AN UPDATE ON RECENT INSURANCE COVERAGE DECISIONS FROM THE SUPREME COURT AND THEIR IMPACT

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INSURANCE LAW TELEPHONE SEMINAR

March 7, 2008 / 12:00 noon Central Time

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I. *Mid-Continent Insurance Company v. Liberty Mutual Insurance Company*, 236 S.W.3d 765 (Tex. 2007)

A. Facts

In November 1996, an automobile accident occurred in a construction zone. Kinsel Industries was the general contractor on the highway project and Crabtree Barricades was Kinsel's subcontractor responsible for signs and dividers. Kinsel was insured by Liberty Mutual for $1 million under a CGL policy and a $10 million excess liability policy. Crabtree was insured by Mid-Continent under a CGL policy providing $1 million in coverage. Kinsel was named as an additional insured under the Mid-Continent policy. The exposure of Kinsel was the subject of some dispute. At mediation, Liberty Mutual agreed to settle for $1.5 million. Mid-Continent believed the settlement value of the case against Kinsel to be only $300,000 and agreed to only pay $150,000. Liberty funded the remaining $1.35 million of the settlement and tried to seek recovery from Mid-Continent. Liberty initially sued Mid-Continent in state court in Dallas County, Texas. This case was then removed to federal court by Mid-Continent. At the district court level, the trial judge determined that each insurer owed a duty to act reasonably in exercising its rights under the CGL policy and found that Mid-Continent was objectively unreasonable in assessing Kinsel's share of liability and ordered Mid-Continent to pay the remaining limits ($550,000) under its general liability policy. Mid-Continent had previously paid $300,000 to settle the claim against Crabtree.

Three questions were certified by the Fifth Circuit to the Texas Supreme Court. They were as follows:

1. Two insurers, providing the same insured applicable primary insurance liability coverage under policies with $1 million limits and standard provisions (one insurer also providing the insured coverage under a $10 million excess policy), cooperatively assume defense of the suit against their common insured, admitting coverage. The insurer also issuing the excess policy procures an offer to settle for the reasonable amount of $1.5 million and demands that the other insurer contribute its proportionate part of that settlement, but the other insurer, unreasonably valuing the case at no more than $300,000 contributes only $150,000 although it could contribute as much as $700,000 without exceeding its remaining available policy limits. As a result, the case settlements (without an actual trial) for $1.5 million funded $1.35 million by the insurer which also issued the excess policy and $150,000 by the other insurer.

   In that situation is any actionable duty owed (directly or by subrogation to the insured's rights) to the insurer paying the $1.35 million by the underpaying insurer to reimburse the former respecting its payment of more than its proportionate part of the settlement.

2. If there is potentially such a duty, does it depend on the underpaying insurer having been negligent in its ultimate evaluation of the case as worth no more than $300,000, or does the duty depend on the underpaying insured's evaluation having been sufficiently wrongful to justify an action for breach of the duty of good faith and fair dealing for denial of a first party claim, or is the existence of the duty measured by some other standard?

3. If there is potentially such a duty, is it limited to a duty owed the overpaying insurer respecting the $350,000 it paid on the settlement under its excess policy.

The Texas Supreme Court answered the first certified question in the negative and therefore did not reach the next two questions.

B. Holdings

1. Contribution

On the issue of contribution, the supreme court noted that in its earlier decision of *Traders & Gen. Ins. Co. v. Hicks Rubber Co.*, 140 Tex. 586, 169 S.W.2d 142 (Tex. 1943), that the right of contribution does exist where one insurer pays amounts concurrently due by other insurers. However, the court in *Hicks Rubber* pointed out that the direct claim for contribution between co-insurers disappears when the insurance policies contain "other insurance" or "pro rata" clauses. The court in this case noted that the policies in question did contain "other insurance" clauses limiting their liability under the terms of the policy. As a result, under *Hicks Rubber*, there was no right of contribution. The court did note that a San

Antonio Court of Appeals in *General Agents Insurance Co. of America v. Home Insurance Co. of Illinois*, 21 S.W.3d 419 (Tex.App.—San Antonio 2000, *pet. dism'd by agr.)*, such a right had been recognized. The court specially disproved of the *General Agent's* decision to the extent it created a common law duty between co-primary insurers to reasonably exercise rights under an insurance policy.

2. Subrogation

The second cause of action addressed was the right of subrogation. The supreme court noted that both *Hicks Rubber* and *Employers Cas. Co. v. Transportation Ins. Co.*, 444 S.W.2d 606 (Tex. 1969), contain language that such an avenue of reimbursement could exist. The majority pointed out that two types of subrogation exists. The first is conventional, which is created by an agreement or contract. The second is equitable (or "legal") subrogation which is not dependent upon a contract, but arises in every instance in which one person, not acting voluntarily, has paid a debt for which another was primarily liable and which equity should have been paid by the later. Both Liberty Mutual and Mid-Continent policies contain subrogation clauses. However, the majority pointed out that whether the asserted right was at equity or conventional, Liberty Mutual must step into the shoes of Kinsel. As such, Liberty Mutual would be subject to any defenses that Mid-Continent possessed against Kinsel. The majority noted that the insured in this case was fully indemnified and had no right to recover additional insured amounts from any other insurer.

Liberty Mutual also argued that it was subrogated to the common law right of Kinsel to enforce Mid-Continent's duty to act reasonably when handling an insured's defense. The court noted that only one common law duty exists in the third-party context and that is limited to the *Stowers* duty. The court held that Mid-Continent did not breach any *Stowers* duty to Kinsel because the plaintiffs did not make a settlement offer within Mid-Continent's policy limits, and the court declined to extend *Stowers* any further.

3. Concurring Opinion

Justice Willett concurred in the result. However, the basis for the concurring opinion was that Mid-Continent had defended and fulfilled all the terms of its obligations under the policy. Willett indicated that a different result would attach if Mid-Continent had denied coverage and refused to pay anything or to defend its insured. Specifically, Justice Willett stated that:

> The result might also be different in a case involving a primary insurer and an excess carrier, where the primary alone provided the defense and failed to settle within its policy limits, if a judgment had been entered against and paid in part by Kinsel and Mid-Continent refused to cover its proportionate share of the judgment, or if Mid-Continent had denied coverage and had refused to pay anything or defend the insured. . . .

The later language presents several new issues. Obviously, if Mid-Continent had refused to defend its insured, it would not be in a position to rely upon any of the conditions in the policy. However, according to Willett, if Mid-Continent had not breached any of the policy provisions, but merely had determined that the case was not worthy of any settlement dollars, a different result might attach. This is a slippery slope which undoubtedly will create much fodder for litigation in the future.

II. *PAJ, Inc. d/b/a Prime Art & Jewel v. The Hanover Insurance Company*, 51 Tex.Sup.J. 302 (Jan. 2008)

A. Facts

PAJ, Inc. is a jewelry manufacturer and distributor. In 1998, it was sued by Yurman Designs, Inc. for alleged infringement on a particular jewelry line. For six months after the suit was filed, PAJ did not notify Hanover of the lawsuit, but rather defended itself. Finally, it realized that coverage was available under its CGL policy and forwarded notice to Hanover. PAJ brought this suit against Hanover seeking a declaration that Hanover was contractually obligated to defend and indemnify PAJ in the copyright suit. The parties stipulated that PAJ failed to notify Hanover of the claim "as soon as practicable," but that Hanover was not prejudiced by the untimely notice. The trial court granted Hanover's motion and denied PAJ's. The Dallas Court of Appeals affirmed. 170 S.W.3d 258.

B. Holding

The issue before the court was whether prejudice was a requirement for a late-notice defense by Hanover. The supreme court noted that in *Members Mutual Insurance Co. v. Cutaia*, 476 S.W.2d 278 (Tex. 1972), the supreme court had held that in a policy providing that proper notice was a "condition precedent" to the duty to pay, that prejudice was a requirement. Shortly thereafter, the State Board of Insurance responded with Board Order 23080 requiring a mandatory endorsement for all Texas CGL policies. The endorsement required by Board Order 23080 provides that:

> As respects bodily liability coverage and property damage liability coverage, unless the company is prejudiced by the insured's failure to comply with the requirement, any provision of this policy requiring the insured to give notice of action, occurrence or loss, or requiring the insured to forward demands, notices, summons or other legal process, shall not bar liability under this policy.

The majority held that prejudice was not a requirement in this situation. Several reasons were given. First, the court noted that at the time the State Board of Insurance created the endorsement, there was no standard coverage for advertising injury. Second, the court noted that subsequent to the Board Order 23080, the court had decided *Hernandez v. Gulf Group Lloyds,* 875 S.W.2d 691 (Tex. 1994) holding that a consent-to-settle clause under a insured motorist policy could not be enforced unless prejudice was shown. This, of course, is not the issue in a late-notice case. However, the court applied its holding by analogy. The third basis for the court's opinion was that major treatises have acknowledged Texas as a notice-prejudice rule. Again, the cases in Texas have been mixed at best and the fact that some commentators may have misinterpreted Texas law seems hardly a basis for the court's decision.

Finally, the majority noted that the majority trend among all jurisdictions is to require prejudice where there is late notice. As a result, the court held that prejudice would be required and that the six months delay by PAJ in giving notice to Hanover would not bar coverage.

C. Dissent

Four members of the court joined the dissent written by Justice Willett. The dissent first points out that the *Hernandez* case did not involve a condition precedent, but rather an exclusion. Therefore, the majority's reliance upon that was misplaced. Second, the court pointed out that with respect to the State Board's Amendatory Endorsement, that advertising injury and personal injury has been part of the standard coverage provided in the general liability policy now for over thirty years and there has been no response by the State Board for over thirty years in reaction to this change. Finally, the dissent points out that in October 2000, ISO promulgated an endorsement that requires prejudice not only for bodily injury and property damage, but also for advertising injury and personal injury which if the TDI should desire, could require to be mandatory.

III. *National Union Fire Insurance Company of Pittsburgh, PA, v. Crocker*, 51 Tex.Sup.J. 518 (Feb. 15, 2008)

A. Facts

In this case, Beatrice Crocker was a resident of a nursing home owned by Emeritus Corporation. She filed suit against Emeritus and one of its employees, a Richard Morris, for injuries she received when she was struck by a door swung open by Morris. Emeritus was insured by a CGL policy issued by National Union. Morris would be an additional insured under the terms of the policy since he was an employee acting within the course and scope of his employment. The evidence was undisputed that Morris did not know he was an additional insured under the policy and did not request a defense. Likewise, the evidence was undisputed that National Union did not inform Morris that he was an insured nor did it offer to defend him. Morris refused to meet with any counsel employed by Emeritus. The trial resulted in a take-nothing judgment against Emeritus. However, the claims against Morris were severed from the trial and a default judgment in the amount of $1 million was entered against him on the severed claims.

Suit was brought by Crocker against Morris to recover under the judgment. National Union asserted that Morris had failed to comply with the notice provision. Crocker asserted that there was no prejudice from failure to comply with the notice provision because National Union was aware of the lawsuit and National Union had a duty to inform Morris of the existence of coverage available to him as an additional insured. The Federal District Court agreed with Crocker and concluded that Texas law required National Union to show prejudice and that National Union had breached a duty to defend Morris by failing to notify him that it would defend him and a judgment was entered in the amount of $1 million against National Union. National Union appealed to the Fifth Circuit and certified three questions to the Texas Supreme Court. The three questions certified were as follows:

1. Where an additional insured does not and cannot be presumed to know of coverage under an insurer's liability policy, does an insurer that has knowledge that a suit implicating policy coverage has been filed against its additional insured have a duty to inform the additional insured of the available coverage?

2. If the above question is answered in the affirmative, what is the extent or proper measure of the insurer's duty

to inform the additional insured, and what is the extent or measure of any duty on the part of the additional insured to cooperate with the insurer up to the point he is informed of the policy provisions?

3. Does proof of an insurer's actual knowledge of service of process in a suit against its additional insured, when such knowledge is obtained in sufficient time to provide a defense for the insured, establish as a matter of law the absence of prejudice to the insurer from the additional insured's failure to comply with the notice-of-suit provisions of the policy?

The Fifth Circuit answered the first and third questions "no" and did not answer the second question.

B. Holdings

The supreme court answered the first question in the negative based upon its 1978 decision in *Weaver v. Hartford Accident & Indemnity Co.*, 570 S.W.2d 367 (Tex. 1978). In *Weaver*, the court held that an insurer was not liable to an additional insured's judgment creditor when the additional insured failed to notify the insurer that he had been served with process, even though the insurer knew about the suit, and the additional insured knew nothing about the policy. The court noted five similarities between the *Crocker* case and the *Weaver* case. First, both Morris and the employee in *Weaver* were additional insureds under the liability policies at issue. Second, the injured party in each case sued both the named insured and the additional insured but did not recover anything from the named insured. Third, both additional insureds failed to forward suit papers to the insurers, so neither was defended by the insurer. Fourth, both additional insureds lacked knowledge of the existence of their status as additional insureds under the employers' policies. Fifth, both insurers argued that they had no duty to inform the additional insured of the possibility of coverage. The supreme court held that a request for coverage is a *sine qua non* to the duty to provide a defense. However, the court noted that:

> Of course, an insurer that is aware an additional insured where an additional insured has been sued may, and perhaps should, choose to inform the insured that a defense is available; in this case, had National Union done so, a judgment against Morris and years of subsequent litigation would have been avoided. But an insurer that has not been notified that a defense is expected bears no extra-contractual duty to provide notice that a defense is available to an additional insured who has not requested one.

The last quote no doubt will result in continued litigation in the future. If an insurer "should" inform the insured that a defense is available, then what are the consequences? Clearly there would be no extra-contractual consequences; however, can there be recovery under the policy.

The third certified question that was posed was whether there was prejudice if the insurer had actual knowledge of the lawsuit in sufficient time to provide a defense. The court noted that notice of service of process lets an insurer know that the insured is subject to a default and expects the insured to impose a defense. The court noted that an insurer cannot necessarily assume that an additional insured who has been served but has not given notice to the insurer is looking to the insurer to provide a defense. The court addressed several reasons why the insured may choose not to seek a defense and as a result, it would be improper on the part of the insurer to impose a defense without one being requested.

IV. *Fairfield Insurance Company v. Stephens Martin Paving, LP*, 51 Tex.Sup.J. 491 (Feb. 15, 2008).

A. Facts

In this case, Roy Edward Bennett was a brooming machine operator for Stephens Martin Paving and, on December 20, 2002, died as a result of injuries that occurred when a brooming machine rolled over. Fairfield Insurance Company provided workers' compensation benefits to Bennett's wife pursuant to a policy issued to Stephens Martin Paving. Later, Bennett survivors sued Stephens Martin Paving for gross negligence under Section 408.001 of the Texas Labor Code. The only damages recoverable under Section 408.001 of the Labor Code are exemplary damages. Thereafter, Fairfield sued Stephens Martin Paving and Bennett's survivors in the federal district court seeking a declaratory judgment that Fairfield owed no duty to defend or indemnify Stephens Martin Paving in the suit for exemplary damages. The federal district court, relying upon *Ridgway v. Gulf Life Insurance Co.*, 578 F.2d 1026 (5th Cir. 1978), concluded that the policy did cover exemplary damages and that Texas had no public policy that would prohibit coverage for those damages. On appeal, the Fifth Circuit certified the question of the insurability of exemplary damages to the Texas Supreme Court. A majority of the Texas

Supreme Court held that Texas does not prohibit exemplary damages for gross negligence in workers' compensation context. The majority determined that the issue of whether exemplary damages are insurable requires a two-step analysis. First, the court will look to the language of the policy. Second, the court would determine whether Texas Public Policy would prohibit insurability.

B. Policy Language

Looking at the language of the policy, the court noted that Fairfield had agreed to pay "all sums" that the insured must pay as damages because of bodily injury to its employee. The court noted that there were exclusions for "punitive or exemplary damages because of bodily injury to an employee employed in violation of law" as well as endorsement that added that "this exclusion does not apply unless the violation of law caused or contributed to the bodily injury." The policy also excluded damages resulting from intentional acts. Based upon the language of the policy, the court concluded exemplary damages were not excluded.

C. Texas Statutory Prohibitions

On the issue of statutory prohibitions, the court noted that Texas statutes prohibit insurability of punitive damages by health care provider (Article 5.15-1, Section 8 of the Texas Insurance Code), as well as payments by the Guaranty Funds and Excess Liability Pools.

With respect to workers' compensation policies, the court noted that only workers' compensation policies approved by the Texas Department of Insurance are available in Texas. The court also noted that the workers' compensation scheme allowed the recovery of exemplary damages if the employee's death is caused by the employer's gross negligence. The court posed the question that if under Section 408.001, workers' compensation insurance provides the exclusive remedy for an injured employee who is participating in the system, then why would the TDI-approved, standard policy—the only policy workers' compensation insurers may use—provide any additional liability insurance to employers? Based upon that fact, the court concluded that there was some intent in the regulatory scheme to provide coverage for exemplary damages.

The court also examined the public policy considerations for insuring punitive damages. The court noted that of the forty-five states in which the highest court of the state where the Legislature has addressed the insurability of punitive damages in some fashion. Twenty-five states have established generally that public policy does not prohibit coverage, sometimes including or excluding the uninsured motorist or vicarious liability context. Eight states have adopted a broad prohibition against insuring exemplary damages while seven allow insurance coverage for exemplary damages only in the vicarious context.

The court then shifted its focus on the purpose of exemplary damage which for many years was to punish and deter. The court then revealed intermediate decisions from Texas courts which held that there was no public policy prohibiting the insurability of punitive damages in Texas in particular and vicarious situations. The court concluded by saying it was not making a broad proclamation of public policy here, but instead was limited its decisions to the facts in this case. The court held that public policy of Texas does not prohibit insurance coverage of exemplary damages for gross negligence in the workers' compensation context.

D. Dissent

A fairly extensive dissent was filed by Justice Hecht which was joined by three other members of the court. The dissent noted that initially the purpose of punitive damages was to punish and deter. However, with respect to amendments of Chapter 41, the sole purpose now of punitive damages was to punish the defendant. The court noted that if the payment were made by the insurer, the insured would not be punished but rather all other policyholders with policies with that insurer. The court concluded that allowing insurability of punitive damages in inconsistent with the stated purpose of punitive damages that has been adopted by the Texas Legislature.

V. *Lamar Homes, Inc. v. Mid-Continent Casualty Company*, 239 S.W.3d 236 (Tex. 2007)

A. Facts

Vincent and Janice DiMare purchased a new home from Lamar Homes and later encountered problems due to defects in the foundation. Suit was filed against Lamar and its subcontractor complaining about the defects. Lamar forwarded the lawsuit to Mid-Continent seeking defense and indemnity under a CGL policy. Mid-Continent refused to defend. Thereafter, Lamar filed a declaratory judgment suit in the federal district court. The trial court granted summary judgment for Mid-Continent concluding it had no duty to defend Lamar for construction errors that harmed only Lamar's own product. *Lamar Homes, Inc. v. Mid-Continent Casualty Company*, 335 F.Supp.2d 754 (W.D. Tex. 2004). The court held that the purpose of CGL policy was to protect the insured from liability resulting from property damage or bodily injury caused by the product, but not for the replacement or repair of the insured's own product.

Noting disagreement among Texas courts about the application of the CGL policy, the Fifth Circuit who certified took the case to the Texas Supreme Court to resolve the conflict.

Three questions were certified. They are:

1. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege an "accident" or "occurrence" sufficient to trigger the duty to defend or indemnify under a CGL policy?

2. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege "property damage" sufficient to trigger the duty to defend or indemnify under a CGL policy?

3. If the answers to certified questions 1 and 2 are answered in the affirmative, does Article 21.55 of the Texas Insurance Code apply to a CGL insurer's breach of the duty to defend.

B. Holding

1. Occurrence

With respect to the question no. 1, the court concluded that allegations of construction defects may constitute a "accident" or "occurrence" sufficient to trigger the duty to defend under a CGL policy. The court noted that the term "occurrence" is defined in part as an accident. However, an accident is not otherwise defined. The supreme court defined an "accident" to mean: "A fortuitous, unexpected, and unintended event." The court noted that some courts have made the distinction on whether or not defective workmanship is an accident or an occurrence depending upon whether it is the insured's own work that's damaged or whether or not some third party's work has been damaged. The court saw no basis for the distinction and held that the complaint in the *Lamar Homes* alleged an occurrence because it asserted that Lamar's defective construction was the product of its negligence.

2. Property Damage

The court next addressed the issue of whether there were allegations of property damage. The policy defined "property damage" as "physical injury to tangible property, including all resulting loss of use of that property." The court noted on its face the provision did not eliminate the general contractor's work. The court then attempted to ascertain the intent of the policy from the language of the policy itself. The court noted that certain exclusions (j.5 and j.6) eliminated property damage to the work while operations were being performed. Coverage is excluded regardless if the work is performed by the contractor or the subcontractor. On the other hand, the court noted that exclusion (l) excluded property damage to "your work" included in the "products-completed" operations hazard. However, exclusion (l) has an exception to the exclusion for work performed on your behalf by a subcontractor. It was Lamar's position that exclusion (l) would have eliminated coverage here, since it was in the completed operations hazard, but for the exception to the exclusion. The court went through the drafting history of exclusion (l) and noted that the drafting history indicated that the subcontractor exception into the "your work" exclusion was placed there to provide property damage coverage caused by subcontractors' defective performance. The court also noted that recently ISO had issued an endorsement which may be included in the policy to eliminate the subcontractor's exception to exclusion (l). The majority dismissed the dissent reliance upon the economic-loss rule on the basis that it was not a useful tool in determining insurance coverage.

3. Article 21.55

The last issue to be addressed by the court was whether the "Prompt Payment of Claims" statute, formerly codified as *article 21.55* (now codified as Sections 542.051-061) of the Texas Insurance Code applied to a claim for defense costs. The statute defined "claim" as "a first party claim made by an insured or policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract that must be paid by the insurer directly to the insured or beneficiary." The statute does not contain a definition of "first-party claim." The court noted there were two lines of cases dealing with the issue of the duty to defend. One line held that an insured's claim for defense costs under a liability policy is not a "first-party claim" where a conflicting line of authority supported the proposition that a claim for defense costs was a "first-party claim."

The court noted that it had earlier defined a first-party claim as one where: "an insured seeks recovery for an insured's own loss" whereas a third-party claim is one where "an insured seeks recovery for injuries to a third party." *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48, 54 n.2 (Tex. 1997). Based upon that definition, the court held that a defense claim was a first-party claim because it relates solely to the insured's own loss, without the defense benefit provided in the liability policy, the insured would be

responsible for the costs. The court noted that unlike the loss incurred in satisfaction of a judgment or settlement, the loss only belongs to the insured and is not derivative of any loss suffered by a third party. The court further noted that in order to mature a claim under article 21.55, it would be incumbent upon the insured to submit the attorney's fees bills to an insurer as they were incurred. A denial of a defense alone would not trigger a claim under article 21.55.

VI. *Fortis Benefits v. Vanessa Cantu and Ford Motor Co.*, 234 S.W.3d 642 (Tex. 2007)

A. Facts

Cantu was injured in a car wreck. These injuries later resulted in a suit against the driver of the vehicle as well as the manufacturer of the vehicle, Ford Motor Company. Fortis intervened and asserted contractual subrogation and reimbursement rights to recoup from Cantu the amount of medical benefits it paid under the policy. Cantu settled her claim with the defendants before trial for $1,445,000. A dispute arose as to what percent, if any, of the proceeds should go to Fortis. Cantu claimed she had not been "made whole" by the settlement because her future medical expenses were estimated to be $1.7 million to $5.3 million. She argued that her past and future medical expenses, exclusive of other amounts like pain and suffering, exceeded the amount of the settlement. The trial court granted summary judgment in favor of Cantu. The court of appeals affirmed holding that the "made whole" doctrine was applicable.

B. Holding

The supreme court reversed the holdings of the trial court and court of appeals. The court noted that it had adopted the "made whole" doctrine in *Ortiz v. Great Southern Fire & Casualty Ins. Co.*, 597 S.W.2d 342 (Tex. 1980). In that case, Great Southern had paid under a homeowner's policy for a fire to the Ortiz's residence. Great Southern asserted a claim under equitable subrogation. The supreme court had held that an insurer is not entitled to subrogation if the insured's loss is in excess of the amounts recovered from the insurer and the third party causing the loss. The court noted that one of the primary reasons for equitable subrogation is to prevent the insured from receiving double recovery. However, where the insured's total recovery is less than his or her losses, the loss should be borne by the insurer since that was the risk the insurer was paid to assume.

Unlike the *Ortiz* case, the Fortis Benefits' policy had a contractual subrogation provision. It stated that:

> Upon payment of benefits, We will be subrogated to all rights of recovery a Covered Person may have against any person or organization. This includes but is not limited to recoveries against such third party, against any liability coverage for such third party or against automobile coverage for such third party or against automobile insurance in the event a claim is made under the uninsured or underinsured motorist coverages. Such right extends to the proceeds of any settlement or judgment; but is limited to the amount of benefits. We have paid. You must 1) do nothing to prejudice any right of recovery; 2) execute and deliver any required instruments or papers; and 3) do whatever else is necessary to secure such rights.

The court held that the *Ortiz* decision was in the context of equitable subrogation as opposed to contractual subrogation. It noted that the Austin Court of Appeals in *Esparza v. Scott & White Health Plan*, 909 S.W.2d 548 (Tex.App.—Austin 1995, writ denied), had refused to apply the "made whole" doctrine when dealing with contractual subrogation as opposed to equitable subrogation. The court also noted that the United States Supreme Court in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 126 S.Ct. 1869, 164 L.Ed.2d 612 (2006), had reached the same result the court reached in this case.

The court noted that the parties are free to contract and the court was loath to judiciary rewrite the parties' contract by engrafting extra-contractual standards that neither the Legislature nor the Texas Department of Insurance had required. The court concluded that Fortis was contractually entitled to recover the total amount of benefits from Cantu. The court held that since the subrogation provision gave Fortis Benefits the right to "all rights of recovery," there was no need to segregate into damages what the settlement paid.

VII. *Excess Underwriters at Lloyd's London v. Frank's Casing Crew & Rental Tools, Inc.*, 51 Tex.Sup.J. 397 (Feb. 1, 2008)

A. Facts

Frank's Casing fabricated a drilling platform for ARCO/Vastar. When the platform collapsed, ARCO sued Frank's Casing and several others. Frank's Casing had a $1 million primary liability policy and excess coverage up to $10 million with Excess Underwriters at Lloyd's. The excess policy did not require the underwriters to assume control of the defense or the settlement, but gave them the right to

associate defense counsel retained by Frank's Casing or the primary insurer. As trial approached, ARCO offered to settle its claims against Frank's Casing for $9.9 million. This offer was rejected by Frank's Casing without passing it on to the excess underwriters. Two weeks before trial, the excess underwriters contacted ARCO directly and attempted to settle the claims for which the underwriters were willing to concede were covered. No agreement was reached and ARCO made a demand for $8.8 million to settle with all of the defendants. About $7.55 million was allocated to Frank's Casing. The excess underwriters offered to pay two-thirds of this amount if Frank's Casing and its primary insurer would pay the balance and further agreed to waive all coverage defenses if Frank's Casing accepted the proposal. Alternatively, the excess underwriters offered to pay $5 million and defer all coverage issues to be resolved in arbitration. This offer was rejected by Frank's Casing, and shortly before trial, the excess underwriters were presented with an offer to settle for $7.5 million. The underwriters agreed that the case should be settled but noted a coverage issue remained. The underwriters offered to fund the entire settlement if Frank's Casing would agree to reserve the coverage issues for later. This offer was rejected by Frank's Casing. Excess underwriters then advised Frank's Casing that it would pay the $7.5 million to settle less any contribution from the primary carrier, and then seek reimbursement from Frank's Casing.

Before the settlement was consummated, the excess underwriters filed suit. The trial court originally concluded that no coverage existed under the excess underwriter's policy and granted a judgment to the excess underwriters. However, before the judgment was final, the supreme court issued its opinion in *Texas Association of Counties County Government Risk Management Pool v. Matagorda County*, 52 S.W.3d 128 (Tex.2000). In light of the decision, a new trial was granted and the trial court entered a take-nothing judgment in Frank's Casing's favor. This judgment was affirmed by the court of appeals. 93 S.W.3d 178 (Tex.2005).

B. Holding

In addressing the issues presented, the court first reviewed its holding in *Matagorda County*. There were four holdings in *Matagorda*. First, the court held that the Texas Association of Counties could only reserve rights that were express in the policy, and the policy did not contain a right of reimbursement. Second, the court held that neither the County's silence in response to the reservation of rights nor its failure to contest the reasonableness of the settlement were sufficient to create an implied in fact reimbursement obligation. It did not appear in the policy. Third, the court held that the Texas Association of Counties had not established a right to reimbursement under quasi-contractual theories of *quantum meruit* or unjust enrichment. Finally, the court held that an insurer could impose a reimbursement obligation on its insured by either drafting the policy to specifically include such a reimbursement right or obtain an insured's "clear and unequivocal" defense to the settlement and insurer's right to seek reimbursement. The court then went on to address theories advanced by the excess underwriters. First was an implied in fact agreement. The excess insurers contended that since the policy did not allow the insurers to settle without Frank Casing's consent, there was an implied consent to settle and seek reimbursement. The court held that while the policy did require the consent of the insured to settle, there was nothing in the policy regarding reimbursement rights should the excess underwriters decide to negotiate a settlement of the claim.

The second theory was under equitable theories of *quantum meruit* and *assumpsit*. This was also rejected because the court held that to recognize an equitable right to reimbursement would require the court to "rewrite the parties' contract or add to its language." The court then noted that most other states had rejected the right of reimbursement and followed the majority rule in the decision by not allowing the excess underwriters to seek reimbursement from Frank's Casing.

VIII. *Evanston Insurance Company v. ATOFINA Petrochemicals, Inc.*, 51 Tex.Sup.J. 460 (Feb. 15, 2008).

A. Facts

ATOFINA contracted with Triple S Industrial Corporation to perform maintenance and construction work at ATOFINA's Port Arthur refinery. The service contract contained an indemnity provision and a requirement that Triple S to carry certain minimum levels of liability insurance coverage naming ATOFINA as an "additional insured." Matthew Todd Jones, a Triple S employee, was drowned after he fell through a corroded roof of a storage tank filled with fuel oil. Jones's survivors sued Triple S and ATOFINA for wrongful death. Admiral, the primary CGL insurer for Triple S tendered its $1 million policy limits. ATOFINA then demanded coverage from Evanston as an additional insured under the umbrella policy. Evanston denied the claim, and ATOFINA brought Evanston into the case as a third-party defendant seeking a declaration of coverage. This claim was then severed. While the coverage case was pending, the Jones case was settled for $6.75 million. ATOFINA sought to recover from Evanston the $5.75 million not covered by Admiral.

The trial court granted summary judgment in favor of Evanston, and the court of appeals reversed the judgment holding that the Evanston policy covered ATOFINA. 104 S.W.3d 247 (Tex.App.—Beaumont 2003).

B. Holding

Evanston made two arguments in the court of appeals. First, it agreed in the indemnity agreement that it would not seek indemnification for losses resulting from its own negligence. One of the additional insured provisions had similar language. As a result, ATOFINA claimed that it should not have any responsibility. Second, under *Fireman's Fund v. Commercial Standard Ins. Co.*, 490 S.W.2d 818 (Tex. 1972), ATOFINA claimed that since it cannot get indemnity arising from its own negligence, likewise it should not be entitled to additional insured status.

The Evanston policy contained two provisions regarding additional insured status. The first was section III.B.5. which provides:

> Any other person or organization who is insured under a policy of "underlying insurance." The coverage afforded such insureds under this policy will be no broader than the "underlying insurance" except for this policy's Limit of Insurance.

The second provision is contained in section III. B.6. which provides as follows:

> A person or organization for whom you have agreed to provide insurance as is afforded by this policy; but that person or organization is an insured only with respect to operations performed by you or on your behalf, or facilities owned or used by you.

With respect to Section III.B.6, Evanston argued that the insurance provided did not apply to ATOFINA's own negligence, but rather for liability for Triple S's conduct. Evanston relied primarily on *Granite Construction Co. v. Bituminous Ins. Cos.*, 832 S.W.2d 427 (Tex.App.—Amarillo 1992, no writ), in support of the proposition. The court noted that other Texas cases, including *Admiral Ins. Co. v. Trident NGL, Inc.*, 988 S.W.2d 451 (Tex.App.—Houston [1st Dist.] 1999, *pet. denied*), had taken a much more expansive view holding that so long as the liability arose out of the work of Triple S, there could be coverage for ATOFINA's own negligence. The court held that this result was dictated by the ordinary and natural meaning of the phrase "with respect to" and was also supported by the majority of other courts facing the same issue. The court noted that although the pleadings in the underlying case did not indicate whether Jones was performing a Triple S operation at the time of the accident, Jones was present at the ATOFINA facility for the purposes of Triple S's operations when the accident occurred. As a result, even if ATOFINA's negligence alone caused Jones's injuries, Section III.B.6 of the Evanston policy provided direct insurance coverage to ATOFINA.

Evanston next argued there was no coverage by virtue of Section III.B.5. Again, Section III.B.5 says an insured can be: "Any other person or organization who is insured under a policy of "underlying insurance." The coverage afforded such insureds under this policy will be no broader than the "underlying insurance" except for this policy's Limit of Insurance." Looking to the underlying policy, Evanston argues that it specifically excludes coverage for ATOFINA's sole negligence and, as a result, Section III.B.5 is limited and excludes losses caused by ATOFINA's sole negligence. The court noted that on the record before, it was unable to determine whether the Jones's accident was the product of ATOFINA's sole negligence. Both ATOFINA and Triple S had originally been sued by both parties. In addition, there were allegations that Jones himself was contributorily negligent. However, the case was settled against ATOFINA with no admission of liability by either party. Thus, the court held that without such factual determination, it is impossible to determine whether the accident would be excluded under Section III.B.5 of the Evanston policy.

ATOFINA argued that regardless of a determination, it was entitled to the coverage under whichever provision afforded it the broadest coverage. Therefore, it is entitled to rely upon Section III.B.6 if Section III.B.6 provided broader coverage than Section III.B.5. The court held that because ATOFINA was entitled to coverage under more than one "who was an insured" clause, it was not unreasonable to conclude the policy should be read to provide the broader measure of coverage available under the applicable clauses. Therefore, the court held that ATOFINA was entitled to coverage under Section III.B.6 which does not exclude liabilities arising out of ATOFINA's sole negligence.

Evanston next argued that coverage attributed under *Fireman's Fund Insurance Co. v. Commercial Standard Ins. Co.*, 490 S.W.2d 818 (Tex. 1972). In that case, Sam P. Wallace Co., Inc. was performing work at the General Motors Corporation plant in Arlington, Texas. The agreement had an indemnity provision with insurance to secure the indemnity

agreement. The court held that the contract of indemnity would not afford protection to the indemnitor against the consequences of his own negligence unless the contract fully expressed that such an obligation in unequivocal terms. This contract was being construed under the old "clear and unequivocal" rule. However, there was no distinct additional insured status like there was in the *ATOFINA* case. The court held that the additional insured status was separate and independent from the contractual indemnity provided ATOFINA.

The next issue was whether Evanston was entitled to challenge the reasonableness of the $6.75 million settlement. The supreme court relies primarily upon its earlier decision in *Employers Casualty Company v. Block*, 744 S.W.2d 940 (Tex. 1988), in holding that an insurer who agrees to a duty to defend is not entitled to litigate the reasonableness of a settlement or the judgment. In *Block*, the supreme court had held:

> While we agree with the court of appeals' conclusion that [the insurer] was barred from collaterally attacking the agreed judgment by litigating the reasonableness of the damages recited therein, we do not agree with its conclusion that the recitation in the agreed judgment that the damage resulted from an occurrence on August 6, 1980 is binding and conclusive against [the insurer] in the present suit.

The court had some difficulty in distinguishing its later language contained in *State Farm Fire & Casualty Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996). There the court said:

> In no event, however, is a judgment for plaintiff against defendant, rendered without a fully adversarial trial, binding on defendant's insurer or admissible as evidence of damages in an action against defendant's insurer by plaintiff as defendant's assignee. We disapprove the contrary suggestion in dicta in *Employers Casualty Company v. Block*, 744 S.W.2d 940, 943 (Tex. 1988), and *United States Aviation Underwriters, Inc. v. Olympia Wings, Inc.*, 896 F.2d 949, 954 (5th Cir. 1990).

First, the language in *Employers Casualty* was dicta. Second, the supreme court in *Gandy* did entirely overrule that language. However, the court never indicates that *Gandy* was limited just to those situations where five unique elements were present. However, a fair reading of the *Gandy* holding does not limit it to those situations where the *Gandy* elements were present.

The last issue addressed by the court was whether Article 21.55 would apply to the claim for recovery of the settlement proceeds that were due as opposed to attorneys' fees. The court employed language consistent with that in *Lamar Homes* in distinguishing between first and third-party claims. The court noted that "a loss incurred in satisfaction of a settlement belongs to the third party and is not suffered directly by the insured." As a result, the court held that the statute did not apply to the case.

C. Dissent

Justices Hecht and Johnson filed the dissent only with respect to the issue of ability of Evanston to contest the reasonableness of the settlement. As aptly pointed out by the dissent, Evanston had no duty to defend and therefore could not have breached any duty to defend. The umbrella gave Evanston the right to defend the covered claim, but no duty unless the claim was not covered by an underlying policy or that policy's limits were exhausted. Neither of those situations was applicable here since ATOFINA had its $1 million coverage in place. The question posed by the dissent was what possible basis is there to stop an insurer who has breached no duty to its insured? Even where there has been a breach of the duty to defend, the rule announced by the majority will not work and is inconsistent with the Restatement (2nd) of judgments. This rule will have to be reexamined by the court and in all probability, when reexamined, the court will conform their holding to prior decisions.