (1) the “top-down” provision violates public policy when applied to bar recovery of the insured’s unreimbursed loss; (2) the equitable principles underlying subrogation are not implicated because the insured will not obtain a “double recovery” of its loss; (3) because the insurer accepted a premium for assuming a risk of loss, its subrogation interest should yield to the insured’s interest in full compensation for its loss; and (4) as between an insurer and its insured, the insurer is better able to spread the risks of unreimbursed losses among multiple policyholders.

While courts have not adopted uniform principles in dealing with such issues, even under the analysis in the Vesta decision (and certainly under the rulings in Century Indemnity, Sphere Drake Underwriting, and Crown Central), the court should be willing to allow a policyholder to “insure” its SIR obligation either by other insurance that it procures directly or by insisting that its subcontractor cover that risk by naming the self-insured policyholder as an “additional insured.” Moreover, there is no sound policy reason why the same result could not be accomplished through a specific, contractual indemnity clause or perhaps even by settlement. Thus, when structuring settlements, the practitioner should review the applicable state’s law regarding actual payment” to determine whether a partial or complete credit may be deemed to satisfy the SIR. If the governing law interprets the policy provision to require an SIR to be exhausted by “cash actually paid,” then considerable flexibility in structuring a complex settlement may be lost.

Practitioners should be especially mindful of choice of law provisions in evaluating coverage disputes. Like no other area of the law, choice of forum is often outcome determinative in complex insurance coverage disputes. Before filing any action against an insurer, whether it be
for bad faith, declaratory judgment, or other relief, the practitioner must carefully review the forum’s choice of law provisions to determine which state’s law will govern issues of complete compensation, subrogation, allocation, bad faith, and satisfaction of a self-insured retention. Similarly, applicable law characterizing contractual indemnity, deductibles, or an SIR as “insurance” may be outcome determinative.

§ 2.05 SUGGESTIONS FOR RESOLUTION OF SUBROGATION ALLOCATION DISPUTES

As illustrated by the cases discussed above, and as stated by Professor Keeton, the precedents addressing allocation of losses between excess carriers, primary carriers, and self-insured or partially self-insured policyholders continue to be unsettled in application and “rather inconclusive in principle?” The lack of clear precedent suggests that parties faced with significant personal injury and property damage claims resulting from a construction accident should carefully explore a variety of settlement options in negotiating to share responsibility for the loss, including responsibility for absorbing the portion of the loss that is not reimbursed by indemnity or other insurance. Basic principles of construction risk management and insurance suggest that in assigning responsibility, the carrier whose underwriting department assumed the risk of loss and the indemnitor actually at fault should bear the greatest percentage of the financial exposure.

Insurers may argue that the premiums they charge are appropriately reduced and that their subrogation clauses carefully drafted to account for an insured’s “retained risk”; but such an argument has little persuasive force, especially if made by a carrier who is not a direct party to the SIR or deductible arrangement. Most SIR or deductible clauses are not drafted with the expectation that some or all of the loss may be recoverable from a third party; therefore, such clauses do not address subrogation allocation issues. Moreover, when an underlying, partially or wholly self-insured “layer” of coverage is deemed satisfied by settlement or otherwise, there is no reason that the excess carrier should not be called upon to bear full responsibility for all losses within its policy limits without insisting on priority to payments made by third parties. Thus, the “last in/first reimbursed” priority rule works well when applied to competing subrogation claims by different insurance carriers, but the rule does not specifically address relative priorities between carriers and policyholders who are partially self-insured.

When the allocation rules are unclear, as they often are, policyholders who are partially self-insured should consider negotiating with their carriers to share any future recovery from third parties, to share the risks of no recovery, and to take into account potential recoveries from recalcitrant carriers or carriers who improperly decline to participate in the settlement process. If carriers refuse to negotiate a reasonable solution, self-insured policyholders faced with large construction-related claims should consider using the following guidelines to maximize their potential recovery from third parties and to minimize the risk of a significant, unreimbursed loss:

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88 See note 4, supra, and accompanying text.
• Review available insurance coverages and notify all potentially responsible primary and excess carriers as soon as practicable after a loss. Late notice of the claim is a viable coverage defense; and depending on the jurisdiction, a late notice defense may be upheld regardless of any prejudice to the carrier.

• Immediately forward all suit papers or third-party demands to primary and excess carriers. Notice of a lawsuit and the allegations contained therein will be the trigger for a duty to defend, if any.

• Even if a carrier has no obligation to defend or has been unwilling to defend the claim, the carrier should be invited to participate in any settlement negotiations, especially if negotiations are commenced before a lawsuit or demand for Arbitration is filed. If the carrier refuses to become involved, it may be considered to have waived any objections to the reasonableness of the settlement and to a rational allocation of settlement payments and any indemnity contributions from third parties.

• If carriers participate in settlement negotiations or attend a settlement conference before the presiding judge, the insured should seek to clarify its right to allocate contributions from other insurance and indemnity sources to satisfy any SIR or deductible, asking the insurer to commit to the proposed allocation.

• Do not sign a separate subrogation agreement or form that assigns all rights to collect from third parties to the carriers without considering the potential for reimbursement of the SIR. Instead, if reimbursement from other insurance or an indemnitor is potentially available, consider asking the carrier to pay some or all of the SIR as consideration for a complete assignment to the carrier of any rights to pursue the other insurers or the indemnitor in the name of the insured.

• If the plaintiff is willing to enter into a “reasonable” settlement and the carrier is not, consider offering a sum of money that is less than the SIR, conditioned on receiving credit for the full SIR amount, while agreeing to allow the plaintiff to pursue claims against any carriers who refuse to participate in the settlement.

• If the various interested parties cannot agree to a proper allocation of settlement payments, be prepared to assign policy rights to whichever party is willing to cooperate and to protect your interests. Thus, if an excess carrier is concerned about settling a potentially catastrophic loss and a primary insurer is recalcitrant or acting in bad faith by refusing to settle, an assignment to the plaintiff or perhaps to another carrier of rights to sue the non-participating carrier may reduce or eliminate a large, out-of-pocket loss.

• Understand the law, understand the policies, and, within the boundaries of good faith and the forum’s rules, be creative in resolving claims by negotiating agreements that maximize all available coverage, that satisfy some or all of the insured’s SIR, and that otherwise eliminate the cost and risks of lengthy litigation or arbitration of disputes arising out of construction-related claims.