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Environmental Insurance Recovery: Legal Issues in Relation to the Buy-Back of Insurance Policies

This paper is a combined effort from the firm of Branch MacMaster, presented by Jim MacMaster for the Continuing Legal Education Society of British Columbia, September 2008.

ENVIRONMENTAL INSURANCE RECOVERY: LEGAL ISSUES IN RELATION TO THE BUY-BACK OF INSURANCE POLICIES[1]

I. Introduction

Over the past several years, a number of Canadian resource oriented companies whose business activities date back to at least the 1960s or 70s have negotiated or attempted to negotiate "buy-back agreements" with the insurers who provided liability coverage during the period prior to the introduction of the absolute pollution exclusion in 1986. The object of the "buyback" is to remove the inherent uncertainty associated with both long tail environmental exposures and the insurance coverage available to cover these risks.

The insured receives the certainty of a cash payment now from an historical insurance asset which offsets some of the costs the insured may incur in relation to its present and future environmental liability exposure for clean up claims, third party property damage or bodily injury.

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1 This paper is the combined effort of the firm of Branch MacMaster. The primary author is Chris Rhone who is rapidly becoming one of the leading environmental insurance coverage lawyers in Canada. As well, Ward Branch, who has been a leader in the field of construction insurance coverage for the past 10 years, contributed many valuable insights and comments.

The insurer receives the certainty that no future claims for coverage will be presented by the insured in relation to the environmental risks.

For the most part, in Canada, these transactions are invisible. The negotiation and the outcome are always kept confidential. To date, there is only one Canadian case which deals with the validity of policy buy-backs and then in a completely different context. Further, we are not aware of any academic discussion in Canada of the buyback or "reverse underwriting" of policies of insurance.

The partial details of one insurance buy-back was revealed in a 2003 judgment from Quebec.[2] The parties involved in the buy-back were Domtar Inc and certain Underwriters at Lloyd's. The Quebec action did not concern the buy-back itself, however the Court was required to consider whether a portion of the payment made by Lloyd's to Domtar should be deducted from the amount claimed by Domtar in the action. The court described the buy-back arrangement as follows:

> The discontinuance was prompted by a letter in October 2001 to Domtar from an American attorney acting on behalf of Lloyd's which referenced a Confidential Settlement Agreement and Release entered into between Domtar and Lloyd's in June 2001 under which Domtar was paid a total of U.S. $10,500,000. Pursuant to the agreement, this sum was said to comprise U.S. $9,500,000 "for the settlement of all past, present and future Canadian pollution claims", and U.S. $1,000,000 "for the settlement of all past, present and future claims of any and all other types", excepting only a certain type of claim that is not relevant for present purposes.

In the US a small but active industry of "insurance recovery" specialists (mostly lawyers and environmental consultants) has emerged to provide services to mostly large, resource oriented companies who prefer to take the "bird in the hand," rather than the "two in the bush" of extensive environmental coverage litigation in relation to long tail exposures. These American firms have been marketing their services to Canadian resource companies who then embark upon environmental insurance recovery projects. To our knowledge, Canadian law firms have not lead these efforts.

Accordingly, the purpose of this paper is to throw some light on the insurance policy buyback phenomenon, to identify some of the important legal questions to be considered, to suggest some potential answers, and to create a foundation for further analysis and discussion.

II. The Key Elements of an Insurance Recovery Project

The starting point for all insureds is to develop an historical understanding of their liability insurance coverage. This involves identifying the policies of insurance available to the insured at primary and excess levels on a year by year basis, the insurance companies or their successors who underwrote the policies, the limits of the available insurance, the deductible amounts or self insured retentions which apply in relation to each policy or year, and the relevant conditions, exclusions, definitions, and endorsements.

The historical policy analysis is nearly always depicted in a coverage chart which shows the total liability coverage available, the insurance companies responsible at primary and excess levels, and key developments in the timeline such as insolvencies, the introduction of pollution exclusions and other relevant policy provisions. For insureds with a long history of business activity, the coverage chart will begin with the first known liability policies. Often insureds have a difficult time reconstructing the coverage that was available to them 30 to 40 years ago. Typically, the insurance recovery portion of the coverage chart ends with the 1986 year since most insurers adopted the absolute pollution exclusion at that time. Environmental liability exposures allocated to the years after 1986 will be the responsibility of the insured.

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2 *Domtar Inc v. Abb Inc, Alstom Canada, and Chubb Insurance*, [2003] Q.J. No. 9442, Quebec Superior Court, Hilton J., rev'd 2005 QCCA 730, [2007] 3 S.C.R. 461.

Once the available sources and amounts of liability insurance coverage have been identified, the next step is to develop a comprehensive understanding of the actual and potential environmental liability exposures. This involves the insureds typically making a significant effort to review all of their business activities and sites over the past 40-50 years to identify incurred costs in relation to environmental exposures as well a potential environmental claims relating to clean up costs, third party property damage or bodily injury that may be advanced against the insured in the future. Undoubtedly a good due diligence exercise in any event, the insured essentially builds the theoretical worst case scenario for its environmental liability exposures. Environmental consultants play a key role at this stage in reconstructing the incurred costs, estimating the costs associated with investigation of potential environmental claims, feasibility studies to assess damage and determine remediation, the remedial work itself, and the defence and payment of third party damages claims.

Once the total potential liability is estimated it is necessary to allocate this potential liability to the available insurance coverage. Essentially this process applies sets of alternative assumptions to the factors relating to a particular risk both in relation to the liability exposure and the available coverage. There are a multitude of factors to be considered including the likelihood of the environmental liability materializing, its magnitude, the appropriate response, and the validity of the evidence supporting the cost assumptions. On the coverage side, there are assumptions to make in relation to trigger theories, allocation methods, pollution exclusion applicability, occurrence definitions, exclusions and conditions.

In reality, there is a continuum of risk for both the insurer and the insured that runs from zero to tens or hundreds of millions of dollars depending upon the circumstances. It is important to keep in mind that the entire exercise is based on a series of significant assumptions in relation to the likelihood of claims, the costs associated with investigation, remediation, defence, and indemnity, and the strength or weakness of various coverage positions. It is an exercise where the participants can get to almost any position they like simply by changing the variables.

In any event, in order to play in the buyback game, you have to do the exercise. Therefore, firstly, the insured may well attach percentage chances to the various risks it faces and the assumptions it makes in relation to the cost exposure. For example, the insured might determine that there is only a 30% chance that a particular environmental exposure at a particular site will materialize as a claim. Therefore, it may reduce the cost estimate for that site accordingly in order to reflect the reduced risk mathematically.

Second, the insured will recognize that not all risks of environmental liability will attach to all policy years. Therefore, certain portions of the potential liability will be allocated to particular policy years. For example, if an insured only commenced a particular activity (e.g., operating a mine site) in 1975, then obviously any potential environmental liability from that operation could not be assigned to earlier policy years.

Third, the insured's legal counsel will review the policy language for the different policies and assess the likelihood that particular environmental exposures will be found to be covered or not. Depending on the situation, in relation to any particular site or potential claim, an insured may find that it is applying different percentage factors for success to several different aspects of the coverage. For example, the insured may determine that for a particular policy there is a 60% chance that the pollution exclusion will apply, a 70% chance that investigation and remediation costs will be treated as damages not defence costs, and a 90% chance that defence and indemnity costs will be pro-rated across all of the years of the alleged occurrence. Therefore, once the math is done, only a small proportion of the potential liability exposure for that site might be allocated to that policy year.

Fourth, the insured's insurance recovery team will allocate the potential liability and the potential recovery by insurer. Some insurers will be primary and some will be excess. Some will only be on the risk for a few years, some may be on the risk for a number of years. Some primary insurers may have limited indemnity risks because the limit of liability of their old policies was small. Indeed, for those

primary insurers, the defence cost exposure may be greater than the indemnity exposure. Some excess insurers may not face any defence cost exposure but could be exposed to tens of millions of dollars of indemnity exposure because of the large amounts of excess coverage they underwrote for 15 or 20 years. The variations are endless.

The goal of the insurance recovery team is to determine for each insurer: (1) its worst case scenario assuming all the environmental liabilities materialize and the insured wins all the coverage issues, and (2) a more realistic exposure for the insurer once all the risk factors are reasonably estimated and applied. The latter usually becomes the opening offer from the insured. Typically, given the tendency to overestimate the projections of the theoretical exposure to the insured and, in Canada, the application of coverage principles which are generally favourable to the insurer, the discount between the worst case scenario and the initial offer is quite substantial.

Once all of this work has been completed and the insured finalizes it instructions to the insurance recovery team, the claim is ready for presentation to the insurer. The insurer is typically asked to enter into a non-disclosure agreement and a standstill agreement while the planned confidential settlement discussions occur. Assuming the insurer agrees, then the next step is for a meeting to take place where the insured makes its claim presentation to the insurer. The message is invariably: "Have we got a deal for you." The insured presents an environmental risk assessment of its potential liabilities and its analysis of its coverage and the amount to be allocated to this particular insurer. The insured then concedes that discounts are appropriate to reflect the uncertainties in the risk assessment and in the availability of coverage. An offer is presented and the insured offers to provide access to detailed background information if the insurer is interested.

If the insurer is interested, it usually will then retain its own environmental consultants to examine the assessment of the potential environmental liabilities and costs associated with investigation and remediation. As well, the insurer's coverage counsel will consider the coverage issues and the weighting to be given to the chances of success on the various issues. If the insurer concludes that it values certainty and is prepared to pay a price to obtain it (even though much, if not all of the potential liability risks are still theoretical) then it will negotiate with the insured.

The total time from the initiation of the insurance recovery project to the completion of the negotiation with the last insurer may take many years to complete. Needless to say it can also be very expensive if there are multiple sites and many years of business activity to consider.

In the process, both parties but in particular the insurer should give consideration to a number of questions about the buyback agreement? Can the insurer really purchase certainty? Will the insured remain solvent enough to satisfy all future liabilities? What about the statutory rights of third party claimants to advance claims against insurers for recovery of insurance money? What about the potential claims from other insurers for contribution or indemnity? Is buying back insurance coverage contrary to any public policy?

III. Legal Analysis

This paper will consider the American, English, and Canadian approaches to buy-back mechanisms of settlement between insurer and insured.

We begin with the American consideration, as these schemes appear to have originated in the US. American commentators either applaud buy-back agreements as fulfilling a policy objective which encourages settlements; or decry them as a scheme which is collusive and deprives innocent third parties and co-insurers of their rightful money. As such, innocent third parties are often granted rights of action against settling insurers; particularly if the buy-back arrangement was entered into post-loss, and the settlement runs counter to public policy considerations.

The English position is that a third party has no cause of action against the insurer absent statutory rights enabling same. Literature and judgments reviewed do not reveal any real debate on the issue of buy-backs. Perhaps this novel process has not yet entered the English framework.

In BC, a statutory cause of action exists against insurers. The discussion below considers this statutory right in relation to insurance buy-back schemes. In addition, bankruptcy and insolvency legislation may grant certain rights to third parties to seek funds directly from the bankrupt insured's insurer. Buy-back arrangements also run the risk of being ignored by non-settling insurers, who as non-parties are not bound by the agreement. Such parties may be able to seek contribution and indemnity from settling insurers.

A. American Approach

1. The Concept Generally

The concept of policy buybacks appears to be an American invention. As such, American academic literature and jurisprudence represents a helpful starting point in understanding this settlement mechanism.

Insurance policy buybacks are seen by some as a convenient tool for settlement between insurer and insured. Thus, one American law firm claims that "Typically, insurers are interested in a buyback of coverage for all future environmental claims."[3]

Another American commentator, Goldberger, describes buyback settlements as follows[4]:

> A policy buyback settlement typically results in the insurer making a lump-sum payment to the debtor [the insured] in a negotiated amount in exchange for a full release of all of the insurer's obligations, and extinguishment of the debtor's rights, under the policy. A policy buyback settlement need not necessarily provide for a lump-sum cash payment; it might provide for a payout over time. A common feature is, however, a discounted cash payment from the policy limit. The amount of the settlement reflects the strength of the insurer's coverage defenses and applicable exclusions; the stronger the defenses and exclusions, the higher the discount from policy limits.

There are several types of buybacks: complete and partial. Under a "complete buyback," the policy is treated by the parties (but not necessarily by others) as though it never existed, leaving the policy holder without coverage for future claims.[5] It is also possible to draft a "partial buyback," in which the insured gives up a portion of its future coverage in exchange for a payment by the insurer.

Goldberger notes that such settlements are often attractive to and beneficial for the insurer for the following reason:

> ... the settlement payment satisfies the insurer's contractual obligation to the debtor after which it no longer has any further obligations under the policy. Policy buyback settlements often provide that policy limits are exhausted, thereby relieving the

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3 Morgan, Lewis & Bockuis LLP, "Insurance Recovery"(January 17, 2001) at 61.

4 in "Insurance Issues in Mass Tort Bankruptcy Cases: Strategic Perspectives" (April 20, 2001) (White and Williams LLP, www.abiworld.org/committees/masstorts/insurance.html). White and Williams LLP holds itself out as follows: "Our group's mission is to service the insurance industry, particularly in the area of complex and emerging coverage issues." (http://www.whitewms.com/FSL5CS/practiceareadescriptions/practiceareadescriptions47.asp)

5 Morgan, Lewis & Bockuis LLP, "Insurance Recovery" (January 17, 2001) at 61.

> insurer of any further defense obligation. See *UNR Industries, Inc. v. Continental Insurance Company, Inc*., 682 F. Supp. 1434, 1445 (N.D. Ill. 1988). Policy buyback settlements also provide insurers with finality in dealing with any uncertainty of continuing obligations under the policies.

Despite Goldberger's assertion of "finality," there is a body of criticism for the approach, which is founded upon principles of American law. As one author notes: "There is no fully developed jurisprudence on this matter. However, courts are nervous about insurers and policyholders collusively destroying coverage for injured third parties."[6] Additionally, as discussed below, the settling insurer also faces risks from non-settling co-insurers seeking contribution and indemnity for defence costs and indemnification of the insured's obligations.

2. Third Party Rights

Unlike the relatively simplistic English position described below, the general American approach appears to distinguish between third party rights which accrued prior to the insurance policy's termination, and third party rights accruing after the cancellation. In the former circumstance the third party may have rights against the insurer; whereas in the latter case he generally has no such rights. The distinction is noted by Appleman in his text as follows[7]:

> An injured person ordinarily cannot recover against an insurer which had cancelled its liability policy prior to the time of the accident. Where an insurance policy was not certified with the insurance commissioner as proof of financial responsibility, it was subject to cancellation for any breach occurring prior to the accident. And a Massachusetts statutory provision that no act or default of the insured could bar recovery by the injured person gave a judgment creditor no rights under a compulsory liability policy lawfully cancelled before his injuries were sustained.[8] Nor was a Missouri statute, prohibiting the cancellation of insurance contracts after the occurrence of an accident, applicable to an accident which occurred approximately four months after a policy had been cancelled.
>
> However, it is the general rule that an injured person's rights cannot be defeated by a cancellation or settlement after an accident has occurred.[9] And since a policy cannot be cancelled after an accident, neither can a prior unauthorized or defective cancellation be ratified after an accident, so as to cut off the rights of the injured person. ...
>
> Some courts had taken the view that the injured person's judgment is not a lien on the insurer's indebtedness under a liability policy, so that the insurer could pay the amount owing to the insured and thereby relieve itself of liability to the injured person. However, as has been seen in earlier volumes, this is not the current rule, as the liability of the company to the third person is independent of its obligations to the insured, and there is no way the company and its insured can destroy any vested rights of the injured party. [Emphasis added]

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6 M. Quinn and A. Levin, "Directors and Officers Liability Insurance: Probable Directions in Texas Law" (Spring, 2001) 20 Rev. Litig. 381 at footnote 169, and citing *Spann v. Commercial Std. Ins. Co. of Dallas*, 82 F.3d 593, 599 (8th Cir. 1936); and *Indem. Co. of America v. Pitts*, 58 S.W.2d 53 at 54. The authors also note that In *Lincoln-Electric Co. v. St. Paul Fire & Marine Ins. Co.*, 210 F.3d 672, 691 (6th Cir. 2000) the Court recognized the existence of policy buy-backs.

7 Appleman, *Insurance Law and Practice* (St. Paul Minn: West Publishing Co., 1981) (footnotes omitted, emphasis added).

8 Citing *Chamberlain v. Employers' Liab. Assur. Corp.*, 1935, 194 N.E. 310, 289 Mass. 412 (G.L. (Ter. Ed.) c. 175, para. 113A(5)).

9 Citing *Indemnity Ins. Co. of America v. Pitts* Tex.Com.App. 1933 58 S.W.2d 53 at 54 affirming Civ.App., 38 S.W.2d 883. The underlined text was cited in *National Sur. Corp. v. Sands*, 1974, 301 So.2d 93 at 96, 53 Ala.Civ.App 405.

It is perhaps for this reason that Americans have not uniformly accepted policy buyback schemes. For example, Quinn and Levine offer the following critique[10]:

> It is becoming increasingly fashionable for insurance companies and insureds to do "policy buy-back" deals. In these deals, the insurance company pays the insured a sum of money, often a substantial one, in return for the cancellation of its liability policy. Although they may be legal under some circumstances, these transactions are troubling. It seems as though the insurance company and the policy-holder are engaged in some sort of collusive scheme to feather the nest of the policyholder and deprive injured people of their pittance. Why, after all, would the insured draw the policy back if he intended to use the money to compensate those he had injured? As indicated, this problem occasionally arises in bankruptcy. That is not surprising. Every once in awhile, a policyholder (or its trustee) and an insurance company try to engage in a buy-back deal involving D&O insurance. One bankruptcy court has recognized that such a deal is essentially unfair and refused to approve it.

The author of the above text cites several authorities, including *Indemnity Ins. Co. of America v. Pitts*, Tex. Com. App. 1933, 58 S.W.2d 53 at 54, affirming Civ. App., 38 S.W.2d 883. In that case, the Court held, in part, as follows:

> It appears from the petition that at the time the agreement for cancellation of the policy [automobile liability policy] was made between Kakisaki and the Indemnity Company, the accident in question had already occurred, and the liability which the Indemnity Company was bound to assume, subject to the terms and conditions of the policy, had already become attached. That Florence Pitts, without her consent, could not be deprived of her rights against the Company, by agreement between Kakisaki and the Company after her rights had accrued, is perfectly plain. Her rights against the company, subject to the terms and conditions of the policy, accrued the moment the liability of Kakisaki for the personal injuries suffered by her arose. The subsisting obligation of the company, upon which her rights against the company depended, was, of course, originally due to Kakisaki; but even so, that obligation could not, in the absence of a policy provision to that effect, be rescinded, and her dependent rights destroyed, by the agreement to which she was not a party. ...

More recently, in *Ranger Ins. Co. v. Ward*, Tex. Ct. App., 6th District, 2003, 107 S.W.3d 820, an insured who was engaged in the business of crop dusting was faced with a claim for environmental damage. After receiving notice of the claim, the insured entered a settlement with his liability insurer, wherein the liability insurer paid $100,000 in exchange for a retroactive release of its obligations under the policy as of the date of issuance. The insured subsequently declared bankruptcy; and plaintiffs in a liability claim against the insured secured default judgment in the amount of approximately $4,000,000. The plaintiffs in that action sought to enforce the judgment against the liability insurer.

The Court held (at 824) that "... we find the attempted retroactive release of a liability insurance policy, after a known claim had arisen, is void based on public policy." And further (at 827): "The retroactive release is contrary to public policy, rendering the Release entirely void and keeping *fully* intact the policy that was in effect at the time of the loss."

Of note, the Court in *Ranger Ins. Co.* distinguished cases in which insurance was not compulsory from those in which insurance was compulsory. The Court explained that the public policy rationale for compulsory insurance was the protection of the public. Avoidance of such policies by release between insurer and insured contravened that public policy.

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10 M. Quinn and A. Levin, "Directors and Officers Liability Insurance: Probable Directions in Texas Law" (Spring, 2001) 20 Rev. Litig. 381 at 414 to 415 (footnotes omitted).

Thus, the Court held (at 827) that "A release, just as any other contract, however, is subject to the public policy of the State."[11] The Court concluded (at 829) that "[the insured's and insurer's] attempt to circumvent the intent of the required insurance clearly violates public policy. ... Such an attempt to avoid legally imposed duties and to undermine the intent of the laws of the State violates public policy in the most egregious manner."

However, the Court seemed to indicate that the fact of compulsory insurance does not represent the only ground for voiding a buy-back settlement. In this regard, the Court, using broad language, explained that there are numerous public policy goals which might be subverted by the release; and that the public policy is whatever is embodied in a State's constitution, statutes, and the decisions of its courts.[12]

3. Claims for Contribution, Indemnity and Subrogation by Co- and Excess Insurers

Insurers of the same insured may have, against one another, rights to claim equitable contribution or subrogation. Thus, the risk to an insurer that has settled with its insured under a buy-back scheme does not come from injured third parties alone. In this regard, Hyman explains as follows[13]:

> A liability insurance carrier who decides to settle an environmental coverage case wants the dispute with its insured to end the litigation. An insurer's decision to settle, however, may not end the litigation. An insurer may still face claims for contribution, indemnity, or subrogation from other carriers who issued primary or excess insurance to the same insured or from other carriers who issued environmental impairment liability insurance (EIL).

Hyman reviews numerous California and federal court cases, and notes the risk to the settling insurer. He provides several suggestions to improve the legal climate to minimize the risk of successful claims against settling insurers in order to promote the policy objective of settlement.

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11 Similar law applies in BC. In *Harry v. Kreutzinger* (1978), 9 B.C.L.R. 166 (C.A.) at 177 Mr. Justice Lambert stated the most succinct test for determining whether a contract ought to be enforced. He stated that the "single question" is "whether the transaction, seen as a whole, is sufficiently divergent from community standards of commercial morality that it should be rescinded." In *Everywoman's Health Centre v. Bridges*, [1990] B.C.J. No. 2859 (C.A.), Southin J.A. set out the following passage from Broom's Legal Maxims (10th ed. p. 498):

> It is, moreover, a general proposition that an agreement to do an unlawful act cannot be supported at law—that no right of action can spring out of an illegal contract; and this rule, which applies not only where the contract is especially illegal, but whenever it is opposed to public policy or founded on an immoral consideration, is expressed by the well-known maxim ex turpi causa non oritur actio, and is in accordance with the doctrine of the civil law, pacta quae turpem causam continent non sunt observanda, that is to say, wherever the consideration, which is the ground of the promise, or the promise which is the consequence or effect of the consideration, is unlawful, the whole contract is void.

In *Mira Design v. Seascape Holdings*, [1982] B.C.J. No. 51 (S.C.), the Court said: "[11] ... courts have invoked public policy to declare a contract invalid or illegal, or both, because by its nature and purpose it contravenes a fundamental tenet of society. ..." And see the lengthy discussion of illegal contracts (statutory and at common law) explained in *Brazier v. Columbia Fishing Resort*, [1997] B.C.J. No. 1006.

12 *Ranger Ins.* at 827.

13 S. Hyman, "Settlement of Complex Environmental Insurance Coverage Cases Under the California Code of Civil Procedure" (1995) 24 Sw. U.L. Rev. 1157 at 1158.

Another author, O'Connor, examines the issue from the perspective of the excess insurer.[14] O'Connor analyzes the manner in which courts have dealt with the issues that arise when a policyholder settles with some of its liability insurers, and then seeks additional coverage from excess insurers. In particular, he focuses on situations where one or more excess insurers contend that an underlying insurer settled for less than its actual policy limits; and examines how courts have determined who must cover the gap in coverage between what an underlying insurer actually owed under its policy and the amount it paid in settlement.

O'Connor concludes that American courts generally find that an excess insurer is liable only when the policyholder's liabilities exceed the actual limits of the underlying policies, even if the policyholder received less than such limits in underlying settlements. To the extent that the policyholder's settlements cause a gap in coverage, the policyholder must pay that amount before seeking coverage from its excess insurers.

In one case reviewed by O'Connor, *Allstate Insurance Co. v. Dana Corp.* 759 N.E.2d 1049, 1063 (Ind. 2001), which involved a settlement between insurer and insured in relation to environmental liability claims, the court held that if the primary policies were found on remand not to have applicable aggregate limits, a release of the insurer would require the insured to step into the insurers shoes and pay first-dollar amounts on all future environmental liabilities, with the excess insurer being liable only to the extent that the insured's liability at a particular site exceeded the per occurrence limits of the released insurer's policies.

O'Connor does not explore the issue of a bankrupt or insolvent insured; or an insured that is otherwise unable to make payment. In such circumstances, could the non-settling excess insurer pursue the primary insurer? If, as O'Connor argues, the courts have more or less uniformly ruled that a policyholder's settlement with an underlying insurer cannot negatively affect the obligations of a non-settling excess insurer, then the non-settling insurer should be entitled to recover the difference between settlement and policy limits from the settling insurer.

The questions in this area have been dealt with head-on by the Court of Appeal of California in a leading case on the topic of equitable subrogation and equitable contribution: *Fireman's Fund Ins. Co. v. Maryland Casualty Co.*, 65 Cal. App. 4th 1279 (1998).

In *Fireman's*, the Court identified the parties' primary problem as a failure to distinguish properly between the concepts of equitable subrogation and contribution. In this regard the Court cited several cases which have highlighted the semantic difficulties. In the words of one court cited in *Fireman's*: "[i]t is hard to imagine another set of legal terms with more soporific effect than indemnity, subrogation, contribution, co-obligation and joint tortfeasorship."[15] And, quoting from another decision: "It is also difficult to think of two legal concepts that have caused more confusion and headache for both courts and litigants than have contribution and subrogation."[16] The Court also noted that the confusion is found in case law (at 1300, footnote 7); and explained that this is perhaps because as a practical matter the issue rarely arises:

> ... We suspect this is because the conceptual distinction between equitable subrogation and contribution generally has no practical impact on the ordinary contribution case. Here, however, the insurer from whom contribution is sought argues it was previously released by the insured, and there are therefore no rights to which the other primary insurer can be 'subrogated.' *We have found no reported case addressing this precise scenario of an insured releasing a nonpaying insurer while accepting payment from a second insurer, which thereafter seeks contribution from the first*. [Emphasis added]

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14 J. O'Connor, "Insurance Coverage Settlements and the Rights of Excess Insurers" (2003) 62 Md. L. Rev. 30.

15 *Herrick Corp. v. Canadian ins. Co.* (1994), 29 Cal. App. 4th 753 (at 756).

16 *Fireman's Fund Ins. Co. v. Maryland Casualty Co.*, 65 Cal. App. 4th 1279 (1998).

In *Fireman's*, one insurer, Fireman's, was granted an order for contribution and indemnity, which required another insurer, Maryland, to contribute to the costs of defending and settling an underlying lawsuit on behalf of a common insured.

Maryland had opposed Fireman's motion for contribution and indemnity on the ground that any equitable subrogation rights Fireman's may have had as against Maryland were extinguished by the insured's full release of Maryland from all claims arising from its refusal to defend and indemnify the insured in the underlying action. In reply, Fireman's successfully argued that a claim for contribution is distinct from and independent of a claim based on subrogation, and its action against Maryland was based on the former and not the latter.

On appeal, Maryland argued that Fireman's claims for indemnity and contribution were actually based on its equitable subrogation to the rights of the common insured against Maryland. Because those rights had been settled, released and dismissed with prejudice in previous litigation between Maryland and the insured, Maryland argued that there were no longer any remaining rights against Maryland to which Fireman's could be subrogated. Paraphrasing Maryland's argument, the Court said (at 1290 to 1291):

> Maryland and the insured no longer has any valid and existing claims against Maryland, it argues that Fireman's Fund is 'subrogated to nothing' and consequently barred from seeking equitable contribution.

The Court disagreed, and found that "Maryland has confused the concepts of equitable contribution and equitable subrogation, and is incorrect on the law."

The broad question was thus described by the Court of Appeal as follows (at 1287): "... we address the question whether the equitable doctrines of contribution and subrogation are entirely distinct and independent concepts, or instead are merely different terms for the same principle." And, further (at 1288 to 1289):

> The principal issue raised by Maryland's appeal is whether one insurer's claim against another for contribution of the costs of defending and settling a claim against the insured is based on the theory of equitable subrogation, and is therefore dependent on and limited by the underlying rights of the insured, to which both insurers may be subrogated; or whether instead an insurer possesses a direct cause of action for equitable contribution entirely independent of the rights of the insured. The parties to this appeal agree that if subrogation applies, the judgment for Fireman's Fund should be reversed and judgment entered instead for Maryland; if not, then the judgment must be affirmed as it stands.

In answering this question, the Court of Appeal held as follows (at 1289):

> We conclude that where two or more insurers independently provide primary insurance on the same risk for which they are both liable for any loss to the same insured, *the insurance carrier who pays the loss or defends a lawsuit against the insured is entitled to equitable contribution from the other insurer or insurers, without regard to principles of equitable subrogation*. As a corollary to this principle, we hold that *one insurer's settlement with the insured is not a bar to a separate action against that insurer by the other insurer or insurers for equitable contribution or indemnity*. [emphasis added]

The Court then proceeded to define the two concepts. Concerning subrogation, the Court said (at 1291): "Subrogation is defined as the substitution of another person in place of the creditor or claimant to whose rights he or she succeeds in relation to the debt or claim." And, further (at 1292, citation omitted): "As now applied [the doctrine of equitable subrogation] is broad enough to include every instance in which one person, not acting as a mere volunteer or intruder, pays a debt for which another is primarily liable, and which in equity and good conscience should have been discharged by the latter." And, further,

> The right of subrogation is purely derivative. An insurer entitled to subrogation is in the same position as an assignee of the insured's claim, and succeeds only to the rights of the insured. The subrogated insurer is said to 'stand in the shoes' of its insured, because it has no greater rights than the insured and is subject to the same defenses assertable against the insured. Thus, an insurer cannot acquire by subrogation anything to which the insured has no rights, and may claim no rights which the insured does not have.

The Court then turned to the concept of equitable contribution, which it said was "entirely different" (at 1293-95):

> ... It is the right to recover, not from the party *primarily* liable for the loss, but from a *co-obligor* who *shares* such liability with the party seeking contribution. ... Where multiple insurance carriers insure the same insured and cover the same risk, each insurer has independent standing to assert a cause of action against its coinsurers for equitable contribution when it has undertaken the defense or indemnification of the common insured. Equitable contribution permits reimbursement to the insurer that paid on the loss for the excess it paid over its proportionate share of the obligation, on the theory that the debt it paid was *equally* and *concurrently* owed by the other insurers and should be shared by them pro rata in proportion to their respective coverage of the risk. The purpose of this rule of equity is to accomplish substantial justice by equalizing the common burden shared by coinsurers, and to prevent one insurer from profiting at the expense of others. ...
>
> This 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. ... Instead, the reciprocal contribution rights of coinsurers who insure the same risk are based on the equitable principle that the burden of indemnifying or defending the insured with whom each has independently contracted should be borne by all the insurance carriers together, with the loss equitably distributed among those who share liability for it in direct ratio to the proportion each insurer's coverage bears to the total coverage provided by all the insurance polices. ...
>
> Unlike subrogation, the right to equitable contribution exists *independently* of the rights of the insured. It is predicated on the commonsense principle that where multiple insurers or indemnitors share equal contractual liability for the primary indemnification of a loss or the discharge of an obligation, the selection of which indemnitor is to bear the loss should not be left to the often arbitrary choice of the loss claimant, and no indemnitor should have any incentive to avoid paying a just claim in the hope the claimant will obtain full payment from another co-indemnitor.

The Court pointed out that once an individual insured by multiple policies has been fully indemnified by one policy, the insurer has a right to claim against its co-insurers even though the insured would have no right to do so (having been already fully indemnified). The remaining insurers are not liable to the insured, because he has been indemnified. "They *remain* liable, however, for contribution to those insurers who have already paid on the loss or for the insured's defense." (at 1295). These principles are set out in *Couch on Insurance* at 62:1 (quoted by the Court in a footnote at 1295):

> Where there are several insurance policies covering the same risk on the same insured, the fact the insured is only entitled to recover the actual amount of its loss does not bar it from demanding full coverage from *each* insurer, as long as its demand is made in good faith. By the same token, the insured may obtain recovery from any *one* of its coinsurers for the entire loss, not in excess of the face amount of the policy and in the absence of any provision in the policies limiting liability to a proportionate share of the loss. The coinsurers would then have no further liability to the insured, but *would* be liable for equitable contribution to the carrier which paid the loss.

The Court then cited a lengthy series of cases for the proposition that:

> This right of equitable contribution between coinsurers is not based on, and indeed has nothing to do with, the coinsurers' subrogation to the rights of their insured against the party legally and primarily responsible for the loss. Whereas subrogation requires that the party to be charged be in an 'equitable position ... inferior to that of the insurer' such that justice requires the entire loss be shifted from the insurer to the party to be charged (*Fireman's Fund Ins. Co. v. Wilshire Film Ventures, Inc.*, *supra*, 52 Cal. App. 4th at 556), contribution permits liability for the loss to be allocated among the various insurers without regard to questions of comparative fault or the relative equities between the insurers.

Concerning the public policy principles which underlie each of equitable subrogation and contribution, the court said (at 1296): "The aim of equitable subrogation is to place the burden for a loss on the party ultimately liable or responsible for it and by whom it should have been discharged, and to relieve entirely the insurer or surety who indemnified the loss and who in equity was *not* primarily liable therefor." In contrast, "... the aim of equitable contribution is to apportion a loss between two or more insurers who cover the same risk, so that each pays its fair share and one does not profit at the expense of the others."

In short, the *Fireman's* decision provides strong support for any non-settling insurer seeking to recover a pro-rata payment of obligations from settling insurers. If a non-settling insurer pays more than its proportionate share of indemnity and defence costs, it may be able to pursue settling insurers for contribution. We note, also, that the definitions of subrogation and contribution explained by the court in *Fireman's* have been cited by numerous State and Federal courts. This case appears to be a leading decision on these issues.

We located one short decision which contrasts with *Fireman's*: *Stonewall Ins. Co. v. National Gypsum* No. 86 Civ. 9671 (SWK) (U.S. Dist. Ct. S. Dist. N.Y. (1990). In *Stonewall*, a policy holder was insured or potentially insured by several policies of insurance which related to certain asbestos liability.

The insurers included Hartford, Travelers, AMI and Republic. All had issued or had potentially issued similar insurance policies to the insured. Hartford and Travelers argued that they were not obliged to indemnify their co-insurers because each had releases and agreements to indemnify obtained from the insured in settlement of prior litigation. Travelers had obtained a release from the insured from all liability under the alleged insurance policies for past, present and future asbestos-related bodily injury or property damage and lawsuits against the insured. Hartford's settlement agreement stated that the insured would indemnify Hartford from liability arising out of any property damage claims; and thus, the insured assumed Hartford's obligations under the Hartford policies. A magistrate granted Hartford and Travelers' summary judgment motions, and dismissed an action against them by a co-insurer with prejudice.

Before the magistrate AMI and Republic argued that they might have an equitable right of contribution or indemnification against Travelers and Hartford, and therefore, the dismissal ought to be without prejudice. The magistrate concluded that no basis for such a claim for contribution existed because the settlement agreements abrogated any policy liability, and no evidence even existed that Travelers and Hartford had issued such liability insurance policies to the insured.

On appeal to the District Court, AMI and Republic argued that their equitable right of contribution would arise from the insured's "continuous trigger" theory of coverage. They argued that Travelers and Hartford should have been dismissed without prejudice because future contribution from these defendant insurers would be warranted if (1) the Court eventually accepted the "continuous trigger" theory, (2) it was later learned that Hartford and Travelers issued policies co-existent with the AMI and Republic policies, and (3) the insured's future financial problems rendered it unable to satisfy its assumption of liability on the alleged Hartford policies.

The District Court refused to allow the appeal, holding that the Magistrate had correctly dismissed the declaratory action against Hartford and Travelers with prejudice. In this regard, the Court held as follows:

> ... The Magistrate appropriately relied on *Bunker Hill*,[17] which also granted summary judgment with prejudice to a similarly situated insurance company that had obtained a release from the insured. In *Bunker Hill*, the Court declined to grant summary judgment to a second insurance company that had neither obtained a release nor an assumption of liability by the insured. Instead, this insurance company acted as a "fronting company" for the insured, which in fact reinsured the liability and agreed in a "hold harmless" clause not to sue the insurance company. ... Upon the possibility that the reinsurer might be financially unable to pay, the *Bunker Hill* Court granted summary judgment dismissing the action against the second insurance company without prejudice because it would then have an obligation under its policy.
>
> The unusual "fronting" arrangement in which the insured on the primary policy actually reinsured that policy does not exist here. This Court finds no other basis on which these objecting insurers would have an action for contribution. In the present action, Traveler's release precludes any liability on purported policies, and thus, there is no basis for future contribution. With regard to Hartford, the objecting insurance companies argue that if [the insured] is financially unable to assume the insurance liability obligation of the purported Hartford policies, then the objecting companies may have an equitable claim for contribution against Hartford. However, any required contribution from the alleged Hartford policies would serve as a set-off against the amounts owing to [the insured] from its other insurers.

With these few words the Court ended its analysis of this complex area of the law. The Court did not delve deeply into the concept of contribution as an independent right of one insured against another, severed from rights of the insured against its insurers. Thus, while the case does provide support for the proposition that settling insurers are protected from claims of non-settling insurers; the support may be questionable because of a lack of exposition. A Canadian court, presented with *Fireman's* and *Stonewall* may prefer the detailed analysis provided in the former case. What can be said is that there remains a risk of direct action by another insurer on risk.

4. The American Experience: US Bankruptcy Rule 9019

In the US under Bankruptcy Rule 9019, bankruptcy court approval is required to settle any controversy involving property of the estate or a claim against the estate. As such, Goldberger explains that "Settlements with insurers are subject to bankruptcy court approval, after notice and a hearing." He notes that the threshold for approval "rather low":

> ... requiring only proof that the terms of the settlement do not fall below the 'lowest point in the range of reasonableness.'

However, Goldberger explains that in *In re Dow Corning Corp*., 198 B.R. 214, 222 (Bankr. E.D. Mich. 1996) "...the court held that a settlement of rights to coverage under liability policies in a mass tort context is more akin to an asset sale, and thus may be subject to a higher level of scrutiny."

Indeed, in the US, tort claimants' have brought motions to contest buy-back agreements between the insurer and bankrupt insured. However, such motions (at least in the context of unliquidated tort claims) have generally not met with success. As Goldberger explains:

> In most cases, the underlying tort claims against the debtor have not been liquidated to judgment, and tort claimants do not have direct claims against the insurer. Thus,

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17 *State v. Idaho v. The Bunker Hill Co*., No. 83-3161, slip op. (D. Idaho February 13, 1987).

> their consent may not be required for a settlement between the insurer and the insured. In *Dow Corning*, 198 B.R. at 233-38, the court held that tort claimants had standing as parties in interest under bankruptcy law to be heard regarding the fairness of the settlement, *but in a later decision ruled that their lack of a legally-cognizable interest in the policies mandated dismissal of their objections*.

Additionally, Golderberger notes that

> Courts have approved the release of the debtor's insurers as part of settlements of coverage disputes. *In re A.H. Robins Co.,* 880 F.2d 694, 702 (4th Cir. 1989), cert. denied, *Menard-Sanford v. A.H. Robins Co.*, 493 U.S. 959 (1989); *In re Johns-Manville*, 837 F.2d at 92-93. But see *Feld v. Zale Corp. (In re Zale Corp.)*, 62 F.3d 746, 760 (5th Cir. 1995) (section 524(e) of the Bankruptcy Code bars release of claims against non-debtor insurer).

Nonetheless, bankruptcy of the insured creates a real risk that the buy-back agreement will be set aside by the bankruptcy court.[18] For example, in *Medical Asset Mgmt.*, 249 B.R. 659, the Court held that a settlement agreement between the insured and insurer could not be approved because it was not "fair and equitable" to certain parties in a non-bankruptcy litigation who were not parties to the settlement. The settlement agreement essentially sought to buy-out the policy for nearly 50 cents on the dollar.

The Court held that the settlement agreement was not fair to the plaintiffs in various actions against the bankrupt insured, most of which had not proceeded to judgment. At page 666 the Court said: "They will not be fairly and reasonably compensated in exchange for having to forego any rights they may have to proceed against [the insured] arising out of the [insurance] policy."

The Court further held that the insurer's mere assertion of a "50-50 chance" of the bankrupt insured prevailing against the insurer if the insurer denied coverage "without more, does not enable us to estimate [the bankrupt insured's] chances of prevailing on the matter if it had to pursue the matter in litigation." Thus, it is necessary to adduce evidence to show that the buy-back is reasonable before the court will countenance same.[19]

5. Concluding Remarks Concerning the American Approach

There is certainly a body of American jurisprudence which seeks to support the buy-back regime. Indeed, several authors point towards a public policy goal supporting settlement.[20] Nonetheless, there are those who view such schemes as a mechanism to avoid liability to injured third parties, and to avoid their fair share of contributions with co- and excess non-settling insurers. This is also seen within the context of bankruptcies, where injured parties may be thwarted in their efforts to realize on judgments. Settlements (or buy-backs) which are not fair and equitable will not be approved, or may be set aside.

Concerning liability to third parties, several American decisions seek to avoid buy-back settlements where third parties are prejudiced. Such prejudice will, of course, only arise where the injured party is unable to recover judgment from the insured (for example, due to bankruptcy). In such circumstances, the court may view the buy-back agreement as a void contract, and compel the insurer to pay the judgment (subject to applicable policy exclusions and limits).

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18 M. Quinn and A. Levin, "Directors and Officers Liability Insurance: Probable Directions in Texas Law" (Spring, 2001) 20 Rev. Litig. 381 at 414 to 415.

19 See, also *In re Enron Corp.*, 40 Bankr. Ct. Dec. 228 (2003), which followed this same approach, and cited *Medical Asset Mgmt.*, although the court in *Enron* noted that a "mini-trial" was unnecessary; all that the parties need do is "canvas[ ] the issues to determine whether the settlement falls below the lowest point in the range of reasonableness."

20 See, generally, S. Hyman, "Settlement of Complex Environmental Insurance Coverage Cases Under the California Code of Civil Procedure" (1995) 24 Sw. U.L. Rev. 1157.

In determining whether a policy is void, the courts will generally query (i) whether the buy-back agreement was entered into after the injury to the third party; and (ii) whether there is public policy rationale for avoiding the policy. Concerning the public policy rationale, cases reviewed indicate that where the insured is required to carry the insurance, the courts consider that the insurance is for the public good. Agreements to buy-back such policies, particularly post-occurrence, are often not tolerated, particularly where it undermines a compulsory insurance scheme.[21]

So even the legal regime within which the buy-back vehicle was created has definite risks for the settling insurer.

B. English Approach

1. Insurance Contract—Like Any Other Contract—Use in Settlement

The general English approach is to treat insurance contracts like any other contract. As such, an insurance policy may be discharged by the parties' agreement. In order to bring about discharge, then, it is necessary to fulfill the usual requirements of a binding contract such as consideration and consent.[22]

Upon discharge, the insured abandons his rights under the policy. For example, he abandons rights to insurance cover for the unexpired period of the contract term. In return (i.e., as consideration), the insurer usually returns a proportionate part of the premium.[23]

2. Effect on Third Parties—Policy Considerations

The effects of termination on third parties is generally ignored. One English author, Clarke, explains that[24]:

> ... the solvent insured may terminate his contract with his liability insurer, even though the practical effect is to defeat the claim of the third party against him [citing *Rowe v. Kenway* (1921) Ll L Rep 225]. The law draws a distinction between rights, such as rights in tort against the insured, and the enjoyment of those rights. The third party may be unable to enjoy his rights because the tortfeasor has neither money nor insurance, but the rights themselves, although of no practical value, are unaffected. This being so, the law will not intervene to prevent the discharge of the contract of insurance.

The only exceptions are statutory. As Clarke explains: "A statutory exception appears in respect of motor insurance, whereby the rights of a third party against the insurer may be enforced notwithstanding that the insurer may be entitled to avoid or cancel the policy, for this situation is thought to include the case of discharge by agreement."[25]

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21 *Ranger Ins.* at 827.

22 *Lowlands SS Co Ltd v. North of England P & I Assn* (1921), 6 Lloyds Law Rep 230.

23 M. Clarke, *The Law of Insurance Contracts* (London: Lloyd's of London Press, 1989) at 357 to 58.

24 M. Clarke, *The Law of Insurance Contracts*, 3rd ed. (London: Lloyd's of London Press, 1997) at 18-3D. Concerning the latter point, Dr. Clarke provides a footnote with the following text: "No one's right was infringed" – *Quinn v Leathem*, [1901] AC 495, 539 *per* Lord Lindley; see also *Allen v. Flood*, [1898] AC 1. *CF Hood's Trustees v. Southern Uninon General Ins. Co.*, [1928] Ch 793 (CA – motor).

25 M. Clarke, *The Law of Insurance Contracts*, 3rd ed. (London: Lloyd's of London Press, 1997) at 18-3D.

C. Canadian Approach

We did not locate any Canadian academic discussion of buy-back schemes. As well, we were unable to find any discussion of the issues in the case law, with one exception discussed below. We have, however, discovered several statutes which impact the topic. Following, we provide a discussion of these statues.

1. Statutes

a. Insurance Act

In BC, third party tort claimants have rights provided by statue. In this regard, we consider BC's *Insurance Act* and the federal *Bankruptcy and Insolvency Act*.

The BC *Insurance Act*, R.S.B.C. 1996, c. 226, (the "BC *Insurance Act*") provides a right of action by a third party against an insurer:

> **24**(1) If a judgment has been granted against a person in respect of a liability against which the person is insured and the judgment has not been satisfied, the judgment creditor may recover by action against the insurer the lesser of
>
> (a) the unpaid amount of the judgment, and
>
> (b) the amount that the insurer would have been liable under the policy to pay to the insured had the insured satisfied the judgment.
>
> (2) The claim of a judgment creditor against an insurer under subsection (1) is subject to the same equities as would apply in favour of the insurer had the judgment been satisfied by the insured.[26]

In *Azvedo v. Markel*, [1999] A.J. No. 1201 (C.A.), the Alberta Court of Appeal concluded that a third party could claim against a tortfeasor's insurer pursuant to s. 219 of the Alberta *Insurance Act*, R.S.A. 1980, c. I-5 (the "Alberta Act"), which section is similar to the BC *Insurance Act*. Picard J.A., speaking for the majority, described the issue in the case as follows: "[1] ... whether a mutual agreement that is entered into post-loss between the insured and the insurer to waive insurance coverage can defeat the right of the insured's judgment creditor to look to the insurer for payment of an unsatisfied judgment."

Of note, the insurance policy held by the tortfeasor in *Azvedo* was one which he was required, by law, to carry (see para. 7 of the reasons for judgment).

Section 219 of the Alberta Act provides as follows:

> **219.** In any case in which a person insured against liability for injury or damage to persons or property of others has failed to satisfy a judgment obtained by a claimant for the injury or damage and an execution against the insured in respect thereof is returned unsatisfied, the execution creditor has a right of action against the insurer to recover an amount not exceeding the face amount of the policy or the amount of the judgment in the same manner and subject to the same equities as the insured would have if the judgment had been satisfied.

Picard J.A., speaking for the majority, explained that there are three prerequisites which must be satisfied before the third party can claim against the insurance company: (i) the insured had a valid liability policy in place at the time of the loss; (ii) the third party has obtained a judgment against the insured; and (iii) the judgment remains unsatisfied (see para. 6, reasons for judgment). Picard J.A. held that all three features were present.

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26 The words "is subject to the same equities" has been interpreted as including "a defence available to the insurer under the terms of the written contracts of insurance."

Picard J.A. drew these three "prerequisites" from the wording of the Alberta Act, s. 219. The wording of the Alberta Act and the BC *Insurance Act* differ in one respect. In particular, the Alberta Act arguably does not indicate *when* insurance coverage must have extended to the liability in question.

In contrast, the BC *Insurance Act*, s. 24, *does* stipulate the period of time for insurance coverage. Section 24 provides that the rights of a person to recover against the insurance company extends to circumstances "against which the person *is* insured." Arguably, this express language implies that a third party is precluded from bringing an action for recovery against the insurance company for the insurers liability which was, for example, once insured, but is no longer insured. That is, s. 24 does not appear to provide a right of action in cases where the tortfeasor *was* insured. Thus, in the BC context, an additional "prerequisite" might be added to the list enunciated by Picard J.A.; that is, that the insured must be insured on the date the judgment relating to the liability in question is granted.

While this argument certainly has some attraction, a court in BC seeking to recompense the owner of contaminated land, or seeking to recompense or uphold a government remediation order, may not view the language so strictly. Rather, the court may do all in its power to require the insurer to indemnify the third party judgment creditor.

In *Azvedo*, the Court also focused on the words in s. 219 which provide that the third party''s rights are "subject to the same equities as the insured would have if the judgment had been satisfied." The Court considered the issue of whether the insurer could have asserted an equitable defence to the insured's request for coverage in light of the agreement to waive insurance coverage. In this respect, Picard J.A considered it important that the insured was required, by statute, to hold insurance:

> [11] The issue, then, is this: when an insured requests and the insurer agrees to its insured voluntarily assuming liability for a loss that has already occurred, thereby eliminating coverage *that is required by legislation*, is the right to compensation of a person who otherwise fulfills the requirements of s. 219 defeated? ...

Picard J.A. rejected Markel's argument that the Alberta Insurance Act did not specifically prohibit an agreement to waive insurance coverage. In this respect, she again emphasized the fact that the insurance was required by law:

> [14] If we were to accept Markel's submission, the result would be an inconsistent legislative regime that requires carriers to maintain liability insurance, presumably for the benefit of the third party, yet at the same time allows insurers and insureds to agree to waive coverage thus depriving the third party of the benefit and protection of compulsory insurance. In reality, the insurance industry enjoys a guaranteed market for its policies and a guaranteed source of premiums because of compulsory insurance schemes, and yet Markel's proposed resolution would leave intended third party beneficiaries with no certainty of recovery at all.

Picard J.A. then considered whether the release agreement between the insurer and the insured provides the insured with an "equity" (which is required to defeat the claim of a third party under s. 219 of the Alberta Act). She held that

> [16] ... There are significant differences between the situation where the insured, by its unilateral act, breaches the insurance contract or one of its terms and that where an insured and insurer enter into a post-loss agreement that there will be no coverage, *in the face of legislation requiring it*.

Using language and arguments similar to those employed by the Texas Court of Appeal in *Ranger Ins. Co. v. Ward*, Picard J.A. held that "[16] ... an equity is not something that two parties can deliberately create. ..."; that public policy militates against upholding such agreements; and to countenance such agreements "[17] ... leaves open the possibility of collusion ..."

Arguably, these comments must be seen in light of Picard J.A.'s determination that the insurer's and insured's release agreement ran counter to legislative requirements that insurance be in place. In the

context of liability insurance covering environmental risks, we are not aware of any legal requirement that the insured hold the insurance policies in question. Therefore, Picard J.A.'s comments regarding public policy militating in favour of the third party's cause of action against the insurer are arguably inapplicable.

Nonetheless, whether the agreement runs counter to legislative requirements or not is irrelevant to Picard J.A.'s other two points. That is, even absent compulsory insurance, the equity referred to in s. 24(2) of the BC *Insurance Act* is not something that could be deliberately created. As well, a BC court may view the buy-back agreement (which is an unusual creature in Canada) with suspicion, and perhaps view it as leaving "open the possibility of collusion."

While *Azvedo* may be distinguished on the two grounds identified above, the case undoubtedly creates a real risk that the third party claimants will demand that the insurer provide insurance coverage notwithstanding the buy-back agreement. Such risk will, of course, only arise if the insured is unable to satisfy claims made against it. However, if the gloomy picture which insureds paint in their worst case scenario comes to fruition, there is a real possibility the insured may face bankruptcy. In such circumstances, judgment creditors will come to the settling insurers under s. 24(1) of the BC *Insurance Act*.

b. Bankruptcy and Insolvency

Bankruptcy or insolvency of an insured represents another potential problem for an argument seeking to uphold a buy-back agreement. In such circumstances, statutes exist to protect the rights of the insured's creditors. Where the insured declares bankruptcy, the buy-back of an insurance policy may be scrutinized by the courts.

i. The Canadian Experience: The Bankruptcy and Insolvency Act

In the Canadian context, the *Bankruptcy and Insolvency Act* (the "*BIA*"), which is a federal Act, may govern the agreement between an insurer and insolvent insured for the buyback of an insurance policy.

Under s. 91(1) of the *BIA*, certain settlements are deemed to be void. Specifically,

> Any settlement of property made within the period beginning on the day that is one year before the date of the initial bankruptcy even in respect of the settler and ending on the date that the settlor became bankrupt, both dates included, is void against the trustee.

Similarly, a settlement of property made within five years before the bankruptcy is void, but only (among other reasons) if the trustee can prove that the settlor was, at the time of making the settlement, unable to pay all the settlor's debts without the aid of the property compromised by the settlement (s. 91(3)).

However, s. 91(1) and (3) do not extend, pursuant to s. 91(3)(a), to "any settlement made ... in favour of a purchaser ... in good faith and for valuable consideration ..."

An insurance policy, or at least the right to make a claim under that policy, is property of the insured. Therefore, any buy-back may fall under s. 91 of the *BIA* should the insured become insolvent within five years of the buy-back.

It is therefore necessary to ensure that any buy-back of the policy is made "in good faith and for valuable consideration." Failure to adhere to these requirements may result in the court setting aside the buy-back, and putting the insurance policy in the hands of the trustee in bankruptcy. The trustee in bankruptcy will then likely seek to enforce the terms of the insurance policy in order to meet the claims of tort claimants.

The terms "good faith" and "valuable consideration" have been considered in numerous cases. "Consideration" is consideration moving to the bankrupt from the beneficiary of the settlement (*CIBC v. Thimianis* (1985), 54 C.B.R. (N.S.) 314 (Ont. S.C.) and *First Canadian Land Corp. v. First Canadian Plaza Ltd*, (1991), 6 C.B.R. (3d) 308 (B.C.S.C.)). "Nominal" consideration does not make the transferee a purchaser for "valuable" consideration (*Re. Shickele*, [1977] 5 W.W.R. 421 (B.S.C.S.)). "Good faith" means to act honestly, and the onus of so proving rests on the beneficiary of the settlement (*Springside Farms Ltd. v. Spence* (1991), 95 Sask. R. 193 (Q.B.)). The "good faith" is that of the beneficiary of the settlement, not of the bankrupt (*CIBC v. Thimianis*). Furthermore, the intent of the transferor is irrelevant on this issue (*Re Grant* (1926), 7 C.B.R. 254 (N.S.S.C.)).

Therefore, any settlement allowing the insurer to "buy-back" the policy, must be made for valuable consideration *cf*. nominal consideration. And, further, the insurer must act honestly in effecting the buyback.[27]

It is also necessary to avoid falling afoul of the provincial *Fraudulent Conveyances Act*. The Act renders void a conveyance of real or personal property made with intent to defeat, hinder, delay or defraud creditors or others. The Act makes in important distinction between voluntary conveyances and conveyances made for good consideration. If a conveyance is voluntary, it is only necessary to show the fraudulent intent of the maker; if it is made for good consideration, it is necessary to show the fraudulent intent of both parties to the transaction (*Bank of Montreal v. Ngo and Wong* (1985), 66 B.C.L.R. 171 (S.C.)). Furthermore, if the transfer was made for good ("valuable") consideration, it will be difficult to impeach it for "bad faith": *Meaker Cedar Products Ltd. v. Edge* (1968), 68 D.L.R. (2d) 294.

Therefore, in the case of buy-back of an insurance contract, where valuable consideration is provided by the insurer to the insured, it seems very unlikely that a court would find fraudulent intent on the part of either party.

Additional decisions in the bankruptcy context are informative. In *Re Duvall* (1992), 63 B.C.L.R. (2d) 97 (S.C.), the Court held that a creditor can bring proceedings against a discharged bankrupt in order that the creditor may claim against an insurer under a policy of liability insurance. In that case the policy of insurance had not been terminated. The Court noted that by statute it is normally impermissible to allow an action to proceed against an undischarged bankrupt. In this case, however, the bankrupt was insured. To allow the proceedings would in no way effect other creditors as the insurer would pay any award of damages. The plaintiff (tort victim) had a beneficial interest in the policy of insurance, and on that basis, the Court held that she had a right to enforce the contract.

One bizarre feature of this case is the judge's finding that "The respondent has no proprietary interest in the insurance policy in question." The judge relied on *Re Major* (1984), 54 C.B.R. 28 for that proposition; but in *Re Major*, Wood J. (as he then was) held that the insured had no proprietary interest "in the proceeds of that insurance." The proceeds of the insurance, and the policy itself, are two different things. We do not think it would be difficult to convince a court of the error in *Re Duvall*.

In any event, a case such as *Re Duvall* can be distinguished where the policy has been terminated prior to the bankruptcy, and the termination was more than five years prior to bankruptcy, or the termination falls within the exceptions to setting the transaction aside, which exceptions are outlined above. In *Re Major*, Wood J. held that the applicants were entitled to the benefit of any money *which became payable* under the insurance policy. If no funds became payable, *i.e.*, if the policy had been terminated, then clearly the applicant would be entitled to nothing. If the policy is terminated, no policy exists which can be enforced.

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27 See, generally, S. Hyman, "Settlement of Complex Environmental Insurance Coverage Cases Under the California Code of Civil Procedure" (1995) 24 Sw. U.L. Rev. 1157. Hyman reviews good faith settlements between insurer and insured in California. Settling insurers which have not settled in good faith are subject to claims for contribution and indemnity from non-settling insurers.

2. Claims for Contribution, Indemnity and Subrogation by Co- and Excess Insurers

In Canada, as in the US, excess and co-insurers may be able to seek contribution and indemnity from one another (see, for example, *Ayr Farmers Mutual Ins. Co. v. CGU*, [2003] O.J. No. 1523). This is because the insurers must share obligations.[28] The contributing insurer may be entitled to pursue non-contributing insurers.

If the co-insurer limits his damage to those claims coming within his own policy without paying anything arguably covered by the settling insurer, then there would be no need to sue the other insurer. However, particularly in relation to defence costs, there remains some risk that the non-settling insurer may incur some costs that arguably ought to have been paid by the settling insurer.

In one Ontario case discussing this right to pursue other insurers, they refer to the right between insurers as "subrogation."[29] This could suggest that this court would be more likely to adopt the approach which reduces the risk of non-settling insurers pursuing a settling insurer.

However, we note the recent BC Court of Appeal decision in *Pacific Forest Products Ltd. v. AXA Pacific Ins.*, 2003 BCCA 241 (leave to appeal to the S.C.C. dismissed, with costs). The exposition of subrogation and contribution in *Pacific Forest* is materially identical to the explanation of same in *Fireman's*. Thus, the law of California and the law of BC appear to be the same, and a BC court will likely be untroubled in following *Fireman's*.

In *Pacific Forest*, Axa brought a motion to have Pacific Forest's claim against it dismissed. Pacific Forest had contracted with GBA Logging to perform certain logging activities. Pursuant to the contract, GBA was required to carry insurance coverage, and it did so with Axa. Pacific Forest maintained its own insurance with Lumberman's Underwriting. Pacific Forest claimed under its policy for certain firefighting expenses and it was indemnified by Lumberman's for the full amount less a $100,000 deductible. Lumberman's then commenced an action in Pacific Forest's name against Axa, Axa brought its dismissal motion arguing that the action was misconceived because Lumberman's was seeking to recover by suing in Pacific's name rather than suing in its own name for contribution. Axa argued that Pacific Forest had no cause of action because it had already been indemnified by Lumberman's. The judge held that Pacific Forest's claim was sufficiently well framed to survive the pleadings challenge.

The Court of Appeal allowed the appeal, in part. The pleading assumed that Pacific Forest was an insured under the Axa policy. Pacific Forest therefore had two policies covering the same risk. The case was therefore one of double insurance and thus beyond the reach of subrogation. The claim for the indemnified sums was therefore misconceived. However, it was possible that Pacific had its own claim against Axa for the amount of the deductible. It was therefore appropriate that that portion of the claim proceed.

In the course of her reasons, Saunders J.A., writing for the court, discussed the differences between subrogation and contribution as follows:

> [16] The claim, it is clear, is advanced on the premise that Pacific was insured to the limit of $1,000,000 for forest fire-fighting expenses. If that central allegation is

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28 *Canadian Universities' Reciprocal Ins. v. Halwell Mutual Ins. Co.* (2002), ONCA C31352 at para. 18.

29 In *Broadhurst and Ball v. American Home Assurance*, [1990] O.J. No. 2317 (C.A.) the Court said (at 13) that while there was no contract between the policyholder's insurers "Nonetheless, their obligations should be subject to and governed by principles of equity and good conscience, which, in my opinion, dictate that the costs of litigation should be equitably distributed between them." And further, between insurers there exists an "equitable subrogation right ... to compel [one insurer] to pay [to the other insurer] a fair share of the costs of defence."

correct, Pacific is in the position of having two insurance policies covering the same risk. In my view, it is accordingly a claim in a case of double insurance and thus beyond the reach of subrogation but, for reasons long expressed by courts, within the reach of a claim for relief in the nature of contribution.

[17] The principle of subrogation is a device which gives effect to the contract of insurance, protecting the insurer by permitting it to pursue claims against a third party in the name of the insured in respect of losses which have been indemnified. So, for example, Brett L.J. in *Castellain* [*v. Preston* (1883), 11 Q.B.D. 380 (C.A.)] described subrogation in these terms at pp. 388:

> as between the underwriter and the assured the underwriter is entitled to the advantage of every right of the assured, whether such right consists in contract, fulfilled or unfulfilled, or in remedy for tort capable of being insisted on or already insisted on, or in any other right, whether by way of condition or otherwise legal or equitable, which can be, or has been exercised or has accrued, and whether such right could or could not be enforced by the insurer in the name of the assured by the exercise or acquiring of which right or condition the loss against which the assured is insured, can be, or has been diminished.

[18] The statement in Castellain is well accepted today. For example, at p. 495, Ivamy's General Principles of Insurance Law refers to Castellain in describing the general rule, as does MacGillvray on Insurance Law, 9th ed. (London: Sweet and Maxwell 1997) at p. 22-2.

[19] Contribution, on the other hand, is a device for relief of an indemnifier where others have undertaken to indemnify for the same risk, described as a case of 'double insurance'. Thus in *Family Insurance Corp. v. Lombard Canada Ltd.*, [2002] S.C.J. No. 49, Bastarache J. described the principle at paras. 14 and 15

> [14] It is a well-established principle of insurance law that where an insured holds more than one policy of insurance that covers the same risk, the insured may never recover more than the amount of the full loss but is entitled to select the policy under which to claim indemnity, subject to any conditions to the contrary. The selected insurer, in turn, is entitled to contribution from all other insurers who have covered the same risk. This doctrine of equitable contribution among insurers is founded on the general principle that parties under a coordinate liability to make good a loss must share that burden *pro rata*. It finds its historic articulation in the words of Lord Mansfield C.J. in *Godin v. London Assurance Co.* (1758), 1 Burr. 489, 97 E.R. 419, at p. 420:
>
> > If the insured is to receive but one satisfaction, natural justice says that the several insurers shall all of them contribute *pro rata*, to satisfy that loss against which they have all insured.

[15] More recently, *Ivamy's General Principles of Insurance Law* (6th ed. 1993) set out at p. 518 the general principles concerning the right of contribution among insurers as follows:

> (1) All the policies concerned must comprise the same subject-matter.
>
> (2) All the policies must be effected against the same peril.
>
> (3) All the policies must be effected by or on behalf of the same assured.

> (4) All the policies must be in force at the time of the loss.
>
> (5) All the policies must be legal contracts of insurance.
>
> (6) No policy must contain any stipulation by which it is excluded from contribution.

[20] In often quoted reasons of Sholl J. in *Dawson v. Bankers & Traders Insurance Co. Ltd*., [1957] V.R. 491 (S.C. Vict.) at pp. 502-3

> The principle upon which such contribution can be recovered has not, I think, been put more clearly in any case than it was put by the Lord Ordinary (Lord Law) in *The Sickness and Accident Insurance Association Ltd. v. The General Accident Assurance Corporation Ltd*. (1802), 19 R. (Court of Session) 977, at p. 980: '... a rule which has been long recognized is that when the insured has recovered to the full extent of his loss under one policy, the insurer under that policy can recover from other underwriters who have insured the same interest against the same risks a rateable sum by way of contribution. The foundation of the rule is that a contractor of marine insurance is one of indemnity, and that the insured, whatever the amount of his insurance or the number of underwriters with whom he has contracted, can never recover more than is required to indemnify him. The different policies being all with the same person, and against the same risk, are therefore regarded as truly one insurance, and if one of the underwriters is compelled to meet the whole claim, he is entitled to claim contribution from the other underwriters, just as a surety or cautioner who pays the whole debt is entitled to claim rateable relief against his co-sureties or co-cautioners.'

Based on the differences between equitable subrogation and contribution, and the *Fireman's* decision, the following example shows what could happen in BC, and reveals the risk to settling insurers under a buyback scheme:

> Smith is insured by two insurers, insurer A and insurer B. Both insurers provided policies which limit indemnity to $1,000,000 per occurrence. Policy A (insurer A's policy) provides coverage for year 1; and Policy B provides coverage for year 2.
>
> Smith is confronted with a liability claim by a third party. The claim relates to an occurrence spanning years 1 and 2.
>
> Insurer A and B deny coverage. Smith commences a coverage action. Before the coverage action concludes, insurer A settles with Smith for 50% of the policy limits ($500,000) (i.e., the insurer purports to buy-back the insurance policy). The court orders insurer B to provide a defence.
>
> The third party's claim against Smith proceeds through trial. An order is entered against Smith in the amount of $1,500,000.
>
> Smith has already spent the $500,000 he received from Insurer A and he declares bankruptcy.
>
> Insurer B tenders its policy limits $1,000,000 (in addition to defence costs which it already incurred).
>
> Insurer B feels that it has been prejudiced by the settlement which Insurer A entered into with Smith. Not only did Insurer B pay the entire defence costs, but it also tendered its full policy limit of $1,000,000. Allocating the damages across the 2 year period, it should have only been obliged to pay $750,000 plus 50% of defence costs. Insurer B cannot collect from Smith as he is bankrupt. Does Insurer B have any recourse against Insurer A?

In this example, there is a risk that Insurer B could sue Insurer A directly for equitable, pro rata contribution ($250,000 plus 50% of the defence costs). It could be argued that Insurer B should have protected itself by not paying the full $1,000,000 if it was not properly covered under his policy (for example, if the damage was incurred over two policy years only one of which was covered by Insurer B). However, this leaves the issue of defence costs. Again, it could be argued that Insurer B could protect itself by asserting an equitable set off in any action by the insured. However, there remains a risk that Insurer B will be stuck paying sums that Insurer A would have paid absent the settlement, either in terms of indemnity or defence costs. Hence Insurer B will pursue Insurer A. While Insurer A could theoretically seek to enforce the Settlement Agreement or buyback agreement against Smith; Smith is bankrupt and Insurer A is unlikely to recover anything.

IV. Conclusion

In relation to any buy-back arrangement there is a risk of attack from third party claimants under the BC *Insurance Act* and bankruptcy legislation or from co-insurers.

The extent of the risk depends on the following variables:

a. Will the insured successfully defeat any claims brought? To the extent the insured is able to defeat the claim on the merits, or make the claim sufficiently uneconomic to be brought at all, then all risk is removed.

b. Will the insured have the assets necessary to satisfy any judgment? This factor requires a forward-looking accounting analysis and considerable economic speculation. However, if the insured is able to pay the judgments as they arise, all risk is removed.

c. Will a court conclude that the insurer was acting in good faith? This depends on a reasonably thorough analysis of the merits of the claim in order to come to a settlement amount that is within a zone of reasonableness. If a court finds that the amount paid was fair, then the risk is substantially reduced.

d. Will a Canadian court conclude that buy-backs should be allowed at all as a matter of public policy? The law is mixed in the US, but generally if the deal is in good faith and there is no compulsory insurance requirement being undermined, such arrangements appear to be respected. In Canada, there is only one case, and it arose in the context of compulsory insurance. However, it used relatively strong and broad language to strike down the buy-back. BC's legislation can be read as slightly more favourable to buy-backs, and environmental liability is not a compulsory insurance situation, but is that enough?

e. Will any non-settling co-insurer be wise enough to manage its exposure so that it does not pay any expenses that arguably should have been paid by the settling insurer? If so, then they should not ever have to pursue the settling insurer.

f. Will the Canadian court conclude that any co-insurer stands in the shoes of the insured (or will they conclude that they have their own independent right of action)? If co-insurers are simply standing in the insured's shoes, then they should have no right to pursue the settling insurer. One Ontario court seems to suggest the former, while a recent BC court suggests the latter (at least in terms of contemporaneous insurers). There is a similar division in the US case law.

None of these risks is immaterial. Combined together, they are substantial. The issue is whether they are so substantial that insurers in Canada should not engage in the exercise at all, or whether they are manageable simply by reducing the amount the settling insurers are willing to pay.

We know that buy-back agreements are being made in Canada. In due course, the case law may or may not reveal the answers to these questions.