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COURT OF APPEALS, DIVISION 1  
OF THE STATE OF WASHINGTON

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AMERICAN STATES INSURANCE COMPANY, in its own right and as  
assignee of JASON MUN and ALEXANDER MUN, d/b/a  
PROFESSIONAL HOMEBUILDERS, a Washington partnership,

Respondent,

v.

CENTURY SURETY COMPANY, a foreign insurance company,

Appellant.

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APPELLANT'S REPLY BRIEF

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**TABLE OF CONTENTS**

I. SUMMARY .....1

II. ARGUMENT .....3

    A. To Obtain Summary Judgment on Its Claim  
    Against Century, ASIC's Burden Was to  
    Eliminate the Possibility That It Paid the  
    Arbitration Award Because of Either a  
    Contractual or an Extra-Contractual Duty. ....3

    B. Coverage Under the '98-'99 ASIC Policy Is a  
    Triable Issue of Fact. ....6

        1. The Record Contains Evidence of Damage  
        During the Period of the '98-'99 ASIC  
        Policy. ....6

        2. Coverage Under the '98-'99 ASIC Policy  
        Would Preclude Coverage Under the  
        Century Excess Policy. ....10

    C. ASIC's Extra-Contractual Liability for the  
    Arbitration Award Is a Triable Issue of Fact. ....14

        1. ASIC Would Have No Right to Recovery  
        from Century if It Was Liable to PHB for  
        Breach of Its Duty to Pursue Settlement. ....14

        2. The Record Contains Evidence of ASIC's  
        Breach of Its Duty to Pursue Settlement. ....18

    D. ASIC Has No Right to Recover Its Attorney Fees  
    from Century. ....20

III. CONCLUSION .....22

**TABLE OF AUTHORITIES**

<b>CASES</b>	<b>Page(s)</b>
<i>Cadet Mfg. Co. v. American Ins. Co.</i> , 391 F. Supp. 2d 884 (W.D. Wa. 2005) .....	11
<i>City of Phoenix v. Com/Systems, Inc.</i> , 706 F.2d 1033 (9th Cir. 1983) .....	7
<i>Essex Ins. Co. v. Heck</i> , 186 Cal. App. 4th 1513, 112 Cal. Rptr. 3d 915 (2010).....	2-5, 14
<i>Fireman's Fund Ins. Co. v. Maryland Cas. Co.</i> , 21 Cal. App. 4 <sup>th</sup> 1586, 26 Cal. Rptr. 2d 762 (1994).....	16-18
<i>First State Ins. Co. v. Kemper Natl. Ins. Co.</i> , 94 Wn. App. 602, 971 P.2d 953 (1999).....	14
<i>Hash v. Children's Orthopedic Hosp. &amp; Medical Center</i> , 110 Wn.2d 912, 757 P.2d 507 (1988).....	6-8
<i>McGreevy v. Oregon Mut. Ins. Co.</i> , 128 Wn.2d 26, 904 P.2d 731 (1995).....	22
<i>Millers Cas. Ins. Co. v. Briggs</i> , 100 Wn.2d 9, 665 P.2d 887 (1983).....	16
<i>Olympic Steamship Co. v. Centennial Ins. Co.</i> , 117 Wn.2d 37, 811 P.2d 673 (1991).....	21
<i>Polygon Northwest Co. v. American Natl. Fire Ins. Co.</i> , 143 Wn. App. 753, 189 P.3d 777 (2008).....	1, 11-12, 20-21
<i>Port of Seattle v. American Natl. Ins. Co.</i> , 1998 U.S. DIST. LEXIS 23038 (W.D. Wa. 1998) .....	11
<i>Puritan Ins. Co. v. Canadian Universal Ins. Co.</i> , 775 F.2d 76 (3d Cir. 1985).....	19

<i>Security State Bank v. Burk</i> , 100 Wn. App. 94, 995 P.2d 1272 (2000).....	8
<i>Sequoia Ins. Co. v. Royal Ins. Co. of America</i> , 971 F.2d 1385 (9th Cir. 1992) .....	20
<i>Truck Ins. Exch. v. Century Indem. Co.</i> , 76 Wn. App. 527, 887 P.2d 455 (1995).....	14
<i>Valentine v. Aetna Ins. Co.</i> , 564 F.2d 292 (9th Cir. 1977) .....	15
<i>Wear v. Farmers Ins. Exch.</i> , 49 Wn. App. 655, 745 P.2d 526 (1987).....	7

## I. SUMMARY

American States Insurance Company ("ASIC") seeks money from Century Surety Company ("Century"). ASIC contends money is owed to it as assignee of Professional Home Builders ("PHB"). But ASIC faces a fundamental problem: it is not just PHB's assignee. ASIC is also PHB's primary insurer. Moreover, ASIC is the insurer that controlled PHB's defense in the underlying suit brought by Residential Investment Partners, 1997, LLC ("RIP"). Being PHB's primary insurer poses a problem for ASIC because, as the primary insurer, ASIC was entitled to summary judgment against excess insurer Century only if, as a matter of law, ASIC had paid more than it owed under its primary policies. Being the insurer that controlled PHB's defense poses an additional problem because, in that capacity, ASIC was entitled to summary judgment against Century only if, as a matter of law, ASIC had not become obligated to pay the entirety of the arbitration award because of its failure to engage RIP in settlement negotiations.

The court in *Polygon Northwest Co. v. American Natl. Fire Ins. Co.*, 143 Wn. App. 753, 189 P.3d 777 (2008), recognized the importance of seeing through an insurer's attempt to cloak itself as merely the common insured's subrogee or assignee. Thus, in that action by insurers against insurers, the court held that the claim was properly characterized

as one for equitable contribution rather than subrogation. *Id.*, 143 Wn. App. at 794-795. The issue was addressed at greater length in *Essex Ins. Co. v. Heck*, 186 Cal. App. 4<sup>th</sup> 1513, 1527-1528, 112 Cal. Rptr. 3d 915 (2010), where the court held that the burden rests on the insurer claiming to be an assignee to prove that the money it paid was in consideration for the assignment rather than for a release of its own contractual or extra-contractual liabilities.

In its complaint against Century, ASIC declares that it is suing "in its own right and as assignee of PHB." [CP 449.] Thus, ASIC's own pleading frames the issue. For ASIC to recover as assignee of PHB, the possibility must be ruled out that ASIC paid money to RIP to satisfy ASIC's own contractual liability under its primary policies or its own extra-contractual liability for mishandling settlement negotiations. To win summary judgment, it was ASIC's burden to show the absence of a triable issue of fact material to either theory. The record below contains evidence implicating both of ASIC's primary policies which, combined, are adequate to pay the entire arbitration award. The record also contains evidence from which the trier of fact could conclude that ASIC breached its affirmative duty to engage RIP in settlement discussions. Accordingly, it was error for the trial court to enter summary judgment.

## II. ARGUMENT

### A. To Obtain Summary Judgment on Its Claim Against Century, ASIC's Burden Was to Eliminate the Possibility That It Paid the Arbitration Award Because of Either a Contractual or an Extra-Contractual Duty.

Citing to the Settlement Agreement, ASIC insists it is PHB's assignee. This is central to its arguments. *But, the Settlement Agreement is ambiguous on this point.* In entering into the Settlement Agreement, ASIC bargained for three key items of consideration. An assignment of PHB's "claims and rights, if any, . . . against Other Insurers" was one item of consideration. [CP 1749.] However, ASIC also obtained a release by PHB and RIP of their claims for coverage of the arbitration award under the ASIC primary policies. *Id.* And ASIC obtained a release by PHB of its "bad faith" claim against ASIC. *Id.* The \$1,922,044.68 paid by ASIC under the Settlement Agreement is not apportioned among these three items of consideration received by ASIC. Accordingly, there is no way of knowing – from the Settlement Agreement standing alone – what amount ASIC paid because of its contractual obligation under its policies, versus what amount ASIC paid because of its "bad faith" failure to pursue settlement, versus what amount ASIC paid in consideration for the assignment.

*Essex Ins. Co. v. Heck, supra*, discusses the consequences of an unallocated settlement payment in circumstances like those presented

here. There, the underlying claim was for personal injury which allegedly was caused by Essex's insured and exacerbated by the treating physician, Dr. Heck. Disputing coverage, Essex initially refused to pay the judgment that had been entered against its insured. After being sued for fraud and bad faith, Essex settled with the insured and the claimant/judgment creditor, receiving a release of all claims and a dismissal of the fraud/bad faith suit. 186 Cal. App. 4<sup>th</sup> at 1518-1519. Claiming to stand in the shoes of its insured, Essex then sued Heck for indemnification. *Id.* at 1520. As the court observed, Essex's burden was to "prove that it compensated its insured for the same loss for which Dr. Heck is liable." *Id.* at 1523. The court then held that, [b]ecause it is impossible to tell from the settlement agreement . . . what portion, if any, of the [settlement payment] was paid to compensate the [claimant] for his personal injury claim and what portion, if any, was paid to settle the other claims, in order for Essex to prove that it [is entitled to indemnity], Essex necessarily must resort to evidence outside the settlement agreement." *Id.* at 1524. The court later held that, by not including an allocation of the settlement payment in the settlement agreement, Essex impliedly waived any right it might have acquired to pursue a subrogation action against Heck. *Id.* at 1527-1528.

In its response brief, ASIC takes issue with the implied waiver finding in *Essex Ins. Co. v. Heck*. The criticism is irrelevant. The

importance of the *Essex Ins. Co. v. Heck* decision is the court's observation that, because the settlement agreement was silent as to how the payment was to be allocated among various claims, it was necessary to consider extrinsic evidence to determine what amount, if any, had been paid for the assignment against Dr. Heck rather than for a dismissal of the insured's "bad faith" suit against Essex.

As was true for the insurer in *Essex Ins. Co. v. Heck*, ASIC paid a lump sum under a settlement agreement that resolved various claims, including claims of breach of contract and "bad faith" asserted against it. The teaching of *Essex Ins. Co. v. Heck* is that, because the settlement is silent, allocation can be made only through examination of extrinsic evidence. Thus, assuming, as ASIC argues, that the omission of an allocation in the Settlement Agreement does not constitute an implied waiver of the right to establish an allocation, ASIC could carry its burden only by introducing extrinsic evidence negating any contractual or extra-contractual liability for the amount paid in the settlement. It did not carry this burden. Indeed, the record contains evidence from which a trier of fact could conclude that ASIC was obligated to pay the full \$1,922,044.68 either because RIP's claim was covered under both ASIC primary policies (with their combined \$2,000,000 in limits) and/or because ASIC breached its duty to engage RIP in settlement negotiations.

B. Coverage Under the '98-'99 ASIC Policy Is a Triable Issue of Fact.

Judgment here was entered on a motion for summary judgment. Accordingly, the test on appeal is whether the record contains any evidence raising a triable issue as to a fact material to ASIC's claim. Because the record contains some evidence that RIP suffered property damage during the period of both of ASIC's primary policies, there was a triable issue as to whether the entire settlement was covered by ASIC's primary policies, thereby precluding contribution from Century under its excess policy. Accordingly, ASIC was not entitled to summary judgment.

1. The Record Contains Evidence of Damage During the Period of the '98-'99 ASIC Policy.

ASIC argues that Century failed to present admissible evidence of covered property damage during the '98-'99 ASIC Policy period. The argument suffers from two flaws. First, it ignores the assignment of the burden of proof in a motion for summary judgment. As the Washington Supreme Court has made clear, "[t]he burden of showing that there is no issue of material fact falls upon the party moving for summary judgment . . . . Only after the moving party has met its burden of producing factual evidence showing that it is entitled to judgment as a matter of law does the burden shift to the nonmoving party to set forth facts showing that there is a genuine issue of material fact." *Hash v.*

*Children's Orthopedic Hosp. & Medical Center*, 110 Wn.2d 912, 915, 757 P.2d 507 (1988).<sup>1</sup>

The second flaw in ASIC's argument is that it is contradicted by the record. The record in fact contains evidence of damage during the period of the '98-'99 ASIC Policy. Century presented the testimony of expert witness Kevin Flynn. ASIC did not object to his testimony, and it was received into evidence by the trial court. His testimony, therefore, is in the record. Moreover, having failed to object to the testimony at the time it was offered, ASIC has waived any right it might have had to object to its admission. *See City of Phoenix v. Com/Systems, Inc.*, 706 F.2d 1033, 1038 (9<sup>th</sup> Cir. 1983) (objection must be asserted in trial court to preserve issue for appeal).

ASIC's real argument concerns the *weight* to be given Mr. Flynn's testimony. However, on a motion for summary judgment, the court's task is not to weigh the evidence. Rather, "[i]n reviewing a summary judgment, an appellate court must review material submitted for and

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<sup>1</sup> Citing the arbitrator's ruling, ASIC argues that it presented evidence of the absence of property damage during the period of the '98-'99 ASIC Policy. The arbitrator's ruling is not binding on Century. *See, e.g., Wear v. Farmers Ins. Exch.*, 49 Wn. App. 655, 661, 745 P.2d 526 (1987) (only where the insurer has the same interest as the insured in disputing liability and damages issues is it "fair to treat the insurer as a party for collateral estoppel purposes"). The timing of RIP's property damage was not necessary to the decision in the arbitration, and Century's interest in demonstrating damage during the period of the '98-'99 ASIC Policy was not represented by either PHB or ASIC in the arbitration proceeding.

against a motion for summary judgment in the light most favorable to the nonmoving party." *Hash v. Children's Orthopedic Hosp. & Medical Center, supra*, 110 Wn.2d at 915-916. "[T]he appellate court engages in the same inquiry as the trial court, considering facts and reasonable inferences therefrom in the light most favorable to the nonmoving party . . . ." *Security State Bank v. Burk*, 100 Wn. App. 94, 97, 995 P.2d 1272 (2000).

In his testimony, Mr. Flynn offered his expert opinion that, based on his review of visual evidence of RIP's damage and his understanding of the physical process of wood decay, property damage began before the '98-'99 ASIC Policy expired. [CP 1659.] He also opined that, based on visual evidence and his understanding of the physics of water intrusion, the damage was the result of PHB's deficient work. [CP 1656-1657, 1659.] ASIC characterizes Mr. Flynn's testimony as speculative, but this objection has been waived. Furthermore, because Century is entitled to have inferences drawn in its favor (as the nonmoving party), even speculative evidence creates a triable issue of fact. *See Hash v. Children's, supra*, 110 Wn.2d at 916 ("one of Dr. Wallace's affidavits states that '[i]t is possible for a child to suffer a fractured bone during physical therapy when the therapist is not negligent.' [Cite.] It could be reasonably inferred from this statement that even if . . . the injury could

have occurred without negligence, the injury nonetheless could have been caused by negligence. Since it is the court's duty to draw all reasonable inferences in favor of the nonmoving party, we must conclude that the injury may have been caused by [defendant's] negligence . . . and that therefore summary judgment was inappropriate").

The record also contains evidence of a party admission made by ASIC in its June 13, 2005 letter. [CP 403.] ASIC argues that, when it told PHB that "coverage" was "triggered" under both primary policies, it merely intended to say that its duty to defend was triggered under both policies. This interpretation makes no sense and is contradicted by the context (including ASIC's contemporaneous conduct) in which the statement was made and by PHB's understanding of the statement. It makes no sense because it was irrelevant to PHB whether ASIC was defending under one policy or two and, by the time the statement was made — June 13, 2005 — ASIC's defense of PHB in the arbitration was nearly concluded. It is contradicted by the context because, three days before sending the June 13<sup>th</sup> letter, ASIC had received a settlement demand from RIP for \$1,400,000. [CP 419.] Having received the settlement demand — which exceeded the limit of one policy but was well within the limits of its two policies — ASIC sent its June 13<sup>th</sup> letter to PHB advising it of ASIC's view that RIP's claim "triggered coverage"

under both policies. And, having received a demand that exceeded the limit of one policy but was well within the combined limits of its two policies, ASIC did *not* notify Century of the demand. [CP 314.] A reasonable inference from ASIC's contemporaneous conduct was that it believed and intended to communicate to PHB the belief that both primary policies were available to respond to RIP's claim.

Notably, this is how PHB understood the June 13<sup>th</sup> letter at the time. [CP 1665.] PHB acted on that understanding by refraining from either notifying Century of the \$1,400,000 demand or becoming actively engaged in settlement discussions with RIP. [CP 314, 1739.]

In any event, as the *Hash v. Children's* court held, a party moving for summary judgment (ASIC) is not entitled to have inferences drawn in its favor. Rather, all inferences must be drawn in favor of the nonmoving party (Century). Because one may reasonably infer from the June 13<sup>th</sup> letter an admission by ASIC of coverage under the '98-'99 ASIC Policy, the record contains evidence sufficient to make coverage under the '98-'99 ASIC Policy at least a triable issue of fact.

2. Coverage Under the '98-'99 ASIC Policy Would Preclude Coverage Under the Century Excess Policy.

ASIC insists that "horizontal exhaustion" is not the law in Washington. But ASIC miscasts the issue. "Horizontal exhaustion," as a

principle, can be applied in two distinct contexts. One context is a dispute between an insured and its insurers. As applied in that context, the issue is whether an excess insurer can compel the insured to exhaust the coverage of all of its primary insurers before seeking coverage under an excess policy. The cases on which ASIC relies (one published federal district court case and one unpublished federal district court case) address this context. Those courts held that, in light of Washington's "joint and several liability" rule, an insured need not exhaust all primary insurance unless the language of the excess policy specifically requires it. *Port of Seattle v. American Natl. Ins. Co.*, 1998 U.S. Dist. LEXIS 23038 (W.D. Wa. 1998) (court accepts insured's argument that "in a continuing injury claim implicating several insurance contracts, the insured may sue any of the companies for all its damages, and that company must seek contribution from the others"); *Cadet Mfg. Co. v. American Ins. Co.*, 391 F. Supp. 2d 884, 892 (W.D. Wa. 2005) (citing *Port of Seattle v. American Natl. Ins. Co.*).

The other context in which the issue of horizontal exhaustion arises is an insurer vs. insurer dispute. This is the context in which the issue was considered in *Polygon Northwest Co. v. American Natl. Fire Ins. Co.*, 143 Wn. App. 753, 189 P.3d 777 (2008). The issue presented there was how to apportion a \$7,800,000 continuous loss among primary and excess

policies spanning multiple policies periods. *Id.* at 763 (table). The insuring agreements of the excess policies stated that the policies covered "sums in excess of 'underlying insurance,'" with "underlying insurance" referring to the specific primary policy covering the same policy period. *Id.* at 770–771. In addition, the "other insurance" clauses of the excess policies stated that "the insurance afforded by this policy is excess over any other valid and collectible insurance available to the 'insured' whether or not described in the schedule of underlying policies." *Id.* at 777. Based in particular on the "other insurance" clause language, the *Polygon* court held that each of the excess insurers was only liable for the amount of loss that exceeded the *sum* of the collectible primary coverage, even primary coverage outside its policy period. *Id.* at 778 ("In Assurance's role as excess insurer, that liability was for sums in excess of the valid and collectible underlying policies—Assurance's own \$1 million underlying policy [covering the same policy period], plus CUIC's \$1 million underlying policy [covering a later year]") (footnote omitted); and *id.* at 778-779 ("as to each of its two policy periods, [excess insurer] Great American was jointly and severally liable for that portion of the Polygon settlement exceeding the solvent primary insurers' policy limits plus [the underlying insolvent primary insurer's limit]").

Importantly, the *Polygon* court premised its holding on the "other insurance" clause language of the excess insurers' policies. Thus, with respect to excess insurer Great Western, the court explained:

Great American's policies each provided that "[t]he insurance afforded by this policy is excess over any other valid and collectible insurance available to the 'Insured,' whether or not described in the schedule of underlying policies." . . . Thus, each excess insurer's liability for purposes of contribution was defined by both its "other insurance" clause with respect to all the triggered underlying policies, as well as any other applicable provisions . . . . 143 Wn. App. 777-778.

In addition, in support of its holding with respect to Assurance's excess policy, the court cited in footnote 7 the text of Assurance's "other insurance" clause. *Id.* at 778 fn. 7.

In its response brief, ASIC makes no attempt to argue why it would be *logical* to require Century's excess policy to pay for a loss covered by the '98-'99 ASIC Policy. Instead, ASIC seeks to distinguish *Polygon* by arguing that it addressed only the proper allocation of a loss among excess insurers. As the text cited above shows, ASIC misreads *Polygon*. The central issue in *Polygon* was at what point does an excess policy attach to a continuous loss. The court specifically held that, *in an action among primary and excess insurers*, the excess insurer's obligation to contribute attaches only at the level above the sum of all primary policies.

C. ASIC's Extra-Contractual Liability for the Arbitration Award Is a Triable Issue of Fact.

ASIC is not only PHB's primary insurer. It is also the insurer that assumed control of PHB's defense. It retained defense counsel and, most importantly, handled settlement negotiations with RIP. If it breached its "affirmative duty . . . to make a good faith attempt to effect settlement," it is liable for the consequences of that inaction. *First State Ins. Co. v. Kemper Natl. Ins. Co.*, 94 Wn. App. 602, 971 P.2d 953 (1999); *Truck Ins. Exch. v. Century Indem. Co.*, 76 Wn. App. 527, 887 P.2d 455 (1995). Because RIP formally proposed to settle within the limit of one of ASIC's primary policies (and even hinted it would settle for less than a single limit) [CP 398, 400], the consequence of ASIC's inaction was the arbitration award in excess of the single policy limit. Thus, even if there were no coverage under the '98-'99 ASIC Policy, ASIC would still be liable for the entire arbitration award.

1. ASIC Would Have No Right to Recovery from Century if It Was Liable to PHB for Breach of Its Duty to Pursue Settlement.

ASIC argues that its own "bad faith" is irrelevant because a primary insurer's duty to pursue settlement runs only to an excess insurer that has paid money. This argument is not supported by either law or common sense. In *First State Ins. Co. v. Kemper Natl. Ins. Co.*, *supra*, the court cited approvingly to *Valentine v. Aetna Ins. Co.*, 564 F.2d 292 (9<sup>th</sup>

Cir. 1977), which held: "[w]hen there is no excess insurer, the insured becomes his own excess insurer, and his single primary insurer owes him a duty of good faith in protecting him from an excess judgment and personal liability. If the insured purchases excess coverage, he in effect substitutes an excess insurer for himself. It follows that the excess insurer should assume the rights as well as the obligations of the insured in that position." (Emphasis omitted.) Notably, as articulated by the *Valentine v. Aetna* court, the duty to protect an excess insurer from a judgment in excess of the primary insurer's limits attaches whether or not an excess insurer first pays the judgment.

It is true that, in those cases in which courts have held that primary insurers owe duties to excess insurers, the excess insurers typically have paid the judgment and are seeking reimbursement from the primary insurer. But this is because the issue would not otherwise arise if the insured had paid the judgment (in that case the insured would be suing the primary insurer) or if the primary insurer had paid the judgment. The issue arises here only because, having paid the judgment, the primary insurer (ASIC) now seeks recovery from the excess insurer (Century). But this does not alter the rule that, while managing the litigation, ASIC owed a duty to both PHB and Century to actively pursue settlement so as to avoid unreasonably imposing liability on either PHB or Century.

ASIC contends that, as part of the Settlement Agreement, it purchased a release of "bad faith" claims from PHB and, therefore, Century is barred from raising the "bad faith" issue. This merely proves Century's point. To the extent ASIC paid money because of, and in exchange for a release of its liability for, its "bad faith," it has no right, as PHB's subrogee, to recover that payment from Century. The right to subrogation exists only "when a party . . . pays another's obligation *for which the subrogee has no primary liability.*" *Millers Cas. Ins. Co. v. Briggs*, 100 Wn.2d 9, 13-14, 665 P.2d 887 (1983) (emphasis added). Money paid to PHB to resolve its "bad faith" liability is money for which ASIC had a primary liability. It cannot turn around and assert a subrogation claim against Century for the same money.

In its response brief, ASIC cites approvingly to, and quotes extensively from, *Fireman's Fund Ins. Co. v. Maryland Cas. Co.*, 21 Cal. App. 4<sup>th</sup> 1586, 26 Cal. Rptr. 2d 762 (1994). This illuminating case actually supports Century's position. The equitable contribution action arose out of a construction defect claim. Maryland Casualty was the developer's primary insurer for six years while Fireman's Fund was the developer's excess insurer. The property owner sued the developer and obtained a judgment. The property owner and the insured then entered into a settlement with Maryland Casualty under which Maryland Casualty

paid \$3,550,000 under its four later policies (nothing under the first two) in exchange for a release of contractual and bad faith claims by the property owner and insured and under which the property owner covenanted not to seek any additional recovery from the developer's assets other than the Fireman's Fund policies. *Id.* at 1592. Fireman's Fund entered into its own settlement agreement, and then sued for contribution from Maryland Casualty based on the theory that coverage was owed under the other two Maryland Casualty primary policies. *Id.* at 1592-1593. The court held that Fireman's Fund had no right of contribution because, according to Fireman's Fund's own theory, the money it paid in settlement was as a "volunteer". *Id.* at 1598. The court explained:

The effect of the Maryland settlement agreement, at least insofar as Fireman's was concerned (since both Maryland and [the insured] were free of all further claims), was to narrow the issues to one: Did Fireman's have any liability to the homeowners? Fireman's disclaimed responsibility by asserting the damages had manifested [during the two earliest Maryland Casualty policies and] before Fireman's policy became effective, a contention which, if factually correct, rendered Fireman's nonliable. Assuming Fireman's was factually correct, its payment represented amounts for which neither it nor any other party was liable because it paid an 'obligation' which had already been discharged by the Maryland settlement. Thus if the damages occurred in Maryland's tenure, Fireman's acted as a mere volunteer in making the payment, having had no legal or moral obligation to pay a previously discharged debt. *Id.* at 1597-1598 (citations and footnote omitted).

*Fireman's Fund v. Maryland Cas.* teaches that, if a claim was owed by a primary insurer and the primary insurer has been released from liability for that claim, then the excess insurer has no obligation to pay it and, if it does so anyway, would be a "volunteer" with no right of contribution from the primary insurer. Here, this means that if ASIC was obligated to pay the entire arbitration award because it had handled PHB's defense in "bad faith," then Century has no legal or moral obligation to pay the award and, indeed, if it were to do so, would be acting as a "volunteer".

2. The Record Contains Evidence of ASIC's Breach of Its Duty to Pursue Settlement.

As shown in Century's opening brief, the record contains abundant evidence of ASIC's mishandling of settlement negotiations with RIP. ASIC repeatedly failed to communicate settlement demands to Century. [CP 313, 394 (Century was not informed of the 5/10/05 demand for \$2,738,270); CP 313, 398 (Century was not informed of the 5/27/05 demand for \$1,000,000); CP 314, 419 (Century was not informed of the 6/10/05 demand for \$1,400,000).] In addition, although ASIC's claim handler "expected" a damage award of \$350,000 plus attorney fees, and saw a potential for an award against PHB of \$1,000,000, ASIC never made a settlement offer in excess of \$100,000. [CP 527, 1715-1717.]

In its response brief, ASIC makes no effort to demonstrate that it handled settlement negotiations properly. Rather, ASIC attempts to shift the blame to PHB, insisting that PHB controlled settlement. The case relied on by ASIC — *Puritan Ins. Co. v. Canadian Universal Ins. Co.*, 775 F.2d 76 (3d Cir. 1985) — refutes the argument. There, the court held: "the insured's consent, and indeed direction, to try the case *after being fully informed of the risks involved* is an insurmountable barrier to the maintenance of a bad faith claim against the insurer . . . ." (Emphasis added.) Here, the record shows that PHB was not "fully informed" by ASIC of the risks involved in the litigation. As PHB's personal counsel testified, PHB believed — based on ASIC's June 13, 2005, letter — that any award would be well within the combined limits of ASIC's two policies. "If [PHB] had been told that [ASIC] was taking the position that only one policy year was available, then [PHB's] response to RIP's settlement demand of one million dollars prior to the arbitration would have been different." [CP 1739.]

In any event, because ASIC was moving for summary judgment, the question is not whether ASIC actually breached its settlement duty but, instead, whether there is at least some evidence making ASIC's breach a triable issue of fact. The evidence of the many missed settlement opportunities, and of ASIC's failure to at least attempt to settle for an

amount it believed to be a likely arbitration award, is sufficient to create a triable issue of fact. *See Sequoia Ins. Co. v. Royal Ins. Co. of America*, 971 F.2d 1385, 1393 (9th Cir. 1992) (in an action for contribution brought by a primary insurer against an excess insurer, evidence of the primary insurer's breach of duty to accept reasonable policy limit demands precluded summary judgment in favor of the primary insurer).

D. ASIC Has No Right to Recover Its Attorney Fees from Century.

*Polygon Northwest Company LLC v. American Natl. Fire Ins. Co.*, *supra*, answers the question of whether ASIC has a right to recover attorney's fees. The answer is "no".

ASIC seeks to distinguish *Polygon* by insisting that this is not a contribution action between insurers. But this was the same argument made and rejected in *Polygon*. In *Polygon*, Assurance argued that, having paid more than its share, it stood in the shoes of the common insured and, therefore, its claim against Great American was for subrogation. The court held otherwise, saying: "all of Assurance's claims in this action . . . are equitable contribution claims, *not* claims based on any assignment of rights by Polygon. ¶ Assurance's claims were claims for equitable contribution against jointly liable coinsurers—claims that arise from the rights of the overpaying insurer, *not* from the rights of the insured. The 'right of equitable contribution belongs to each insurer individually. It is

not based on any right of subrogation to the rights of the insured, and is not equivalent to 'standing in the shoes' of the insured.'" *Id.* at 794-795.

According to the holding in *Polygon*, when ASIC paid the \$1,922,044.68 award, it automatically acquired the equitable right to obtain contribution from Century for its "overpayment" (if any). It did not need either an express or implied assignment from PHB. The assignment in the Settlement Agreement, therefore, gave ASIC nothing it did not already have, and it would be unreasonable to allow the assignment to convert ASIC's existing claim — which carries no right to attorney fees — into a claim for which attorney fees can be recovered.

The *Polygon* court's characterization of the insurers' claims as claims for equitable contribution rather than subrogation and its refusal to allow the recovery of attorney fees in that context fit the rationale behind the *Olympic Steamship Co. v. Centennial Ins. Co.*, 117 Wn.2d 37, 811 P.2d 673 (1991), rule. The rule was adopted to address the "disparity of bargaining power between an insurance company and its policyholder" and to honor the insured's expectation that, by purchasing insurance, he is buying "protection from expenses arising from litigation, not 'vexatious, time-consuming, expensive litigation with his insurer.'" *McGreevy v. Oregon Mut. Ins. Co.*, 128 Wn.2d 26, 904 P.2d 731 (1995). In an action between two insurers, there is no "disparity of bargaining power" and no

interference with "the insured's expectation that he is buying protection from litigation." There is, therefore, no basis for deviating from the general rule that litigants are to bear their own attorney fees.

### III. CONCLUSION

ASIC is PHB's primary insurer and is the insurer that controlled PHB's defense. Law and logic preclude ASIC, as a primary insurer, from recovering from Century, an excess insurer, if the arbitration award was within the sum of ASIC's applicable policy limits. Because the record includes evidence implicating coverage under both ASIC policies, ASIC had no right to summary judgment. Law and logic also preclude ASIC, as the defending insurer, from recovering from Century, if the arbitration award could have been avoided or minimized had ASIC actively pursued settlement. Because the record includes evidence of missed settlement opportunities, ASIC had no right to summary judgment.

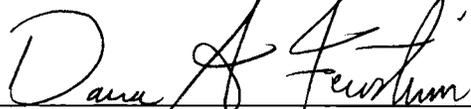
Finally, even if ASIC were entitled to pass off part of the \$1,922,044.68 payment to Century, it had no right to recover attorney fees. ASIC's claim, if it has any, is for equitable contribution, and equitable contribution carries no right to attorney fees.

For these reasons and those stated in its opening brief, Century requests that the judgment of the court below be reversed.

RESPECTFULLY SUBMITTED this 29th day of November,

2010.

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