

**THE INSURER/INSURED RELATIONSHIP
IN SUBROGATION**

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I. INTRODUCTION

The doctrine of subrogation enables an insurer that has paid an insured's loss pursuant to a property insurance policy to recoup the payment from the party responsible for the loss.

Essentially, the principle of subrogation permits one (i.e., the insurer) who is legally obligated to pay the debt of another to "stand in the shoes" of the person owed payment (i.e., the insured) and enforce that person's right against the actual wrongdoer.

Several policy considerations underlie the doctrine of subrogation. First, subrogation has its genesis in the principle of indemnity. Although an insured is entitled to indemnity from an insurer pursuant to coverage provided under a policy of insurance, the insured is entitled only to be made whole, not more than whole. Subrogation principles normally prevent an insured from obtaining one recovery from the insurer under its contractual obligations and a second recovery from the tortfeasor under general tort principles. Additionally, subrogation rights enable the insurer to recover payments made to the insured, who theoretically should have been made whole through those payments. Finally, subrogation advances an important policy rationale underlying the tort system by forcing a wrongdoer who has caused a loss to bear the burden of reimbursing the insurer for indemnity payments made to its insured as a result of the wrongdoer's acts and omissions. This rationale has been termed the "moralistic basis of tort law as it has developed in our system."

Modern legal principles have divided subrogation into two basic categories reflecting how the right of subrogation arises. Legal subrogation, also known as equitable subrogation, arises when an insurer fulfills its obligations to an insured pursuant to the contract of insurance

and, in fact, that obligation should have been paid by another, i.e., the tortfeasor. This right arises in the absence of contractual language granting a right of subrogation.

Conventional subrogation, also known as contractual subrogation, arises by virtue of contract or agreement. Conventional subrogation arises when an insurance policy specifically grants a right of subrogation to the insurer. In this regard, insurance policies routinely include a provision entitling the insurer, on paying a loss, to be subrogated to the insured's right of action against any person whose act or omission caused the loss or who is legally responsible to the insured for the loss caused by the wrongdoer. Conventional subrogation also may arise when the insured specifically assigns its claim to the insurer by way of a subrogation receipt.

Subrogation, like other aspects of the legal relationship between an insured and insurer, is influenced by a number of different legal sources in the United States. First and foremost, the contract of insurance between the insurer and insured sets forth the basic obligations and duties between them by specifically enumerating the obligations of the respective parties. To a lesser extent, custom and usage also play a role in filling in many of the gaps in the express contract language of a policy.

Increasingly, however, the relationship between the insured and insurer is being influenced by administrative, judicial and legislative forces in the United States through the enactment and implementation of "Unfair Claim Settlement Practices" legislation and regulations, and the recognition by courts that an insurance contract creates a fiduciary relationship between the insured and insurer. This is known as the implied covenant of good faith and fair dealing in every insurance contract. When a fiduciary relationship exists, the insurer must "strike a proper balance" between acting in its own best interests and protecting the interests of its insured. As a result of that relationship, the parties (primarily the insurer) are

required to act in good faith in the performance of their express and implied obligations under the insurance contract.

II. THE DUTIES OF THE INSURER AFTER A LOSS

A. The Insurer's Implied Duty to Investigate in Good Faith

It is now widely recognized in courts in the United States that an insurer has a duty to ⁴⁶ act fairly and in good faith in discharging its contractual responsibilities." In fulfilling this duty, an insurer must investigate the claims of its insured promptly and thoroughly. As a fiduciary, the insurer's claims investigation must take into account the interests of the insured as well as those of the insurer. It has been stated by several courts that the duty of the insurer to conduct its claims investigation in good faith is unconditional and not dependent on the insured's performance of its contractual obligations. The insurer must not take a groundless position or fail to adequately investigate its own position. Moreover, an insurer's duty to investigate the insured's claim fairly, in good faith, is not affected by the insured's commencement of an action against the insurer for breach of the duty of good faith. An insurer's exposure to extra-contractual liability as a result of its breach of its duty of good faith and fair dealing can be substantial; accordingly, the investigation process should be carefully planned, monitored and executed to avoid bad faith claims.

B. Other Obligations Imposed on Insurers

Most states have enacted legislation prohibiting insurers from engaging in "unfair insurance practices." Unfair claim settlement practices are generally defined as including the following practices (either individually or with such frequency as to indicate general business practice):

- (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- (b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- (c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- (d) Refusing to pay claims without conducting a reasonable investigation based upon all available information;
- (e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;
- (f) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear (applicable to liability insurance policies);
- (g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;
- (h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made party of an application;
- (i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;
- (j) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;
- (k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- (l) Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;
- (m) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

- (n) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

Although a few of these practices relate to liability insurance policies, most of these are also applicable to property insurance. Furthermore, even though the statutory prohibitions in the various Unfair Insurance Practices Acts are typically enforced by the State Insurance Commissioners, courts are increasingly finding ways to apply these standards to coverage disputes. The damages awarded for one or more violations of these standards vary significantly from state to state. However, damages can comprise actual and consequential damages, attorney's fees, inflated interest charges, fines, mental distress damages and punitive damages.

III. CONTRACTUAL DUTIES OF THE INSURED AFTER A LOSS

The insurance contract ordinarily requires the insured to cooperate with the insured in the insurer's investigation of a claim under the contract. Such cooperation clauses have been upheld by the courts as valid. Indeed, a few courts have even extended the duty of good faith and fair dealing to the actions of an insured. Unlike English law, however, the concept of an insured's duty of good faith and fair dealing to an insurer has not been widely acknowledged in American case law. In fact, only a few cases have recognized such a duty exists. For example, in Commercial Union Assurance Co. v. Safeway Stores, Inc., 26 Cal. 3d 912, 610 P.2d 1038, 164 Cal. Rptr. 709 (1980), the court held that the "duty of good faith and fair dealing in an insurance policy is a two-way street, running from the insured to his insurer and vice-versa." 26 Cal. At 918, 610 P.2d at 1041, 164 Cal. Rptr. At 712. More recent decisions have similarly recognized the obligation of good faith on the part of the insured. See e.g., Greater New York Mutual Insurance Co. v. North River Insurance Co., 872 F.Supp. 1403, 1408 (E. D. Pa. 1995) ("Pennsylvania would apply the duty to act in good faith to 'each party' to an insurance contract,

including the insured"); Johnson v. Farm Bureau Mutual Insurance Co., 533 N.W. 2d 203 (Iowa 1995) ("insurance contracts contain an implied covenant of good faith that 'neither party will do anything to injure the rights of the other in receiving the benefits of the agreement'"); Twin Cities Fire Ins. Co. v. Country Mutual Insurance Co., 23 F.3d 1175, 1189 (7th Cir. 1994) ("The duty of good faith between insured and insurer is a reciprocal one... and though some courts have trouble seeing this, ...we have no reason to suppose that Illinois courts would suffer from this obtuseness.")

Even in those jurisdictions that have not yet recognized a duty of good faith on the part of an insured, the insured's duties to the insurer ordinarily extend beyond mere cooperation. For example, a typical policy provision regarding the duties of the insured in the event of loss or damage provides as follows:

You must see that the following are done in the event of loss or damage to Covered Property:

- (a) Notify the police if a law may have been broken.
- (b) Give us prompt notice of the loss or damage. Include a description of the property involved.
- (c) As soon as possible, give us a description of how, when and where the loss or damage occurred.
- (d) Take all reasonable steps to protect the Covered Property from further damage. If feasible, set the damaged property aside and in the best possible order for examination. Also keep a record of your expenses, for consideration and in the settlement of the claim.
- (e) At our request, give us complete inventories of the damaged and undamaged property. Include quantities, costs, values, and amount of loss claimed.

(f) Permit us to inspect the property and records proving the loss or damage.

(g) If requested, permit us to question you under oath at such times as may be reasonably required about any matter relating to this insurance of your claim, including your books and records. In such event, your answers must be signed.

(h) Send us a signed, sworn statement of loss containing information we request to settle the claim. You must do this within 60 days after our request. We will supply you with the necessary forms.

(i) Cooperate with us in the investigation or settlement of the claim.

It is within the context of the insured's contractual duty to cooperate and the insurer's implied duty of good faith and fair dealing that an insured's claim is investigated.

IV. COMPLYING WITH THE EXPRESS AND IMPLIED OBLIGATIONS

Compliance with contractual, statutory and common law obligations in a potential subrogation loss begins when the loss occurs.

A. Purpose of the Investigation Factors to be Considered

The purpose of the claims investigation is twofold, namely, to determine whether the claim is covered under the policy and, if it is, to ascertain the extent of the loss.

In determining whether the loss is covered under the policy, the insurer should generally consider the following:

- *Accuracy and completeness of the insurance application* - A misrepresentation in the application may serve as a basis for voiding the policy.
- *Status of the policy at the time of the loss* - If the policy was not in effect at the time of the loss (due to non-payment of premiums, expiration of the term of the policy or cancellation of the policy, for example) the loss will not be covered.

- *Perils insured against; exclusions, conditions* - Unless the policy is an all-risk policy, the perils insured against are the measure and the scope of the coverage. If the peril that causes the loss was not insured against, the loss would generally not be compensable under the policy. If the peril was insured against, the satisfaction of all policy conditions and the inapplicability of all policy exclusions should be reviewed to determine coverage of the claim.

When it is established that the loss is covered under the policy, the insurer should turn to ascertaining the extent of the loss. In making this determination, the adjuster should take into account the following:

- *Policy limit* - The specific coverages of the policy, as set forth on the cover or "declarations" page of the policy, must be reviewed to determine the policy cap on the loss.
- *Insured's inventory of loss* - The inventory (together with all bills, receipts and other related documents of the insured), which the insured is ordinarily required under the policy to submit, should be carefully reviewed.
- *Property method of valuation* - The insurer must determine whether the loss is to be valued on an "actual cash value" basis or on a "replacement cost" basis.
- *Rights of mortgage* - Under the standard mortgage clause, the mortgagee is entitled to insurance proceeds in the event of a loss. Under an "open" loss-payee clause, however, a mortgagee has no greater rights than the insured; thus, the failure of the insured to satisfy a policy condition precludes recovery by a loss payee under such a clause. Additionally, a mortgage clause often imposes affirmative duties on the mortgagee, which are a condition to recovery under the policy.
- *Additional policies* - Additional coverage may be prohibited by the policy. Where additional policies are allowed, however, they might provide primary coverage or pro-rate coverage of the loss.
- *Subrogation action* - The insurer should consider the possibility of bringing a subrogation action against a third-party wrongdoer, if any. The insurer will need to preserve evidence and legal proof of damages if a subrogation action is found to be appropriate.

B. The Investigative Process

(1) The adjuster and other participants of the investigation

For the most part, the claims investigation will be conducted by the insurer's adjuster. As a representative of the insurer, the adjuster must take care that his conduct does not adversely affect the right of the insurer. For example, an adjuster's actions in investigating a loss can result in a waiver, binding on the insurer, of certain of the insurer's rights.

Where appropriate, an accountant and an attorney will also be involved in the investigation of a claim. An accountant will be needed when the claim involves a large commercial loss; when a claim for business interruption coverage is made; and, generally, when the claim involves the interpretation of financial data. An attorney should be involved early on in the investigative process to ensure that policy defenses are not waived and that evidence supporting any applicable policy defense is gathered and preserved.

(2) The claims file

The claims file should contain all correspondence, notes and other material relevant to the claim. It should describe in detail all pertinent events and set forth the date on which such events occurred. Any discussion with the insured should be recorded in the file in an objective manner. The claims file should be kept up to date by the filing of notes and memoranda on a regular basis; the status of the case must be readily apparent to anyone reviewing the file at any given time.

(3) Ascertaining whether the claim is covered

(a) Term of the policy

The adjuster should first review the loss report to determine the inception and expiration date of coverage under the policy. If the loss did occur during the term of the policy, the adjuster should investigate further to determine if the policy was renewed. If the policy provides-for an

automatic renewal, the cancellation provisions will need to have been complied with for there to have been complied with for there to have been an effective cancellation of the policy. The adjuster should consult with the insurer's underwriting department to ascertain whether the policy was cancelled and, if it was, the adjuster should secure proof of the mailing of the notice of cancellation.

The adjuster should also determine whether premiums have been paid as required under the policy. If a premium was not paid, the adjuster should advise the underwriting department not to accept any late payment of a premium under the policy. In this way, the insurer might be able to avoid liability for losses that occur after the offer of continuous coverage under the policy has expired.

Additionally, the adjuster should inquire of the agent and the underwriting department whether the insured ever requested that the policy be cancelled and whether such cancellation was ever effected. The agent should also be asked whether the insured procured insurance for the property at issue from another insurer. If the insured obtained other insurance, counsel should be consulted with regard to the possible defense that the policy was effectively cancelled by the insured's obtaining coverage from another carrier.

(b) General review of the policy

At an early stage of the investigation, the adjuster should review the insured's policy to clarify the following issues:

1. What types of coverage does the claim involve?
2. What is the scope of each type of coverage involved in the claim? Specifically, what perils are covered?
3. If the policy covers the claimed loss, what are the limits of liability?

4. Are any aspects of the loss not covered?
5. Who is entitled to recover under the policy?
6. Has there been any suspension of coverage?
7. Are there any exclusions from coverage that might affect the claim?
8. Does the policy contain any restrictive endorsements that might affect the insurer's liability?

The following are examples of those situations, which frequently give rise to a finding that the claim is not covered under the policy:

- Coverage for the reported loss was obtained by endorsement only after the date of the loss.
- Coverage for the reported loss was cancelled after the inception of the policy but prior to the date of loss.
- Coverage for the reported loss was never purchased.

(c) **Notice of loss**

Upon receipt of the notice of loss, the insurer should forward to the insured all forms (including, for example, a form of proof of loss) that the insured will need to complete in connection with the claim.

The adjuster should compare the date when the loss occurred with the date when the loss was reported to the insurer. Late notice may provide for a defense to a claim if the insurer was prejudiced by the late notice. Any police reports should be reviewed to determine whether the loss was timely reported to the police, if required under the policy.

(d) **Request for documentation**

The adjuster should provide the insured with all information necessary for filing the claim. At this time, the adjuster should also request in writing that the insured submit

documentation in support of the claim. Such request should be as specific as possible. If an ongoing investigation appears warranted, the insurer should send a letter reserving its rights, or request the insured to enter into a non-waiver agreement. If the insurer needs more time to determine whether to pay or deny the claim, it should give the insured a written explanation of why more time is needed. All communication with the insured should be objective and prompt. The adjuster should obtain from the insured a written statement covering the loss and a list of the names of witnesses. Written statements from witnesses should then also be obtained.

(4) Determining the extent of the loss

Under the policy, the insurer is generally entitled to a detailed inventory of the items claimed by the insured, as well as any bills, receipts and other documents substantiating the insured's loss. It is important to note that some courts have held that the insurer is entitled to demand compliance with such policy requirements before allowing recovery. In order to enforce these requirements, the insured must give proper notice and the request for documents by the insurer must be specific. It should be noted that the right to examine documents pursuant to the policy's cooperation clause is generally broader than discovery under the civil rules of procedure.

At the scene of the loss, the adjuster should be able to form some idea of the pre-loss condition of the insured's business or home. If a business loss is claimed, the adjuster should request the insured to produce the books and records required by the policy to substantiate the loss. The adjuster may need to consult with an accountant to review these records for accuracy, completeness and relevancy.

The adjuster should attempt to obtain photographs of the property that were taken prior to the loss, after which the adjuster should determine the appropriate depreciation factor by considering the age of the property and its pre-loss condition.

The major part of the investigation in connection with determining the extent of the loss consists of gathering documents and analyzing the information contained in them. If any documentation submitted by the insured is incomplete or if additional documentation is needed, the insurer should promptly so advise the insured. It should be kept in mind, however, that an insurer's request for documents must be specific, reasonable and related to the property at issue.

C. Spoliation of Evidence

In the process of investigating an Insurance claim, an insurer must take special care in its treatment of objects relating to that claim that could potentially be used as evidence in a court proceeding. If an object is destroyed by an insurer, whether intentionally or otherwise, the insurer may either be subject to civil discovery sanctions or perhaps an independent claim for spoliation of evidence," which is defined as "the destruction, or the significant and meaningful alteration of a document or instrument."

V. APPORTIONMENT OF RECOVERY

One of the more potentially contentious issues that may arise in a subrogation claim occurs when the insurance proceeds do not compensate fully for damages sustained as a result of a loss. When this occurs, the insurer has a right to subrogate against a third party deemed responsible for the loss; the insured also is entitled to seek full compensation for its losses from the third-party tortfeasor. In such a case a fundamental issue arises as to the apportionment of any recovery between the insured and the insurer. While the language of the standard property insurance policy and subrogation receipt provides for a right of subrogation, these documents are normally silent on the issue of how to allocate any subrogation recovery between an insured and insurer if the insured has suffered an uninsured loss. When the insured has obtained a judgment against the tortfeasor in a third-party action, the judgment is said to establish conclusively the full scope of the insured's damages. In such circumstances, several courts have held that the insurer is entitled to full reimbursement of the payments made to the insured, less its proportionate share of costs and legal fees. These courts have found that an insured should not be allowed to defeat the insurer's subrogation claim by contending that his or her damages were greater than the sums received from the tortfeasor by way of the judgment. As one noted legal commentator stated:

An insured, who sues a wrongdoer and recovers a less amount than demanded, cannot avoid repaying the insurer which cooperated with him in the suit the amount which the insurer had paid him, on the theory that the latter amount, plus the amount of the judgment, did not equal the actual loss.

In these cases the insured instituted the action against the third-party tortfeasor without the insurer's participation. Consequently, the issue of apportioning any recovery between the insured and the insurer was not addressed prior to the commencement of litigation.

In the absence of a judicial determination of damages, it is much more difficult to apportion a recovery obtained from a third-party tortfeasor when the insured contends that he or she is not fully compensated. An insured often settles with a third-party tortfeasor for an amount less than the total loss. Several courts addressing these circumstances have held that the amount of the settlement is not necessarily co-extensive with the amount of damages given the exigencies that may have warranted a settlement. Because an insured, under these facts, should not be deemed to have been fully compensated simply because of the settlement, the apportionment issue necessarily will arise.

A. Legal Commentaries

When the insured is not fully reimbursed for the loss, there is a split of authority among the jurisdictions as to whether the insurer or the insured has a superior interest in amounts recovered from third-party tortfeasors. Professor Robert Keeton, the well-known commentator on insurance law, has summarized various approaches to apportionment of subrogation recoveries between the insurer and insured as follows:

First Rule [*Insurer: Mole Plus*]: The insurer is the sole beneficial owner of the claim against the third-party and is entitled to the full amount recovered, whether or not it exceeds the amount paid by the insurer to the insured.

Second Rule [*Insurer: Whole*]: The insurer is to be reimbursed first out of the recovery from the third-party, and the insured is entitled to any remaining balance.

Third Rule [*Proration*]: The recovery from the third person is to be prorated between the insurer and the insured in accordance with the percentage of the original loss for which the insurer paid the insured under the policy.

Fourth Rule [*Insured: Whole*]: Out of the recovery from the third party the insured is to be reimbursed first, for the loss not covered by insurance, and the insurer is entitled to any remaining a balance, up to a sum sufficient to reimburse the insurer fully, the insured being entitled to anything beyond that amount.

Fifth Rule [*Insured: Whole Plus*]: The insured is the sole owner of the claim against the third-party and is entitled to the full amount recovered, whether or not the total thus received from the third-party and the insurer exceeds his loss.

In general, U.S. courts have avoided the rules providing either the insurer (Rule 1) or the insured (Rule 5) with exclusive rights because of the windfall effect these rules would have. Surprisingly few courts have utilized the proration formulation (Rule 3), despite its apparent logic. Instead, most jurisdictions have adopted the insurer-whole (Rule 2) or the insured-whole (Rule 4) formulation.

Leading legal commentators generally agree that the insurer should have no right of recovery until the insured is made whole (Rule 4). Although most jurisdictions have adopted the insured-whole rule, some follow the insurer-whole rule. Because of the lack of coherence in the rationales employed to reach a particular result, an examination of the case law is helpful to understand the different methods utilized by the courts to apportion damages in these cases.

B. Majority Rule: Insured-Whole

Most courts have held that the insured must be fully compensated for any uninsured loss before the insurer may share in the proceeds of a recovery from the tortfeasor. The "insured-whole" rule has been adopted in Alabama, Arkansas, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New York, North Carolina, Oklahoma,

Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia and Wisconsin.

The United States Supreme Court may be partially responsible for this widespread adoption of the insured-whole rule through its decision in *American Society Co. v. Westinghouse Electric Mfg Co.* In *Westinghouse Electric*, the court held that "[a] surety liable only for a part of the debt does not become subrogated to collateral or to remedies available to the creditor unless he pays the whole debt or it is otherwise satisfied. "

The decision most frequently cited in support of the insured-whole doctrine was rendered by the Wisconsin Supreme Court in *Garrity v. Rural Mutual Insurance Co.* The *Garrity* decision is significant in that the policy in question was a standard 165-line fire insurance policy containing the standard subrogation provision. Moreover, the insurer in *Garrity* obtained from the insured a subrogation receipt providing that the insurer would be subrogated "to all of the rights, claims, and interest which the [insureds] may have against any person or corporation liable for the loss. "

The insureds in *Garrity* suffered a fire loss and were paid \$67,227.12 by their insurer. This payment represented the policy limit. The insureds sought damages in the amount of \$110,000 from a third-party tortfeasor. The tortfeasor's available assets were limited to liability insurance coverage of \$25,000.

The *Garrity* court began its analysis by reviewing the common law regarding subrogation. Under common-law subrogation the court found that the insured must be made whole before the insurer may recover anything from the tortfeasor because the insurer assumed the risk of loss by accepting the insured's premiums. The court concluded, without discussion, that the subrogation provisions in the standard fire insurance policy and the subrogation receipt

did nothing to change the substantive common-law rights of the insured. Accordingly, the court held that the insureds were entitled to be made whole before any monies were paid to the insurer pursuant to its right of subrogation.

In concluding that the insurance contract and subrogation receipt did not alter the common-law rule, the *Garrity* court specifically rejected the reasoning employed by the Ohio Supreme Court in *Peterson v. Ohio Farmers Insurance Co.* The *Peterson* court had recognized that, notwithstanding the general common law rule, the subrogation receipt assigned to the insurer all rights of recovery against the tortfeasor up to its payout, thus according a priority of recovery to the insurer. The Wisconsin Supreme Court summarily rejected this analysis, however, and held that any difference between the right of subrogation and the assignment was "purely procedural" and that absent express contract language to the contrary, such an assignment did to compel the conclusion that the insurer had priority over the insured to any recovery from the tortfeasor.

In reaching the conclusion that the insured's right to be made whole takes precedence, the *Garrity* court stated: "[w]here either the insurer or the insured must to some extent go unpaid, the loss should be borne by the insurer for that is a risk the insured has paid it to assume." It is not at all clear, however, that the risk of a large uninsured loss is one that the insurer has been paid to assume. In fact, a strong argument can be made that such a risk is one that the *insured* has agreed to assume in exchange for the payment of lower insurance premiums. Nevertheless, several courts have relied, at least partially, upon the dubious rationale advanced by the *Garrity* court in adopting the insured-whole rule.

One of the most troubling aspects of the *Garrity* decision is that the court essentially ignored the distinctions between legal and conventional subrogation. In essence, the court

abrogated the contractual basis of conventional subrogation in favor of purely legal subrogation. To date, no court or commentator has criticized the Wisconsin Supreme Court's abrogation of these important legal distinctions. To the contrary, many courts adopting the insured-whole position have ignored the legal distinctions in similar fashion.

Another case frequently cited in support of the insured-whole proposition was rendered by the Montana Supreme Court in *Skauge v. Mountain States Telephone & Telegraph Co.* The policy involved in this case also contained the standard subrogation provision indicating that the company would require an assignment of the insureds' claim against any party liable for their loss. Despite this policy provision, the court applied the general principles of legal subrogation and determined that absent specific contractual terms giving the insurer the right of first indemnity, the insured must be made whole before the insurer could participate in any recovery. As in *Garrity*, the Montana Supreme Court disregarded the policy provision and concluded that the insurer's legal right to subrogation made the policy provision unnecessary and of no effect.

Subsequent to *Garrity* and *Skauge*, the Tennessee Supreme Court adopted the insured-whole rule in *Wimberly v. American Casualty Co.* In *Wimberly*, the insureds' property was destroyed by fire, leading to undisputed damages in the amount of \$44,619. 10. The insureds obtained \$15,000, which represented their policy limit, from their insurer. The tortfeasor had \$25,000 in liability coverage, which apparently represented the total amount recoverable from the tortfeasor. The fire policy issued to the insureds contained the standard subrogation provision, and the insureds signed a standard subrogation receipt. The Tennessee court reviewed the decisions in *Garrity*, *Skauge* and *Peterson*, and the court adopted the decisions in *Garrity* and *Skauge* as the "better-reasoned authority". Interestingly, the *Wimberly* decision was limited by the subsequent Tennessee Supreme Court decision in *Eastwood v. Glen Falls Insurance Co.* The

insureds in *Eastwood* gave the insurer a subrogation receipt providing that no settlement would be made with a tortfeasor without the written consent of the insurer, but they settled without the requisite authority from the insurer. The Tennessee Supreme Court held that the insureds could not enter into such a settlement without incurring further liability to the insurer because they failed to obtain its consent to the settlement. The court distinguished its prior decision in *Wimberly* noting that the insureds in *Wimberly* had sought and received the insurer's consent to the settlement. To clarify its prior holding in *Wimberly*, the *Eastwood* court stated:

Nothing that was said in *Wimberly* diminishes or in any measure affects the obligation of the insured to obtain the written consent of his or her insurer who has subrogation rights prior to a settlement with the tortfeasor. *Wimberly* clearly stands for and all that it stands for is that when an insured has been paid the policy limits of his or her fire policy and the insured and his or her fire insurance carrier have agreed to a settlement with a tortfeasor that when added to the fire insurance proceeds is less than the insured's fire loss the insurer's subrogation rights cannot be enforced, because the insured has not been made whole.

Notwithstanding this rationale, the court readily enforced certain contractual conditions contained in the subrogation receipt while simultaneously disregarding others and the contractual conditions of the insurance policy pertaining to subrogation. *Wimberly* and *Eastwood* thus are irreconcilable in their legal analysis. Most jurisdictions, as demonstrated by *Garrity*, *Skauge* and *Wimberly*, adhere to the proposition that the insured is entitled to be made whole before the insurer may share in any recovery from a tortfeasor. The rationales used to reach this conclusion are varied and untenable at times. Perhaps most untenable is the apparent willingness by the courts to disregard the provisions of the insurance policy and the standard subrogation receipt. Thus, while the insured-whole rule clearly represents the majority position, it is a position without cohesiveness.

C. **Minority Rule: Insurer-Whole**

Although they represent a distinct minority, courts in a number of jurisdictions have held that the insurer is entitled to be made whole first as a general rule. The jurisdictions adopting this rule include California (under certain circumstances), Idaho, Ohio, Virginia, and Wyoming. Moreover, a number of courts have recognized that an insurer is entitled to be made whole first under certain circumstances, even though the jurisdiction's general rule would entitle the insured to be made whole first.

The most frequently cited decision supporting the insurer-whole doctrine was rendered by the Ohio Supreme Court in *Peterson v. Ohio Farmers Insurance Co.* The insureds suffered a fire loss to their barn and other property. They signed a proof-of-loss and standard subrogation receipt and received payment from the carrier in the amount of \$7,814. The insured's loss, however, totaled \$17,629.56.

After the insurance settlement, the insurer and the insureds commenced an action against the tortfeasor. Each party employed its own counsel, who collaborated in conducting the litigation, and each party paid its own expenditures. The insurer and insureds obtained a joint verdict of \$11,514. The parties disputed the division of the proceeds, however, and the insureds filed a declaratory judgment action seeking indemnification up to the full amount of their loss, plus counsel fees and costs. The policy issued to the insureds contained the following provision relating to subrogation:

This company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefore is made by this company.

Moreover, the subrogation receipt signed by the insureds provided.

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 and to execute and sign releases and acquaintances and endorse checks or drafts given in settlement of such claims in the name of the undersigned, with the same force and effect as if the undersigned executed or endorsed them.

Relying upon these provisions, the Ohio Supreme Court found that the insureds had assigned their entire right of recovery, to the extent of payment, to the insurer. Because the court determined that the policy provision and subrogation receipt amounted to an assignment, the court held that the words "all right of recovery" in the policy would be without meaning if the insurer were not accorded priority as to the funds received from the third-party tortfeasor. The court concluded:

In summary then, we conclude that, where the policy subrogation provisions and the subrogation assignment to the insurer convey all right of recovery against any third-party wrongdoer to the extent of the payment by the insurer to the insured, the insurer, who has cooperated and assisted in proceedings against the wrongdoer, is entitled to be indemnified first out of the proceeds of any recovery against the wrongdoer.

Although the *Peterson* Court predicated its decision on the express language of the insurance policy, the Ohio Supreme Court later found the insurer entitled to priority in the proceeds based on equitable principles of subrogation. In *Ervin v. Garner*, the court held that an insured is not entitled to be made whole first from the proceeds of the recovery if the insured refuses cooperation and assistance from the insurer. As such, under the law in Ohio, only when an insurer refuses to cooperate in the pursuit of a third-party recovery is the insured entitled to be made whole first.

Interestingly, two recent pronouncements of the law in Ohio emphasize the significance of the policy language in resolving the apportionment issue. In *Aetna Life Ins. Co. v. Martinez*,

the Ohio Court of Appeals held that a medical reimbursement agreement provided specifically for proration of the recovery between insured and insurer where full recovery was not obtained from the wrongdoer. Also, in *Risner v. Erie Insurance Co.*, the Ohio Court of Appeals held that the specific and unequivocal language of a subrogation clause in an automobile policy granted the insurer an unqualified right of subrogation to the entire amount paid under the policy. Consequently, although the Ohio cases may be interpreted to provide for an insurer-whole rule, one must scrutinize the contractual language at issue before concluding that the insurer is entitled to be made whole first.

D. When an Insured Impairs a Claim

The insurer-whole rule also has arisen in cases in which the insured has impaired or prejudiced the insurer's rights. In such circumstances several courts have held that the insurer is entitled to be made whole first from any recovery from a third-party tortfeasor, even though the jurisdiction's general rule is to the contrary. In *North River Insurance Co. v. McKenzie*, for example, the insureds suffered property damage and received \$2,537 from their insurer. This payment constituted the limit payable under the policy. The insureds then started an action against the tortfeasor, alleging total property damage of \$7,500. Without notice to the insurer, the insureds subsequently settled their claim against the tortfeasor for \$5,982.15. The insurer subsequently commenced an action against the insureds, seeking repayment of the \$2,537 paid under the insurance contract. The Alabama Supreme Court held that equitable principles dictated that the insured reimburse the insurer for the payment made under the policy. In effect, the court held that when an insured accepts from the insurer the amount of the policy for damage to his property and thereafter settles his claim against the tortfeasor to the detriment of the insurer, the insurer is entitled to recover from the insured the amount paid on the policy

without necessarily demonstrating that the settlement exceeded the actual loss less the amount paid on the policy.

Similarly, in *Winkelman v. Excelsior Ins. Co.*, the New York Court of Appeals held that "an insurer who has paid its insured the full amount due under a fire policy, but less than the insured's loss, may proceed against the third-party tortfeasor responsible for the loss before the insured has been made whole by the tortfeasor. " In *Winkelman*, the New York Court of Appeals concluded that since an insurer's rights of subrogation arise upon payment of the loss, an insurer who has paid the policy limits may proceed as subrogee against the negligent third party to recoup the amount paid on the policy, even though the insurance proceeds do not fully compensate the insureds' losses. Such subrogation does not prevent the insured from suing for the amount of loss not covered by insurance. The *Winkelman* court reasoned that " [i]f the insurer is required to forego its rights while the insured delays asserting its claim against the third party, as [insureds] did here, the delay may compel the insurer to litigate a stale claim, or worse, may result in its action being time barred." Although some may interpret *Winkelman* as adopting the insurer-whole rule, it is more likely a fact specific result recognizing the insurer's subrogation rights in the context of the insureds failure to promptly prosecute a third-party claim.

E. Other Exceptions to the Insured-Whole Rule

The insurer-whole rule also has been recognized when the insured receives full payment for only a portion of his or her total damages in an action against a third-party tortfeasor. Several courts have held that when amounts recovered against a third-party for separate elements of a claim can be identified and attributed toward subrogation claims, an insurer is entitled to subrogation for payments made even though other elements of the third-party claim may not be fully satisfied. Finally, many courts adhering to the insured-whole rule have held that the parties

may modify the insured-whole rule by express terms in their contract. The Indiana Court of Appeals, for example, has recognized that certain subrogation provisions in an insurance policy may be sufficient to modify the insured-whole rule. In *Mutual Hospital Insurance, Inc. v. MacGregor*, the insured was injured in an automobile accident and incurred medical expenses in the amount of \$5,168.58. These were paid by the insurer. The insured then commenced an action against the tortfeasor, which was subsequently settled for \$10,000. The settlement amount equaled the limit of the tortfeasor's liability coverage. The insurer, Blue Cross-Blue Shield, brought suit against the insured to recover the \$5,168.58 payment.

The policy at issue provided, in pertinent part:

In the event of any payment for services under this policy, Blue Cross-Blue Shield shall, to the extent of such payment be subrogated to all the rights of recovery of the Member or Dependent arising out of any claim or cause of action which may accrue because of the alleged negligent conduct of a third-party.

The court noted that "[a]n insurance policy is a contract and the rules governing the construction of contracts generally apply to the construction of a policy or contract of insurance.

" Considering the insurance policy at issue, the court held that the insured was obligated to reimburse the insurer from any monies received from the tortfeasor. Notwithstanding the result in the *Mutual Hospital* case, many courts have found similar policy provisions insufficient to modify the insured-whole rule. Moreover, several courts have found that any contractual attempt to modify the insured-whole rule is fundamentally inequitable and will not be permitted.

VI. THE LITIGATION AGREEMENT

Because of the divergent and often untenable rationales employed by the courts in apportioning recoveries, insureds and insurers should enter into a litigation agreement when pursuing claims against a tortfeasor. Known as a proration agreement, it is the soundest method

of resolving the apportionment of damages issue. Like any contract, a litigation agreement is negotiable, but it typically provides for the sharing of recovery and expenses based on the percentage each party's recoverable loss bears to the entire recoverable loss. For example, when the insured has sustained a total loss of \$100,000 and the insurer has paid the insured the limit of a \$60,000 policy, a litigation agreement would provide for a sharing of any recovery, as well as expenses, on the basis of a 40 percent share for the insured and a 60 percent share for the insurer.

An important issue to consider in preparing a litigation agreement is calculating the "loss" for both the insurer and the insured. It is important to note that the insured's right to recover damages in excess of those paid by the insurer is governed by the law of the local jurisdiction on recoverable damages, not by the total amount for which an insured could have been insured. Generally speaking, the right to recover for damage to real property is limited to the diminution in the fair market value of the property or the cost of replacement, whichever is less. Therefore, if the insured has received payment of a certain sum for property losses under a replacement cost policy, but the diminution in value of the damaged property is a smaller amount, the insured may be considered to have been "made whole" under general principles of damage law even though a substantial deductible remains on the replacement cost policy. A litigation agreement also should express some legally valid consideration. In the subrogation context the consideration typically is found when the insurer promises to pay for all expenses associated with the attempts to recover the damages caused by the actual tortfeasor. Such expenses may include fees paid to expert witnesses, travel expenses, and copying costs. A good litigation agreement also should provide that the insured will cooperate fully with the insurer in the pursuit of a recovery and, most important, that the insurer may prosecute and control any lawsuit in the name of the insured alone.

The issue of adequate consideration is a difficult aspect of litigation agreements. On the one hand, the insurer is contractually obligated to pay its insured for a covered loss. On the other hand, it is essential that the insurer give something of value (i.e., recovery of uninsured damages) to its insured beyond that for which it is already contractually obligated. Otherwise the litigation agreement might be unenforceable for lack of consideration. Additionally, the timing of the "consideration" may be important. Some courts have relied primarily on the timing of the execution of the litigation agreement (before or after the execution of a loan or subrogation receipt) as a basis for determining the agreement's validity and for determining whether the agreement or the receipt controls the lawsuit.

To avoid future misunderstandings (and possible conflicts of interest for counsel), a litigation agreement also should address all possible contingencies that may arise in the litigation, such as attorney fees; uninsured damages; litigation costs; punitive damages; and authority to settle, litigate, and counterclaim.

Several jurisdictions have recently addressed the efficacy of proration agreements as a means of apportioning recoveries between insureds and insurers. In the seminal case of *Culver v. Insurance Co.*, New Jersey courts addressed the validity of proration agreements. In *Culver*, the insured suffered damages in a fire loss estimated at \$185,000. The insurer paid its policy limits of \$82,373.12, leaving an uninsured loss of \$103,000. The insurer took a total assignment of rights and started a subrogation action against the alleged tortfeasors. The insured and the insurer entered into a proration agreement under which 80 percent of any recovery would be paid to the insurer and 20 percent to the insured. The risks of litigation, the questionable potential for a recovery, and the expenses associated with litigation were discussed before entering into the Proration Agreement.

The claims against the alleged tortfeasors ultimately yielded \$160,000 in settlement proceeds. The proceeds were allocated in accordance with the Proration Agreement - \$92,000 to the insurer, \$23,583.33, to the insured and \$44,416.67 for attorneys' fees and costs. Significantly, the insurer was made more than whole as a result of the proration.

The trial court affirmed the distribution of the settlement proceeds, and the insured commenced a collateral action seeking to avoid the proration agreement and vacate the distribution order. The court in that action granted summary judgment in favor of the insurer, holding that the doctrine of res judicata barred the collateral action.

The Appellate Division of the New Jersey Superior Court reversed the decision, finding that the proration agreement was unenforceable as a matter of public policy. The court further held that, pursuant to common-law principles, the insured was entitled to be made whole, to the full extent of her loss, prior to any distribution to the insurer. Thus the insurer was limited to recovering the amounts it had paid. In concluding that the agreement should be set aside, the court stated:

We think it clear then that the facts of record here support plaintiffs' claim for relief from the order enforcing their agreement with INA. At the least, if there are material facts which might yet be the subject of dispute, plaintiffs are entitled to the opportunity to prove their right to relief.

The New Jersey Supreme Court reversed, holding that res judicata barred the insured's action. While the court did not consider the enforceability of the particular litigation agreement in question, it did uphold the general principle that the parties may vary, by contract, the common-law rule entitling the insured to be made whole first from any recovery from a tortfeasor.

The New Jersey Supreme Court's decision in *Culver* appears to recognize the validity of litigation agreements that are fair and equitable. Obviously, caution should be utilized in drafting a litigation agreement so as to ensure that the insurer is not made more than whole while leaving an insured less than whole.

VII. CONCLUSION

There are several potential pitfalls that can arise during the course of a subrogation loss. Given the strict obligations required of the insurer and insured, but particularly the insurer, an insurer can easily find itself defending its actions. However, virtually all criticism of an insurer's practices can be prevented through timely and prudent actions. By promptly initiating a proper investigation of a loss and negotiating a satisfactory and enforceable agreement to apportion damages, among other things, an insurer can avoid the pitfalls on its way to recovery of a loss.

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