Insurance Litigation & Coverage News

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Mid-Continent Ins. Co. v. Liberty Mutual Ins. Co. 236 S.W.3d 765 (Tex. 2007)

The Texas Supreme Court issued a surprising and important decision for carriers doing business in Texas related to the common practice of liability carriers seeking reimbursement against other triggered insurers. In *Mid-Continent Ins. Co. v. Liberty Mutual Ins. Co.*, the Texas Supreme Court sent a strong message to insurance carriers that, in Texas, those that "pay and chase" do so at their own peril. Indeed, the effects of *Mid-Continent v. Liberty Mutual* have already begun to reverberate at mediation and coverage lawsuits around the state.

The liability case at issue in *Mid-Continent* arose out of a November 1996 automobile accident occurring in a construction zone on a State of Texas highway project. As he drove through lanes narrowed by construction, Tony Cooper drove his car into oncoming traffic and collided with a car driven by James Boutin and his family. All members of the Boutin family suffered injuries. Kinsel Industries was the general contractor on the highway project. Crabtree Barricades was Kinsel's subcontractor responsible for signs and dividers. The Boutin family sued Cooper, the State of Texas, Kinsel and Crabtree for damages resulting from the accident.

Kinsel, the general contractor, was a named insured under Liberty Mutual Insurance Company's $1 million commercial general liability policy. Liberty Mutual also provided Kinsel with $10 million in excess liability coverage. Crabtree, the subcontractor, was a named insured under Mid-Continental Insurance Company's $1 million CGL policy. Mid-Continent's policy also provided additional insured coverage to Kinsel for liability arising from Crabtree's work. Therefore, the two insurers, Liberty Mutual and Mid-Continent, each provided Kinsel with $1 million in indemnity for the liability suit and jointly assumed defense of Kinsel. Crabtree was defended by Mid-Continent. Neither insurer disputed that it owed some portion of Kinsel's defense and

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indemnity, and the case progressed to mediation. As is common, Liberty Mutual and Mid-Continent disagreed on the settlement value of the case against Kinsel. At mediation, the Boutins demanded settlement for $1.5 million. Liberty Mutual agreed to pay the $1.5 million and demanded that Mid-Continent contribute half. Mid-Continent refused. Mid-Continent had evaluated the settlement value of the case against Kinsel at $300,000; and, based upon its own calculation, Mid-Continent agreed to pay only $150,000 of the total settlement. The *Boutin* liability case settled for $1.5 million – Liberty Mutual paid $1.350 million and Mid-Continent paid $150,000.

Liberty Mutual sued Mid-Continent in federal court, seeking to recover Mid-Continent's full pro rata share of the settlement under contribution and subrogation theories. The District Court concluded that Liberty Mutual was entitled through subrogation to recover $550,000 from Mid-Continent. The district court reasoned that each insurer shared the duty to act reasonably in exercising its rights under the CGL policy and that Mid-Continent's assessment of its share of Kinsel's liability was objectively unreasonable. Specifically, the district court stated that "Mid-Continent's recalcitrance to consider any change despite the changing circumstances was unreasonable, causing it to unreasonably assess its insured's exposure." While, on the other hand, Liberty Mutual, "by agreeing to settle for $1.5 million, resolved the case within policy limits based on a reasonable estimation of Kinsel's liability and avoided the real potential for joint and several liability." Therefore, the district court concluded that Mid-Continent was liable in subrogation for $750,000, one-half of the $1.5 million settlement with Kinsel, minus the $150,000 already paid. Mid-Continent appealed the decision to the Fifth Circuit. The Fifth Circuit certified the question to the Texas Supreme Court.

The Texas Supreme Court first held that there was no direct duty of reimbursement under a contribution theory. The court cited prior decisions in which it had held that a direct claim for contribution between co-insurers does not exist when, as was true in this case, the insurance policies contained other insurance or pro rata clauses. *See Traders & Gen'l Ins. Co. v. Hicks Rubber Co.*, 169 S.W.2d 142 (Tex. 1943). When these clauses are present, the co-insurers contractually agree with the insured to pay only a pro rata share of the loss; they do not contract to pay each other's pro rata share. *See Employers Cas. Co. v. Trans. Ins. Co.*, 444 S.W.2d 606, 609 (Tex. 1969).

The Texas Supreme Court then concluded that Liberty Mutual had no viable subrogation claim under these circumstances. Although the court acknowledged its statements in the *Employers Casualty* opinion that a co-insurer's right of reimbursement would lie in contract or equitable subrogation, the court observed that having a right to subrogation is distinct from having an ability to recover under that right. The court focused on the requirement that a right of subrogation was derivative of the insured's rights. Because the insured had been fully indemnified, there was no basis for Liberty Mutual to be equitably subrogated for the amounts it paid in settlement. The court reaffirmed that the liability carrier's only common law duty to an insured in this context is the *Stowers* duty to accept reasonable settlement demands within policy limits. The court held that Liberty Mutual had no viable equitable subrogation claim, because *Mid-Continent* did not breach a *Stowers* duty to the insured, given that the underlying plaintiffs never made a settlement demand within policy limits. The court also declined to modify the *Stowers* duty to create a duty between the co-insurers under the facts of the case.

Notably, the court failed to mention or discuss its opinion, *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994). In *Garcia*, the Texas Supreme Court analyzed the rights between multiple insurers and the insured when sequential policies afforded coverage. The court held that the insured is entitled to pick the policy year to respond to the claim, and the insurer chosen may then seek reimbursement from the other insurers via its subrogation rights. While *Garcia* addressed sequential policies rather than co-primary policies, no logical rationale supports a right to reimbursement under one scenario and not the other.

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The apparent inability to recover based upon equitable subrogation is the aspect of the *Mid-Continent* opinion that was particularly surprising to the insurance industry, given that Mid-Continent and Liberty Mutual were effectively co-primary insurers, defending the same insured. The opinion arguably spurs two potentially negative outcomes. First, it encourages recalcitrant, even unreasonable, insurers to refuse to defend and settle claims when other insurance is involved. Second, it discourages insurers to defend and settle claims when other insurance is involved, because there may not be a right of reimbursement against the recalcitrant insurer.

The *Mid-Continent* ripple effect has commenced. Following the *Mid-Continent* opinion, a federal court granted summary judgment against an insurer seeking to enforce identical pro rata sharing provisions contained in multiple primary insurance policies. In doing so, the court highlighted the lack of options primary carriers now face in Texas when co-primary carriers do not contribute to defense or indemnity benefits to a common insured. In *Nautilus Ins. Co. v. Pacific Employers Ins. Co.*, No. G-04-619 (S.D. Tex. February 25, 2008), several insurers defended and indemnified a seismic testing company, their common insured. Only Pacific Employers failed to contribute to settlement. In the subsequent coverage case brought by Nautilus, a paying carrier, the District Court sided with Pacific Employers and reluctantly held that, because the insured had been fully indemnified, the settling insurer had no claim under Texas law against the non-settling insurer. A harsh result indeed and, arguably, an inevitable consequence of the *Mid-Continen*t decision. A notice of appeal has been filed.

Currently pending before the Northern District of Texas is *XL Insurance America, Inc. v. TIG Specialty Ins. Co.*, Civil Action No. 3:07CV1701 (N.D. Tex., Dallas Div.). TIG Specialty Insurance Company requests a dismissal of a case filed by XL Insurance America, Inc. XL's claims are based on contractual and equitable subrogation; as a primary carrier, XL seeks to recover from TIG, an excess carrier, amounts that XL voluntarily paid in excess of its policy limit to settle a claim that had been asserted against XL and TIG's mutual insured, Electric Mobility. In September 2004, XL paid $180,000 to protect the interest of XL and TIG's common insured, Electric Mobility, but this amount exceeded the annual general aggregate limit by $125,069.80, which XL contends falls within the TIG excess layer of coverage. Citing to *Mid-Continent*, TIG argues that, because the insured had fully recovered its loss, the paying carrier had no contractual rights to assert against the non-paying carrier. No ruling on TIG's motions has been made, and the case will be monitored due to its potential expansion of *Mid-Continent* to the context of primary v. excess insurer for a common insured.

Even more recently, the Southern District of Texas issued an opinion supporting the application of *Mid-Continent* to defense costs. *Trinity University Ins. Co., et al. v. Employers Mut. Cas. Co.*, Civil Action No. 4:07CV00878 (S.D. Tex. Houston Div., May 15, 2008). In *Trinity*, the insured, Lacy Masonry, was sued for construction defects and related water infiltration damages. Trinity, the other plaintiff/insurers (collectively "Trinity") and EMC were timely placed on notice of the suit. Trinity accepted Lacy Masonry's defense. EMC denied a defense. Trinity sought a declaration that EMC had a duty to defend and sought reimbursement for EMC's portion of defense costs. The Court first held that the liability petition against Lacy Masonry sufficiently plead a claim within EMC's policy period and, accordingly, held that EMC had a duty to defend Lacy Masonry. However, citing to *Mid-Continent*, the District Court then determined that, even though EMC's duty of defense was triggered by the liability pleading, Trinity was not entitled to reimbursement from EMC for EMC's share of defense costs. The Trinity court reasoned that there was no evidence of harm to Lacy Masonry by EMC's refusal to defend, and "the potential public policy ramifications of *Mid-Continent* do not provide grounds to disregard its binding authority." As with the XL opinion, this case will also be monitored due to its expansion of *Mid-Continent* to reimbursement of defense costs paid by a co-primary insured for a common insured.

The *Mid-Continent* decision, however, should not impact an insured's ability to recover from an insurer when an insured pays, because the insured would not have been fully indemnified. The *Mid-Continent* decision would arguably also not apply when a *Stowers* demand has been sent and rejected by an insurer. For carriers, the *Mid-Continent* opinion could, in fact, serve as leverage against plaintiffs in that it is a cognizable

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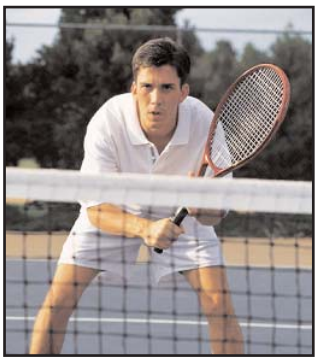
and viable defense to payment when a case includes a recalcitrant carrier. Moreover, *Mid-Continent* does not impose upon carriers an additional duty to reasonably negotiate. Nonetheless, the decision raises significant questions for any insurer facing settlement when the insured has multiple primary carriers. The ultimate, and most likely unintended, outcome of *Mid-Continent* is to force liability carriers to push more cases to trial when a reluctant carrier in their midst chooses to play "hard ball" over realistically and reasonably evaluating exposure to a mutual insured.



Rhonda J. Thompson

NO RIGHT OF REIMBURSEMENT WITHOUT THE INSURED'S EXPRESS CONSENT

In *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42 (Tex. 2008), the Texas Supreme Court examined whether a settling excess carrier has the right of reimbursement from its insured. The court reviewed its earlier ruling in *Matagorda County*[1] which stated that an insurer who settles a claim against its insured when coverage is disputed may seek reimbursement from the insured should coverage later be determined not to exist if the insurer "obtains the insured's clear and unequivocal consent to the settlement and the insurer's right to seek reimbursement." Specifically, the *Frank's Casing* court examined whether to recognize an exception to the rule in *Matagorda County* and imply a reimbursement obligation when the policy involves excess coverage, the insured has no duty to defend under the policy, and the insured acknowledges that the claimant's settlement offer is reasonable and demands that the insurer accept it. In short, the court in *Frank's Casing* declined to recognize such an exception, and held that Excess Underwriters had no right of reimbursement without clear language in the policy to that effect.

Frank's Casing fabricated a drilling platform for ARCO. 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. The policy did not require Excess Underwriters to assume control of the defense or the settlement of any claims, but did give the carrier the right to associate with defense counsel retained by Frank's Casing or the primary insurer, if it was reasonably likely that the excess coverage layer would be reached. Shortly before trial, Excess Underwriters retained counsel to associate with Frank's Casing and its primary carrier in defending against ARCO's claims. During trial, ARCO made a $7.5 million demand upon Frank's Casing. Frank's Casing forwarded the demand to Excess Underwriters,

[1] *Tex. Ass'n of Counties Country Gov't Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128, 135 (Tex. 2000).

No Right of Reimbursement without the Insured's Express Consent, cont'd

suggesting it was reasonable, and reiterated its disagreement with the underwriter's prior coverage position. Excess Underwriters offered to fund the entire settlement, if Frank's Casing would agree to reserve the resolution of the coverage issues for a later date. Frank's Casing refused the offer, and Excess Underwriters then advised Frank's Casing it would pay $7.5 million to settle the claim, less any contribution from the primary carrier, and then seek reimbursement from Frank's Casing. The underwriters contacted ARCO and orally accepted its settlement offer. A written settlement agreement among ARCO, Frank's Casing, and Excess Underwriters preserved "any claims that exist presently" between Frank's Casing and Excess Underwriters.

Both Frank's Casing and Excess Underwriters filed a series of cross motions for partial summary judgment. In light of the *Matagorda County* decision, the trial court signed a take-nothing judgment in favor of Frank's Casing. The court of appeals affirmed, and the Texas Supreme Court granted Excess Underwriters' petition for review to decide whether its decision in *Matagorda County* allowed Excess Underwriters to assert a reimbursement right under these circumstances.

Excess Underwriters argued that Frank's Casing implicitly agreed to reimbursement by taking an active role in procuring the settlement offer and in demanding that Excess Underwriters settle the claim. The Texas Supreme Court disagreed, stating that the actions of Frank's Casing did not demonstrate Frank's Casing's consent to a reimbursement obligation. The court further noted the policy language said nothing about the underwriters' reimbursement rights should they decide to negotiate a settlement of the claim.

Excess Underwriters also claimed a reimbursement right under equitable theories. Excess Underwriters argued that *Matagorda County* did not govern, because Frank's Casing sought a settlement demand from ARCO and demanded the underwriters pay it. Further, their status as excess insurers, with no duty to defend, distinguishes this case from *Matagorda County*. The court, however, opined that the distinctions did not allay the concerns underlying the analysis of *Matagorda County*. The court stated Excess Underwriters were not liable until primary coverage was exhausted, Frank's Casing had provided timely notice, and Frank's Casing had become liable for a judgment either as the result of trial or a settlement to which Excess Underwriters had agreed. The court also indicated that in *Matagorda County* reimbursement was allowed only if the insurer obtained the insured's clear and unequivocal consent to settlement *and* the insurer's right to seek reimbursement. The court did so because, otherwise, the insured is forced to choose between rejecting a settlement within policy limits or accepting a possible financial obligation to pay an amount that may be beyond its means at a time when the insured is most vulnerable. The court determined in *Matagorda County* that the risk of coverage uncertainties was best placed with the insurer. The *Frank's Casing* court stated, "[t]o recognize an equitable right to reimbursement would require us to 'rewrite the parties' contract [or] add to its language,' which we decline to do." Therefore, the Texas Supreme Court held that Excess Underwriters did not establish a right to reimbursement under Texas law.

> *. . . policy language said nothing about the underwriters' reimbursement rights should they decide to negotiate a settlement of the claim.*

This decision will likely result in carriers being more apprehensive toward settlement, since they lack a right of reimbursement for potentially non-covered claims without first obtaining the express consent of the insured. Furthermore, this case negates any insurers' practice of reserving rights to seek reimbursement of the costs of defense and indemnity from the insured without first obtaining the insured's express consent. However, the opinion also suggests that a carrier should aggressively pursue coverage litigation in an effort to determine coverage issues prior to considering settlement opportunity in an underlying liability case.

Melanie Harber Sumrow

TEXAS SUPREME COURT FINDS ONLY THAT PUBLIC POLICY DOES NOT PROHIBIT COVERAGE FOR PUNITIVE DAMAGES UNDER AN EMPLOYERS LIABILITY POLICY

The wait is over for now—the Texas Supreme Court finally rendered its opinion in *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653 (Tex. 2008), addressing coverage for punitive damages.

The *Fairfield* case addresses coverage for punitive damages under the employer's liability portion of a worker's compensation policy. The insurer took the position that punitive damages awarded against the employer are not covered under the employer's liability policy as a matter of Texas public policy. On appeal at the Fifth Circuit, however, the panel certified a much broader question to the Texas Supreme Court: Does Texas public policy prohibit a liability insurance provider from indemnifying an award for punitive damages imposed on its insured because of gross negligence? The Texas Supreme Court narrowly held that Texas public policy does not prohibit coverage under the workers' compensation and employer's liability insurance policy at issue, avoiding the Fifth Circuit's broader question and leaving open the question of whether punitive damages are covered under other types of liability policies.

. . .Texas public policy does not prohibit coverage under the workers' compensation and employer's liability insurance policy. . .

The supreme court began its analysis by enunciating the two steps necessary to answer the issue before it: 1) whether the plain language of the policy covers the exemplary damages sought in the underlying suit against the insured; and 2) if the policy affords coverage, whether public policy allows or prohibits coverage under the circumstances of the underlying suit.

The employer's liability policy before the court covered all sums the insured legally must pay as damages because of bodily injury to an employee. The policy excluded coverage for injuries to employees in violation of the law, unless the violation caused or contributed to the injury, and damages arising from injuries caused by intentional acts. Because the certified question was limited to public policy, the court presumed that the damages were covered. According to the court, to answer the public policy issue, it first had to analyze whether the Legislature had addressed public policy on the issue by its enactments.

The court explained that the worker's compensation system in Texas is optional; and, if an employer and employee subscribe, the only policy available is the TDI-approved form. Moreover, if the employee dies, the statutory beneficiaries may sue the employer for gross negligence. If the worker's compensation system is the exclusive remedy for an injured employee, the court posed the question, "Why would TDI provide additional liability insurance to employers?" The answer, according to the court, must be to harmonize the statutory scheme allowing claims for gross negligence against the employer with the policy coverage. Thus, given the Legislature's enactments, public policy does not prohibit insurance coverage for gross negligence in the context worker's compensation claims.

Notably, the discussion regarding public policy could have ended the court's opinion. Because of the "import of this issue," however, the court discussed some of the considerations relevant to determining whether Texas public policy prohibits insurance coverage of exemplary damages in other contexts, absent clear legislative policy decision.

Initially, the court discussed the law in other jurisdictions regarding coverage for punitive damages, noting that other states' courts or legislatures have addressed the issue in different ways, both finding and prohibiting coverage. The court also noted other jurisdictions' exceptions to punitive damages coverage in the context of UIM coverage and vicarious liability situations. The court then summarized the issue as one of weighing the interest in enforcing a contract, considering the freedom to contract, versus the public policy against such enforcement.

The current purpose behind punitive damages in Texas, according to the court, is to punish the wrongdoer, as evidenced by the Legislature's recent amendments to the statutes addressing punitive damages. Recent

Texas Supreme Court Finds Only That Public Policy Does Not Prohibit Coverage for Punitive Damages Under an Employers Liability Policy, cont'd

statutory amendments downplay the role of deterrence in defining exemplary damages, by deleting the language "as an example to others." Additionally, the statute requires that an award of punitive damages must be specific as to each defendant, and a defendant is only liable for the punitive damage award against it. The court further pointed out the Legislature's intent to provide a limited exception to liability for punitive damages based on the criminal conduct of another, quoting the Texas Civil Practice & Remedies Code sections.

The court suggested that the six statutory considerations in awarding punitive damages, three raising objective concerns (the nature of the wrong; the character of the conduct involved; and the extent to which the conduct offends a public sense of justice and propriety), and three raising subjective concerns (the degree of culpability of the wrongdoer; the situation and sensibilities of the parties concerned; and the net worth of the defendant), may play a key role in answering the public policy question. The court reasoned that spreading the risk of and obligation for exemplary damages through insurance does not affect the objective factors, while the subjective factors are only relevant if the defendant must pay the plaintiff. In other words, if exemplary damages are to be paid by insurance, it is less relevant to set the amount based upon whether the plaintiff was trusting or the defendant was calculating or wealthy.

The court also indicated that considerations may weigh differently when the insured is a corporation or business that must pay punitive damages for the conduct of one or more of its employees. Where employees or management are not involved in or aware of an employee's conduct, the court indicated that the purpose of exemplary damages may be achieved by permitting coverage so as not to penalize many for the acts of one, encouraging courts to consider valid arguments that businesses be permitted to insure against punitive damages in this circumstance.[1]

Based on the opinion, the supreme court has left the door open to argue that punitive damages are not covered under a general liability policy. First, the court acknowledged that the policy language must be considered before any public policy arguments are addressed. This point is relevant in light of the Legislature's definitions of gross negligence and malice, both of which include "intent" on the defendant's part. "Intentional" conduct should not be an "occurrence" or an accident under a liability policy. Moreover, most liability policies exclude damages awarded as a result of an insured's intentional conduct. Accordingly, in most cases—particularly in cases involving an award of punitive damages directly against the actor—public policy arguments should not come into play, as punitive damages simply should not be covered by the policy. The one area in which a court might be reticent to foreclose the insurability of punitive damages is in the context of a principal's/employer's vicarious liability, when the principal/employer was "innocent" of any wrongdoing, which should arise only in few instances.

Jo Allison (Jody) Stasney

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[1] What the court failed to address, however, is that, in most instances, an employer's "vicarious" liability for the punitive damages of its employee is based on the employer's conduct. For instance, an employer can be vicariously liable when the employer authorized the doing and manner of the employee's act or the employer ratified or approved the act. In only one situation is the employer's conduct not considered: when the employee was employed in a managerial capacity and was acting in the scope of employment. *Hammerly Oaks, Inc. v. Edwards*, 958 S.W.2d 387 (Tex. 1997); Purvis v. Prattco, Inc., 595 S.W.2d 103 (Tex. 1980). Thus, it appears under the supreme court's rationale that public policy would allow coverage for the employer's vicarious liability for punitive damages awarded against its employee only in this last scenario.

Fifth Circuit Holds that Punitive Damages Are not Insurable under a CGL Policy

Just three and a half months after the Texas Supreme Court's *Fairfield* opinion, the U.S. Fifth Circuit Court of Appeals, in *American Int'l Specialty Lines Ins. Co. v. Res-Care, Inc., et al.*, __ F.3d __, 2008 WL 2232089 (5th Cir. 2008), applied the principles discussed in *Fairfield* to conclude that punitive damages awarded against a corporation are not insurable under a commercial general liability (CGL) policy. However, the court's opinion is fact-specific and cannot necessarily be read as a blanket prohibition on coverage of punitive damages under a CGL policy.

Res-Care operated a group home in Houston, Texas, that provided services for mentally-disabled individuals. American International Specialty Lines Insurance Company (AISLIC) insured Res-Care through a Hospital Professional Liability and CGL policy providing $1 million in coverage, and a commercial umbrella policy providing $15 million in coverage. The umbrella policy included an exclusion for punitive or exemplary damages, while the CGL policy did not.

The facts leading up to the lawsuit against Res-Care are somewhat shocking. Trenia Wright, a 37-year-old woman with cerebral palsy and mental disabilities resided at Res-Care's facility. Wright fell in a hallway at the facility, and defecated on the floor. Vicki Kennerly, an employee at the home, found the woman and poured a mixture of undiluted bleach and another cleaner onto the floor around the woman, and possibly directly onto the woman. She then escorted the other residents outside, leaving Wright lying on the floor in the home. After spending over an hour outside eating pizza with the other residents, Kennerly returned inside and dragged Wright into a bathroom and finished cleaning the hallway floor. She did not, however, wash the bleach off of Wright. Kennerly left the facility soon afterward when her shift ended.

Two other attendants later found Wright on the floor of the bathroom and put her to bed in clean clothes but, again, did not wash the bleach off of the woman. A staff doctor observed Wright 17 hours later, but diagnosed her only with superficial burns. Two days later, Wright fell out of bed and was found unresponsive, at which point she was taken to a nearby hospital. At the hospital, she was diagnosed with extensive chemical burns on 40% of her body and, four days after the original incident, died from complications due to the severe burns and chemical poisoning. The attendant who first poured the bleach on the woman was later convicted in state court of recklessly causing bodily injury to a disabled individual.

The patient's family filed a wrongful death and survival lawsuit against Res-Care, the hospital, treating physicians, and four of Res-Care's employees. Given the egregious facts of the case, the settlement demands from the plaintiffs, and the coverage issues involving potential exemplary damages, AISLIC and Res-Care entered into a non-waiver agreement that authorized AISLIC to seek settlement of the lawsuit, while reserving the right to bring a claim for recoupment against Res-Care for all sums paid by AISLIC attributable to claims that were not covered under the insurance policies. After executing that agreement, AISLIC settled the lawsuit for $9 million. It then sought recovery under the non-waiver agreement for those amounts purportedly paid as settlement for the punitive damages claim.

Because the underlying lawsuit resulted in a settlement, rather than judgment, the first task of the district court was to apportion the settlement between actual and punitive damages. After considering the factual allegations, expert testimony of the range of actual damages involved, and communications from defense counsel during the underlying lawsuit, the court held that the $9 million settlement was composed of $4 million for actual damages and $5 million for punitive damages. The next task was to determine the extent

Fifth Circuit Holds that Punitive Damages Are not Insurable under a CGL Policy, cont'd

of coverage for punitive damages. Because of the exclusion for punitive damages in the umbrella policy, the issue for the trial court and the Fifth Circuit was whether the $1 million CGL policy could potentially cover these damages.

The court followed the *Fairfield* guidelines in its analysis of whether punitive damages were insurable under the CGL policy issued to Res-Care[1] and first considered the policy language itself. Although AISLIC argued in a supplemental brief that coverage under the CGL policy was exhausted by payment of actual damages alone, the court held that AISLIC waived this argument by not raising it at the trial court level and "presumed" the CGL insuring language encompassed punitive damages.

Next, the court examined whether any statutes specifically addressed the insurability of punitive damages for an entity such as Res-Care. Res-Care was classified as an Intermediate Care Facility for the Mentally Retarded. As noted in the *Fairfield* opinion, certain "healthcare providers" are precluded from obtaining insurance for punitive damages (or are required to do so through an approved endorsement). However, Res-Care's classification did not fall into any of those specific statutes. Because no statute addressed Res-Care's ability to obtain such insurance, the court then considered general public policy, specifically, whether the freedom of contract was outweighed by the primary purpose of punitive damages - to punish the wrongdoer.

In *Fairfield*, the Texas Supreme Court suggested there could be circumstances when insurance coverage for punitive damage may be allowed, such as when the insured is a corporation responsible for damages due to the conduct of its employees. However, the Fifth Circuit also noted the *Fairfield* court's reservations about "extreme circumstances" that may warrant different considerations. The Fifth Circuit concluded such "extreme circumstances" existed for Res-Care. The allegations included accusations of gross negligence by *all* defendants, not only for direct participation in the bleach incident, but also failure to take steps to prevent the situation from occurring, and documented, systemic problems of care. These allegations, in the eyes of the court, "were so extreme that the purposes of punishment and deterrence of conscious indifference outweigh the normally strong public policy of permitting the right to contract." The court did not discuss any of the statutory requirements for awarding punitive damages, either generally or specifically those situations involving liability base on the criminal acts of another (Texas Civil Practice and Remedies Code §41.005).

The Fifth Circuit's holding illustrates the fact-intensive analysis that courts will use in the wake of *Fairfield* to determine whether an insurance policy can insure against punitive damages. Given the extreme nature of the facts, the court's holding is not surprising. However, it remains to be seen how other courts may treat the issue in other less-extreme fact scenarios.

Frank M. Kennedy

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[1] Notably, on June 6, 2008, the Texas Supreme Court denied review in *Westchester Fire Ins. Co. v. Admiral Ins. Co.*, 152 S.W.3d 172 (Tex. App.—Fort Worth 2004, pet. denied), a case in which the court of appeals held that public policy did not prohibit insuring punitive damages under a primary medical professional liability policy. This opinion, however, addresses public policy, as it relates to a statutory scheme in effect in 2001, which has since been amended.

"B" WARE! TEXAS SUPREME COURT ADOPTS THE NOTICE-PREJUDICE RULE FOR COVERAGE B

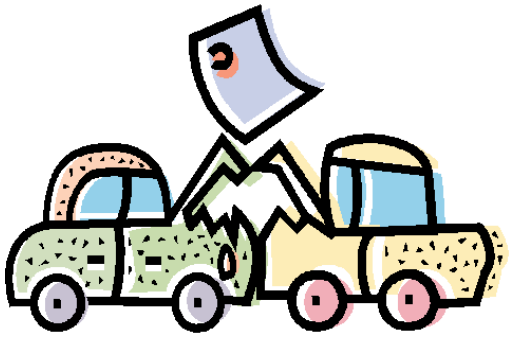
The Texas Supreme Court recently issued its opinion in *PAJ, Inc. v. The Hanover Insurance Company* 243 S.W.3d 630 (Tex. 2008). The primary holding in the case – that an insured's failure to timely notice its insurer of a claim or suit does not defeat coverage unless the insurer was prejudiced by the delay – is a change in Texas law.

To put the issue addressed by *PAJ* in context, the Texas Supreme Court noted it held in *Members Mut. Ins. Co. v. Cutaia*, 476 S.W.2d 278 (Tex. 1972) that a showing of prejudice was not required under Texas common law for an insurer to deny coverage based on late notice. Based on prior Texas cases, the *Cutaia* court held that "when the condition precedent to liability was breached, liability on the claim was discharged, and harm (or lack of it) resulting from the breach was immaterial." *Id*. at 279. The *Cutaia* court, however, noted that it perceived an injustice in its ruling because a reasonable provision or condition in the insurance policy was used by the insurance company to defeat what appeared to be a valid claim. *Id*. at 281. The *Cutaia* court concluded that it would be better policy for the situation to be addressed by the legislature or the insurance regulatory officials.

Following *Cutaia*, the Texas State Board of Insurance responded by adopting an amendatory endorsement that was required in all Texas liability policies. The endorsement provides:

> As respects bodily injury 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.

See Texas State Board of Insurance, *Revision of Texas Standard Provision for General Liability Policies – Amendatory Endorsement Notice*, Order No. 23080 (March 13, 1973). (The wording has now changed slightly, but the basic impact of the amendatory endorsement has not changed). The landscape remained unchanged for over twenty years, until the Texas Supreme Court issued its opinion in *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994), addressing a consent-to-settle clause in an uninsured motorist claim. The Court noted that insurance contracts are subject to the same rules as contracts generally, including that a breach by one party excuses performance by the other party, only if the breach is material. *Id*. at 692. Because "where the insurer is not prejudiced by the settlement . . . the insured's breach is not material." *Id*. at 693. The Court, therefore, held that "an insurer who is not prejudiced by an insured's settlement may not deny coverage under an uninsured/underinsured motorist policy that contains a settlement-without-consent clause." *Id*. Interestingly, the majority decision in *Hernandez* made no reference to the *Cutaia* decision.



Courts generally have expanded the *Hernandez* rationale to apply to any kind of insurance coverage, not just uninsured/underinsured coverage. Because most liability policies in Texas included the 1973 amendatory endorsement, little attention was paid to the fact that the *Hernandez* decision created a dichotomy between consent-to-settle clauses (in which there is a common law requirement of prejudice before coverage could be denied) and timely notice clauses (in which coverage could be denied without prejudice if there were no contractual requirement of prejudice).

The *PAJ* opinion attempts to resolve that inconsistency. The case involved a claim for advertising injury under a general liability policy. The insured, PAJ, was sued in a copyright infringement lawsuit and failed to notify its insurer of the claim until four to six months into the litigation. The insurer, The Hanover Insurance

"B" Ware!
Texas Supreme Court Adopts the Notice-Prejudice Rule for Coverage B, cont'd

Company, denied coverage based upon PAJ's failure to comply with the policy's notice provision. The notice provision required PAJ to provide notice of a claim "as soon as practicable." PAJ brought the declaratory judgment action, in which each party made significant stipulations. PAJ stipulated it did not provide notice as soon as practicable, and Hanover stipulated it was not prejudiced by the late notice.

Hanover argued that the amendatory endorsement and Board Order only applied to bodily injury and property damage claims under Coverage A and not to advertising injury claims under Coverage B. The Dallas Court of Appeals agreed and upheld summary judgment in favor of the insurer. 170 S.W.3d 258 (Tex. App. – Dallas 2005, rev'd). The Texas Supreme Court reversed the court of appeals by a 5-4 vote. The majority opinion discussed *Cutaia* and the amendatory endorsement and found it "important to note that, at the time the State Board of Insurance created this endorsement, there was no standard coverage for advertising injury."

Hanover also argued that its notice provision is a condition precedent to coverage, the failure of which defeats coverage under the policy irrespective of the prejudice to the insurer. PAJ argued that the notice requirement is merely a covenant, the breach of which excuses performance only if the breach is "material." The Court noted that there is no magic language that makes a policy provision a condition precedent. Moreover, the majority concluded it was a distinction without a difference. The Court stated, "[W]e made no distinction between the two in deciding that the insurer had to show prejudice before it could avoid its obligation." The Court did not address, and perhaps did not consider, how tying a prejudice requirement to policy conditions potentially strips the conditions of their meaning, even though Texas law requires all policy terms be given effect.

Finally, the majority reiterated the concern expressed in *Cutaia* that the lack of a prejudice requirement would allow an insurer to avoid coverage for even a *de minimus* deviation from the policy's timely notice provision when the insurer was not harmed. The majority concluded that "an insured's failure to timely notice its insurer of a claim or suit does not defeat coverage, if the insurer was not prejudiced by the delay."

The dissent reasoned that the notice provision is a condition precedent to coverage, that the regulatory officials' response to *Cutaia* was to require prejudice only in a limited class of claims, that *Cutaia* should remain the law of Texas, and that the legislature and regulatory agency retained the power to impose a contractual prejudice requirement if they thought it was appropriate.

Even with this issue apparently resolved, litigation over the late notice defense likely will not subside, because the two biggest issues in late notice cases were not addressed in this case. The parties' stipulations allowed the Court to sidestep (1) whether notice was provided as soon as practicable; and (2) whether the insurer was prejudiced. With regard to the prejudice requirement, the Court noted one factor, among others, that should be considered is "the extent to which the nonbreaching party will be deprived of the full benefit that it could have reasonably anticipated from full performance." The Court did not address any additional factors it would consider in resolving these two issues. Now that Texas has joined the modern trend of adopting the notice-prejudice rule, we may see an increase in declaratory judgment actions over both of these issues.

Jamie R. Carsey

EVANSTON INS. CO. V. ATOFINA PETROCHEMICALS, INC. ___ S.W.3D ___ (TEX. JUNE 13, 2008)

In this case, the Texas Supreme Court holds that (1) an insurer must look at the broadest possible grant of coverage when examining additional insured coverage, (2) an insurer that denies coverage may not dispute the reasonableness of a subsequent settlement between the insured and the claimant, and (3) article 21.55 of the Texas Insurance Code, the "Prompt Payment of Claims" statute, does not authorize the imposition of penalties and attorney's fees for an insurer's failure to pay an indemnity claim timely.

I. BACKGROUND

Triple S Industrial Corporation contracted with ATOFINA Petrochemicals, Inc. to perform maintenance and construction at ATOFINA's refinery. The service contract contained an indemnity provision and a requirement that Triple S carry certain minimum levels of liability insurance coverage. Triple S agreed to indemnify ATOFINA from all personal injuries and property losses sustained during the performance of the contract, "except to the extent that any such loss is attributable to the concurrent or sole negligence, misconduct, or strict liability of [ATOFINA]." Triple S also agreed to carry primary comprehensive general liability (CGL) insurance and an umbrella policy, "[i]ncluding coverage for contractual liability insuring the indemnity agreement." Triple S agreed to provide ATOFINA additional insured coverage, a primary basis, on both its general liability and umbrella policies. Triple S complied with its contract obligations by purchasing a $1 million CGL policy from Admiral Insurance Company and a $9 million umbrella policy from Evanston Insurance Company.

Jones, a Triple S employee working at the ATOFINA facility, was killed in an accident. His survivors sued ATOFINA. Admiral accepted coverage and 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 sued Evanston as a third-party defendant for a coverage declaration. ATOFINA severed its claims against Evanston, and both ATOFINA and Evanston moved for partial summary judgment in the severed action. While the motions were 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 for Evanston, but the court of appeals reversed, holding that the Evanston policy covered ATOFINA and remanding the case for determination of statutory penalties and attorney's fees.

II. INDEMNITEE'S STATUS AS ADDITIONAL INSURED

In support of its insured status, ATOFINA cited to part III of the Evanston policy, which defined who was an insured. Section III.B.6 stated that an insured includes:

> 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.

The court acknowledged that Texas courts of appeal have confronted these additional insured provisions on several occasions, producing divergent results; but it noted that its more recent decisions made clear that "the liability insurer is to determine its duty to defend solely from terms of the policy and the pleadings of the third-party claimant," and, accordingly, that "evidence outside the four corners of these two documents is generally prohibited." *GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church*, 197 S.W.3d 305, 307-08 (Tex. 2006). Moreover, the court differentiated the language of the service contract between Triple S and ATOFINA from those of the earlier court of appeals decisions denying insurance coverage.

Second, the court found it unnecessary to determine fault for the accident to determine coverage under the language of this definition. Generally, an event "respects" operations if there exists "a causal connection or relation" between the event and the operations; the Court does not require proximate cause or

EVANSTON INS. CO. V. ATOFINA PETROCHEMICALS, INC. ___ S.W.3D ___ (TEX. JUNE 13, 2008), CONT'D

legal causation. *Mid-Century Ins. Co. of Tex. v. Lindsey*, 997 S.W.2d 153, 155–56 (Tex. 1999).

Evanston argued that, since ATOFINA also qualified as an insured under section III.B.5, which included an exception that might limit coverage, the case must be remanded for a determination of fault. Section III.B.5 said "insured" includes:

> 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.

Because the Admiral policy did not provide additional insured coverage for ATOFINA's sole negligence, and no determination of fault for the Jones accident was made, Evanston argued that, at a minimum, the case needed to be remanded for resolution of the question of whether the accident was caused by ATOFINA's sole negligence. The court disagreed, concluding that each "Who Is An Insured" clause operates to grant coverage independently. Nothing in paragraph III.B suggested that the limitations of one section granting coverage should be read into another separate section granting coverage. The court refused to read section III.B.5's exception of coverage beyond the scope of the Admiral policy into section III.B.6. Because ATOFINA was entitled to coverage under more than one "Who Is An Insured" clause in paragraph III.B, the court held that the Evanston policy provided coverage under the more expansive coverage provision.

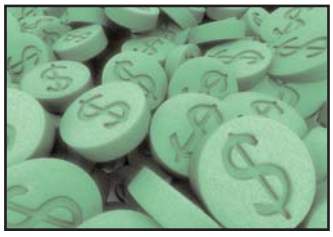
III. OBLIGATION TO PAY UNDERLYING SETTLEMENT

The court then addressed ATOFINA's contention that Evanston's denial of coverage barred it from challenging the reasonableness of the settlement. The court applied its previous opinion in *Employers Casualty Co. v. Block*, 744 S.W.2d 940, 943 (Tex. 1988), in which it held that, if an insurer wrongfully denies coverage and its insured then enters into settlement, the insurer is barred from challenging the reasonableness of the settlement amount. Although this case presents some different facts, the court in *ATOFINA* held that *Block's* rule should apply nonetheless. The court determined that the fact that Evanston did not wrongfully deny a defense did not sufficiently distinguish this case from *Block* (although two Justices strongly disagreed in a partial dissent). The court held that *Block's* position was clear:

> 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. *Id.*

IV. DAMAGES UNDER THE PROMPT PAYMENT STATUTE

Finally, Evanston argues that the court of appeals erroneously awarded ATOFINA 18% per annum of the claim amount and attorneys' fees for Evanston's failure to promptly pay claims under Texas Insurance Code article 21.55 (now recodified at Texas Ins. Code §§542.051-61). Under article 21.55, a court may impose damages "[i]n all cases where a claim is made pursuant to a policy of insurance and the insurer liable therefore is not in compliance with this article." Tex. Ins. Code art. 21.55 § 6. "Claim" is defined as "a first-party claim . . . that must be paid by the insurer directly to the insured or beneficiary." *Id.* at §1.



The court distinguished first-party and third-party claims based on the claimant's relationship to the loss. "[A] first-party claim is stated when 'an insured seeks recovery for the insured's own loss,' whereas a third-party claim is stated when 'an insured seeks coverage for injuries to a third party.'" *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 239 S.W.3d 236, 253 (Tex. 2007). A loss incurred in satisfaction of a settlement belongs to the third party and is not suffered directly by the insured. *Id.* The court held that "[t]his case in which ATOFINA seeks coverage for injuries sustained by a third party presents a classic third-party claim" and held that ATOFINA could not recover §21.55 damages.

Alan J. Rosenberg

THOMPSON, COE, COUSINS & IRONS
INSURANCE LITIGATION & COVERAGE SECTION

Partners

Bradford K. Burdette	(214) 871-8289	bburdette@thompsoncoe.com
Jacquelyn Chandler	(214) 871-8237	jchandler@thompsoncoe.com
Darrell S. Cockcroft	(512) 703-5094	dcockcroft@thompsoncoe.com
Wade C. Crosnoe*	(512) 703-5078	wcrosnoe@thompsoncoe.com
Rodrigo (Diego) Garcia, Jr.	(713) 403-8206	dgarcia@thompsoncoe.com
J. Richard Harmon	(214) 871-8227	rharmon@thompsoncoe.com
Roger D. Higgins**	(214) 871-8256	rhiggins@thompsoncoe.com
James L. Hordern, Jr.	(713) 403-8286	jhordern@thompsoncoe.com
James Nathan Isbell	(713) 403-8387	jamesisbell@thompsoncoe.com
Franklin M. Kennedy	(214) 871-8222	fkennedy@thompsoncoe.com
Robert O. Lamb	(214) 871-8202	rlamb@thompsoncoe.com
Brian S. Martin	(713) 403-8282	bmartin@thompsoncoe.com
Jay S. Simon	(214) 871-8217	jsimon@thompsoncoe.com
Jody Stasney	(214) 871-8274	jstasney@thompsoncoe.com
Rhonda J. Thompson	(214) 871-8273	rthompson@thompsoncoe.com
Ellen M. Van Meir	(214) 871-8220	evanmeir@thompsoncoe.com
Robert B. Wellenberger	(214) 871-8257	bwellenberger@thompsoncoe.com
Harrison H. Yoss	(214) 871-8259	hyoss@thompsoncoe.com

* Certified in Civil Appellate Law, Texas Board of Legal Specialization
** Certified in Civil Trial Law and Civil Appellate Law, Texas Board of Legal Specialization

Thompson, Coe, Cousins & Irons
Insurance Litigation & Coverage Section

Associates

Danah L. Anthony	(214) 871-8230	danthony@thompsoncoe.com
Holly L. Black	(713) 403-8386	hblack@thompsoncoe.com
Eric K. Bowers	(214) 871-8263	ebowers@thompsoncoe.com
Diana M. Brown	(713) 403-8290	dbrown@thompsoncoe.com
Daniel P. Buechler	(214) 871-8262	dbuechler@thompsoncoe.com
Jamie R. Carsey	(713) 403-8209	jcarsey@thompsoncoe.com
Alix K. Cornett	(713) 403-8382	acornett@thompsoncoe.com
Russell L. Dennis	(214) 871-8246	rdennis@thompsoncoe.com
Mariah Baker Quiroz	(214) 871-8258	mquiroz@thompsoncoe.com
Bobby Ramirez	(214) 871-8265	bramirez@thompsoncoe.com
Stephanie S. Rojo	(713) 403-8291	srojo@thompsoncoe.com
Alan J. Rosenberg	(713) 403-8288	arosenberg@thompsoncoe.com
Melanie Sumrow	(214) 871-8248	msumrow@thompsoncoe.com
Linda M. Szuhy	(214) 871-8261	lszuhy@thompsoncoe.com
Jason M. Yacuk	(713) 403-8385	jyacuk@thompsoncoe.com

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