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INSURANCE LAW

*J. Price Collins**
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I. INTRODUCTION

THIS Survey period was one of the most active in recent history for insurance law cases, including long-awaited decisions from the Texas Supreme Court on the insurability of punitive damages and an insurer's right of reimbursement from its insured. Other important decisions from the state and federal courts addressed the applicability of the Prompt Payment of Claims statute, the trigger of coverage under Commercial General Liability ("CGL") policies, rights between co-insurers, the effect of a liability insurer's coverage denial on its right to challenge the reasonableness of a settlement, and when the insured's late notice to the insurer will preclude coverage. Although a few of these opinions were released after the Survey period, they are discussed in this Article because of their significance and the impact they will have on insurers and insureds alike.

II. INSURER'S RIGHT OF REIMBURSEMENT

The Texas Supreme Court issued two decisions limiting an insurer's right to recover amounts paid to settle third-party liability claims against its insured. The first case involved an insurer's right to seek reimbursement from its insured, while the second case involved an insurer's right to seek reimbursement from a co-insurer.

A. INSURER'S RIGHT OF REIMBURSEMENT FROM ITS INSURED

In a much anticipated opinion, *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.*,[1] the Texas Supreme Court revisited the issue of whether an insurer is entitled to reimbursement from its insured of amounts it paid to settle third-party claims against the insured when it later determined that those claims are not covered under

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1. 246 S.W.3d 42 (Tex. 2008).

the policy.[2] The supreme court first addressed this issue in 2000, in *Texas Association of Counties County Government Risk Management Pool v. Matagorda County*,[3] holding that an insurer may seek reimbursement only if it "obtains the insured's clear and unequivocal consent to the settlement and the insurer's right to seek reimbursement."[4] In its original opinion in *Frank's Casing*, the supreme court had "clarif[ied]" *Matagorda County* and had expanded the insurer's right of reimbursement to include the additional circumstances: (1) when the insured demands that the insurer accept a settlement offer that is within policy limits, or (2) when the insured expressly agrees that the settlement offer should be accepted.[5]

The supreme court granted rehearing in *Frank's Casing* on January 6, 2006, and on February 1, 2008, withdrew its prior opinion and issued a new opinion.[6] The supreme court expressly declined to overrule *Matagorda County*, reiterating that in weighing the varying risks surrounding settlement offers when coverage is disputed, "insurers, on balance, are better positioned to handle them 'either by drafting policies to specifically provide for reimbursement or by accounting for the possibility that they may occasionally pay uncovered claims in their rate structure.'"[7]

The supreme court next addressed whether the case was sufficiently distinguishable from *Matagorda County* to justify an exception to the *Matagorda County* rule and thereby permit reimbursement based on the insured's implied consent.[8] The underwriters emphasized that (1) they were excess carriers who did not have a duty to defend or otherwise have unilateral control over settlement, (2) the policy prohibited settlement without the insured's consent, and (3) the insured had demanded that the underwriters settle the claim.[9] Reasoning that "none of these distinctions alleviates the concerns that drove the supreme court's analysis in *Matagorda County*,"[10] the supreme court declined to recognize an exception to the *Matagorda County* rule and accordingly refused to find an implied-in-fact agreement.[11] The supreme court also refused to recognize a reimbursement right under the equitable theories of *quantum meruit* and *assumpsit*.[12]

Consequently, after *Frank's Casing*, an insurer has a right of reimbursement from its insured only if: (1) the policy specifically provides for reimbursement, or (2) the insured clearly and unequivocally consents to the

2. *Id.* at 43.
3. 52 S.W.3d 128 (Tex. 2000).
4. *Frank's Casing*, 246 S.W.3d at 43 (quoting *Matagorda County*, 52 S.W.3d at 135).
5. Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc., 48 Tex. Sup. Ct. J. 735 (Tex. 2005), *withdrawn*, 246 S.W.3d 42, 42 (2008).
6. *Frank's Casing*, 246 S.W.3d at 43.
7. *Id.* at 47-48 (quoting *Matagorda County*, 52 S.W.3d at 136).
8. *Id.* at 48.
9. *Id.*
10. *Id.* at 43.
11. *Id.* at 48-49.
12. *Id.* at 49-50.

settlement and the insurer's right to seek reimbursement.[13]

B. Insurer's Right of Reimbursement from a Co-Insurer

On certified questions from the Fifth Circuit, the Texas Supreme Court addressed whether a liability insurer, which pays more than its share to settle a claim against its insured, has a right to seek reimbursement from an underpaying co-insurer.[14] Liberty Mutual Insurance Company ("Liberty Mutual") and Mid-Continent Insurance Company ("Mid-Continent") both insured Kinsel Industries ("Kinsel") under respective $1 million comprehensive general liability ("CGL") policies.[15] The "policies contained identical 'other insurance' clauses providing for equal or pro rata sharing up to the co-insurers' respective policy limits if the loss is covered by other primary insurance."[16] The insurers agreed that each owed some portion of the defense and indemnity costs for a personal injury lawsuit against Kinsel arising out of an auto accident and that a total verdict for the claimants against all the defendants would be in the $2-3 million range. The insurers, however, disagreed on the settlement value of the claim against Kinsel. Although the insurers initially had the same estimates regarding Kinsel's percentage of fault, Liberty Mutual increased its estimate as the case progressed. After Mid-Continent refused to increase its contribution to a settlement, Liberty Mutual agreed to settle on behalf of Kinsel for $1.5 million. "Liberty Mutual demanded that Mid-Continent contribute half, but Mid-Continent continued to calculate the settlement value . . . at $300,000 and agreed to pay only $150,000. Liberty Mutual . . . funded the remaining $1.35 million, paying $350,000 more than its $1 million CGL policy limit."[17] Liberty Mutual reserved its right to seek recovery from Mid-Continent and subsequently sued Mid-Continent for reimbursement of Mid-Continent's pro rata share of the settlement.[18]

The supreme court first addressed whether Liberty Mutual had a direct claim or right of action for reimbursement from Mid-Continent based on contribution.[19] The supreme court reiterated the general rule that

> if two or more insurers bind themselves to pay the entire loss insured against, and one insurer pays the whole loss, the one so paying has a right of action against his co-insurer, or co-insurers, for a ratable proportion of the amount paid by him, because he has paid a debt which is equally and concurrently due by the other insurers.[20]

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13. *See id.* at 43.
14. Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co., 236 S.W.3d 765, 768 (Tex. 2007).
15. *Id.* at 769.
16. *Id.*
17. *Id.* at 770.
18. *Id.*
19. *Id.* at 772.
20. *Id.* at 772 (quoting Traders & Gen. Ins. Co. v. Hicks Rubber Co., 169 S.W.2d 142, 148 (Tex. 1943)).

The appropriate right of action is one for contribution, which requires that the insurers share a common obligation "and that the insurer seeking contribution has made a compulsory payment or other discharge of more than its fair share of the common obligation."[21]

"This direct claim for contribution between co-insurers disappears when the insurance policies contain 'other insurance' or 'pro rata' clauses."[22] Because the pro rata clause makes the contracts several and independent of each other, the co-insurers have independent contractual obligations and therefore, "do not meet the common obligation requirement of a contribution claim."[23] Thus, if a co-insurer pays more than its contractually agreed upon proportionate share, it does so voluntarily without a legal obligation to do so.[24] Applying these principles, the supreme court explained that under their policies' pro rata clauses, Liberty Mutual and Mid-Continent contractually agreed to pay a proportionate share of Kinsel's loss up to $1 million, but they did not contract to create obligations between themselves or to pay each other's proportionate share of the loss.[25] Accordingly, the supreme court concluded that there was no contractual right of contribution, that the presence of the pro rata clauses precluded an equitable right of contribution, and that it would not create such an obligation under the common law.[26]

Next addressing whether Liberty Mutual could seek reimbursement through subrogation, the supreme court explained that, under either contractual or equitable subrogation, the insurer stands in the shoes of the insured and obtains "only those rights held by the insured against a third party, subject to any defenses held by the third party against the insured."[27] Where two policies "provide coverage for a loss, the pro rata clause does not create an exception to the principle" that an insured's right of indemnity from the insurer is limited to the actual amount of loss; rather, the pro rata clause "implements this principle by eliminating the potential for double recovery by the insured."[28] Therefore, once the insured recovers the full amount of its loss from one carrier, "the insured has no further rights against the other insurer which has not contributed to its recovery," and "the liability of the remaining insurer *to the insured* ceases," even if that insurer has not defended or indemnified the insured.[29] The supreme court held that "a fully indemnified insured has no right to recover an additional pro rata portion of settlement from an in-

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21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.* at 772-73.
26. *Id.* at 773 (disagreeing with Gen. Agents Ins. Co. of Am. v. Home Ins. Co. of Ill., 21 S.W.3d 419 (Tex. App.—San Antonio 2000, pet. dism'd by agr.), "to the extent it creates a common law duty between co-primary insurers to reasonably exercise rights under an insurance policy").
27. *Id.* at 774.
28. *Id.* at 775.
29. *Id.*

surer regardless of that insurer's contribution to the settlement. Having fully recovered its loss, an insured has no contractual rights that a co-insurer may assert against another co-insurer in subrogation."[30]

Applying these principles, the supreme court concluded that, because Kinsel had already been fully indemnified by Liberty Mutual, it had no contractual rights against Mid-Continent and therefore, Liberty Mutual had no contractual subrogation rights against Mid-Continent.[31] Finally, the supreme court explained that because the underlying claimants had not made a settlement offer within Mid-Continent's policy limits, Mid-Continent did not breach a *Stowers* duty to Kinsel.[32] As such, Kinsel had no common law rights against Mid-Continent to which Liberty Mutual could be subrogated.[33]

III. EXTRA-CONTRACTUAL LIABILITY

A. The Prompt Payment of Claims Statute

1. *Texas Supreme Court Ruled That the Prompt Payment of Claims Statute Applies to a Liability Insurer's Defense, but Not Indemnity Obligations for a Third-Party Claim*

The Prompt Payment of Claims statute (the "Statute")[34] authorizes an award of eighteen percent annual interest and reasonable attorneys' fees when an insurer wrongfully refuses or delays payment of a "claim."[35] The Statute defines the term "claim" as a first-party claim made by an insured that must be paid by the insurer directly to the insured, but does not separately define "first-party claim."[36] Texas state and federal courts had been divided over the applicability of the statute to an insured's claim under a liability policy for defense of a third-party claim.[37] In *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, the Texas Supreme Court decided this issue on certified question from the Fifth Circuit.[38]

The supreme court explained that it had "previously distinguished first-party and third-party claims on the basis of the claimant's relationship to the loss."[39] "[A] first-party claim is stated when 'an insured seeks recovery for [its] own loss,' whereas a third-party claim is stated when 'an insured seeks coverage for injuries to a third party.'"[40] Based on this

30. *Id.* at 775-76.
31. *Id.* at 777.
32. *Id.* at 776 (referencing G.A. Stowers Furniture Co. v. Am. Indem. Co., 15 S.W.2d 544, 547 (Tex. 1929)).
33. *Id.* at 776-77.
34. Tex. Ins. Code Ann. §§ 542.051-.061 (Vernon 2008) (formerly codified as Tex. Ins. Code Ann. art. 21.55 (Vernon 1991)).
35. Lamar Homes, Inc. v. Mid-Continent Cas. Co., 242 S.W.3d 1, 16 (Tex. 2007) (citing Tex. Ins. Code § 542.060(a)).
36. *Id.* (citing Tex. Ins. Code § 542.051(2)).
37. *Id.*
38. *Id.* at 4.
39. *Id.* at 17.
40. *Id.* (quoting Universe Life Ins. Co. v. Giles, 950 S.W.2d 48, 54 n.2 (Tex. 1997)).

distinction, the supreme court determined that a defense claim is a first-party claim because it relates solely to the insured's own loss:

> Without the defense benefit provided by a liability policy, the insured alone would be responsible for these costs. Unlike the loss incurred in satisfaction of a judgment or settlement, this loss belongs only to the insured and is in no way derivative of any loss suffered by a third party. The claim for defense costs then is a first-party claim because the insured is the only party who will suffer the loss or benefit from the claim.[41]

The supreme court also addressed other courts' determination that the Statute is "unworkable" in the context of an insured's claim for a defense due to the various deadlines imposed for responding to and paying claims.[42] For example, the Dallas Court of Appeals observed that at the time of a claim for a defense, "the insured typically has not yet suffered any actual loss . . . . [and] queried whether the insured would have to submit its legal bills" to the insurer as received.[43] The supreme court responded that the Statute's "apparent answer" to this query is "yes," explaining that "when the insurer wrongfully rejects its defense obligation, the insured has suffered an actual loss that is quantified after the insured retains counsel and begins receiving statements for legal services," and that these "invoices are the last piece of information needed to put a value on the insured's loss."[44] Accordingly, the supreme court concluded that an insured's right to a defense benefit under a liability policy is a "first-party claim" within the Statute's meaning and therefore, the Statute applies when the insurer wrongfully refuses to promptly pay a defense benefit owed to the insured.[45]

In contrast to the defense benefit at issue in *Lamar Homes*, the Texas Supreme Court's subsequent decision in *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, held that the Statute does not extend to an insured's claim under a liability policy for indemnification of a third-party claim.[46] After the insurer denied coverage, the insured settled with the third-party claimant and then sued the insurer for recovery of the settlement amount it had paid plus interest and attorney's fees under the Statute.[47] Reiterating the distinction between first-party and third-party claims based on the claimant's relationship to the loss, the supreme court reasoned that a loss incurred in satisfaction of a settlement belongs to the third party and is not suffered directly by the insured.[48] Characterizing the insured's claim for coverage for injuries sustained by a third party as a

41. *Id.*
42. *Id.* at 19.
43. *Id.* (referencing TIG Ins. Co. v. Dallas Basketball, Ltd., 129 S.W.3d 232, 239, 241 (Tex. App.—Dallas 2004, pet. denied)).
44. *Id.* at 19-20.
45. *Id.*
46. Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc., 256 S.W.3d 660, at 674-75 (Tex. 2008).
47. *Id.* at 662-63.
48. *Id.* at 674-75.

"classic third-party claim" and emphasizing that the legislature intended that the Statute apply only to claims personal to the insured, the court concluded that the insured was not entitled to any recovery under the Statute.[49]

2. *An Insurer's Interpleader of Policy Proceeds Does Not Relieve It of Statutory Penalties for Delay Before Filing the Interpleader*

In *State Farm Life Insurance Co. v. Martinez*, the Texas Supreme Court addressed whether the Statute applies to an insurer that is faced with rival claims and interpleads its policy proceeds into the court registry.[50] Despite recognizing that "[i]t has long been the rule in Texas that if an insurer promptly interpleads policy proceeds, it cannot be subjected to statutory penalties for delayed payment even if it missed the statutory deadlines," the supreme court held that this interpleader exception to the Statute did not survive the legislature's 1991 amendments to the Statute.[51]

The supreme court stated three reasons for its holding: (1) the Statute itself does not have an interpleader exception, and "creating [such] an exception for interpleaders filed after [the Statute's sixty-day payment] deadline would mean simply ignoring the [S]tatute in some cases"; (2) under the 1991 amendments, the Statute must be liberally construed to promote its underlying purpose, and "[w]hile exempting interpleaders might be consistent with a strict construction, it is inconsistent with a liberal one"; and (3) "compliance with the [S]tatute would not frustrate the primary purpose behind the interpleader" of resolving rival claims because "given recent increases in avenues for communication and dispute resolution, it is hard to argue that the statute's safe-harbor of 60 days—double the period allowed throughout most of Texas history—is insufficient."[52] Emphasizing that continuing to recognize an interpleader exception to the Statute would frustrate its purpose, but that removing the exception would fulfill the purposes of both the Statute and interpleader, the supreme court held that the insurer's interpleader did not render the Statute inapplicable.[53]

Although the supreme court concluded that the insurer was subject to statutory penalties for delay *before* the interpleader was filed, it ruled that the court of appeals had improperly imposed statutory penalties for the time *after* the interpleader was filed.[54] Because Texas law instructs that if a reasonable doubt exists as to the ownership of the policy proceeds, the insurer should interplead the proceeds, applying the Statue post-interpleader would lead to the "absurd result" of "punish[ing] insur-

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49. *Id.* at 675.
50. 216 S.W.3d 799, 800 (Tex. 2007).
51. *Id.* at 800, 804.
52. *Id.* at 804-05.
53. *Id.* at 805.
54. *Id.* at 800.

ers for doing exactly what Texas law encourages."[55]

B. Bad Faith

In *Crocker v. American National General Insurance Co.*, the Dallas Court of Appeals held that an independent adjuster cannot be liable to the insured in the absence of a contractual relationship between the insured and the adjuster.[56] The insureds submitted a claim under their homeowners policy for water damage and mold, and the insurer retained an independent adjuster to investigate the claim.[57] The insurer subsequently denied coverage for the claim based on various policy exclusions, and the insureds filed suit against the insurer and the independent adjuster asserting claims for breach of the common law and statutory duties of good faith.

The court of appeals affirmed the trial court's summary judgment in favor of both the insurer and the independent adjuster.[58] First addressing the insurer, the court determined that the insured's claim was excluded from coverage and that "[a]s a general rule there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered."[59] Concerning the independent adjuster, the court explained that "absent a contractual relationship between the insured and an adjuster, the adjuster could not be liable to the insured for improper investigation and settlement advice, 'regardless of whether [the insured] phrased his allegations as negligence, bad faith, breach of contract, tortious interference, or DTPA claims.'"[60] Therefore, the adjuster had no legal duty to the insureds and was entitled to summary judgment.[61]

IV. CONTRACTUAL LIABILITY

A. Insurability of Punitive or Exemplary Damages

In the long-awaited *Fairfield Insurance Company v. Stephens Martin Paving, L.P.* opinion, the Texas Supreme Court addressed the following certified question from the Fifth Circuit: "Does Texas public policy prohibit a liability insurance provider from indemnifying an award for punitive damages imposed on its insured because of gross negligence?"[62] The supreme court explained that the determination of this issue requires a two-step analysis.[63] First, the supreme court decides whether the policy's plain language "covers the exemplary damages sought in the underlying

55. *Id.* at 806.
56. 211 S.W.3d 928, 937-38 (Tex. App.—Dallas 2007, no pet.).
57. *Id.* at 929.
58. *Id.*
59. *Id.* at 936 (quoting Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 341 (Tex. 1995)).
60. *Id.* at 938 (quoting Dear v. Scottsdale Ins. Co., 947 S.W.2d 908, 917 (Tex. App.—Dallas 1997, writ denied)).
61. *Id.*
62. 246 S.W.3d 653, 654 (Tex. 2008).
63. *Id.* at 655.

suit against the insured."[64] Second, if such coverage exists, the supreme court determines whether Texas public policy "allows or prohibits coverage in the circumstances of the underlying suit," looking first to express statutory provisions on the insurability of exemplary damages "to determine whether the Legislature has made a policy decision."[65] In the absence of an explicit policy decision by the legislature, the supreme court then considers the general public policies of Texas.[66]

Proceeding under this framework, the supreme court noted that because the certified question was directed only at Texas public policy, it was presuming that the policy covered exemplary damages and was limiting its discussion to the second prong.[67] The underlying suit was brought by survivors of a deceased employee, and because the survivors had received workers' compensation benefits, they were barred by statute from recovering actual damages and sought only exemplary damages.[68] After examining the statutory scheme and accompanying insurance regulation of the Texas workers' compensation system, the supreme court concluded based on the legislature's expressed intent that Texas public policy did not prohibit insurance coverage for gross negligence in the instant case.[69]

Although this expressed direction by the legislature resolved the insurability of exemplary damages issue in the instant case, the supreme court, recognizing the "import of this issue," proceeded to discuss "some of the considerations relevant to determining whether Texas public policy prohibits insurance coverage of exemplary damages in other contexts in the absence of a clear legislative policy decision."[70] After examining the history of the debate through statutes, cases, and treatises from across the country, the supreme court explained that the determination of whether to render an agreement for coverage of exemplary damages unenforceable on public policy grounds requires that "Texas' general policy favoring freedom of contract," including consideration of "the reasonable expectations of the parties and the value of certainty in enforcement of contracts generally," be weighed against "the extent to which the agreement frustrates important public policy."[71]

The supreme court instructed that "[i]n situations where the Legislature has not spoken directly on whether public policy prohibits insurance coverage of exemplary damages . . . a court should consider the purpose of exemplary damages," which is gleaned from "the common law and legislative development of exemplary damages."[72] "Legislative enactments [in] the last decade clarif[ied] [that] compensatory recovery is not a com-

64. *Id.*
65. *Id.*
66. *Id.*
67. *Id.* at 656.
68. *Id.* at 655, 655 n.1.
69. *Id.* at 670.
70. *Id.* at 660.
71. *Id.* at 663-64.
72. *Id.* at 660.

ponent of exemplary damages in Texas today, and the most recent enactments downplay[ed] the role of deterrence, and [instead] focus[ed] squarely on the punitive aspect."[73] The current exemplary damages statute identifies the following factors to be considered in determining the amount of exemplary damages:

(1) the nature of the wrong;
(2) the character of the conduct involved;
(3) the degree of culpability of the wrongdoer;
(4) the situation and sensibilities of the parties concerned,
(5) the extent to which such conduct offends a public sense of justice and propriety;
(6) the net worth of the defendant.[74]

The supreme court characterized the first, second, and fifth factors as raising concerns of an objective nature focusing on the nature of the conduct; conversely, the third, fourth, and sixth factors focus subjectively on what it will take to punish this defendant.[75] These factors impact the insurability of exemplary damages question in the following manner:

> There is some inherent tension between the policies recognized by freedom of contract and the policy behind awarding exemplary damages. Spreading the risk of, and obligation for, exemplary damages through insurance does not affect the objective factors. They may be evaluated without regard for individual personalities. The issue is this: What penalty should this conduct, in the abstract, bear? But the subjective factors are relevant to a determination of the amount of exemplary damages only if the *defendant* must pay it to the *plaintiff.* If exemplary damages are to be paid by insurance, it is less relevant to set the amount based on whether the plaintiff was trusting or the defendant calculating or wealthy.[76]

Finally, after discussing the few Texas cases that have considered the insurability issue in light of the purpose behind exemplary damages, the supreme court summarized

> the general considerations that are important when determining whether the policy behind exemplary damages should limit parties' ability to contract for coverage of those damages. In the uninsured and underinsured motorist context, it may be appropriate for policyholders to share in the burden of injuries caused by underinsured motorists, but not in their punishment. In other words, the purpose of exemplary damages may not be achieved by penalizing those who obtain the insurance required by law for the wrongful acts of those who do not.
>
> The considerations may weigh differently when the insured is a corporation or business that must pay exemplary damages for the

73. *Id.*
74. *Id.* at 667-68 (quoting TEX. CIV. PRAC. & REM. CODE ANN. § 41.011(a) (Vernon 2008)).
75. *Id.* at 668.
76. *Id.* at 668 (emphasis in original).

> conduct of one or more of its employees. Where other employees and management are not involved in or aware of an employee's wrongful act, the purpose of exemplary damages may be achieved by permitting coverage so as not to penalize many for the wrongful act of one. When a party seeks damages in these circumstances, courts should consider valid arguments that businesses be permitted to insure against them.
>
> Extreme circumstances may prompt a different analysis. The touchstone is freedom of contract, but strong public policies may compel a serious analysis into whether a court may legitimately bar contracts of insurance for extreme and avoidable conduct that causes injury. For example, liability policies themselves normally bar insurance for damages caused by intentional conduct, as did the liability policy in this case. The fact that insurance coverage for exemplary damages may encourage reckless conduct likewise gives us pause. Were the existence of insurance coverage to completely eviscerate the punitive purpose behind awarding exemplary damages, it could defeat not only an explicit legislative policy but also the court's traditional role in deterring conscious indifference.[77]

Accordingly, in response to the certified question, the supreme court answered that Texas public policy does not prohibit insurance coverage of exemplary damages for gross negligence in the workers' compensation context.[78] The supreme court, however, emphasized that "without clear legislative intent to generally prohibit or allow the insurance of exemplary damages arising from gross negligence," it was "declin[ing] to make a broad proclamation of public policy," but was "instead offer[ing] some considerations applicable to the analysis in other cases."[79] Consequently, while *Fairfield* provides some guidance regarding insurability of punitive damages, this issue has not been finally resolved and will likely continue to be litigated.

B. A Liability Insurer's Erroneous Denial of Coverage Prohibits It from Challenging the Reasonableness of the Insured's Settlement

In another significant case decided on rehearing, *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, the Texas Supreme Court held that a liability insurer which wrongfully denies coverage is barred from challenging the reasonableness of the amount of the insured's settlement with the third-party claimant.[80] There, the insured was sued and requested coverage from its liability insurer, which denied coverage based on the policy's terms. The insured then brought the insurer into the underlying suit as a third-party defendant, seeking a declaration of coverage. When

77. *Id.* at 669-70.
78. *Id.* at 670.
79. *Id.*
80. Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc., 256 S.W.3d 660, 671-74 (Tex. 2008).

the insurer continued to deny coverage in its pleadings, the insured settled with the underlying claimants. The insured then continued the litigation of the coverage issues against the insurer, and it was determined that the insurer had wrongfully denied coverage.[81]

The supreme court explained that its last occasion to address this issue was in *Employers Casualty Co. v. Block*,[82] where it had held that "if an insurer wrongfully denies coverage and its insured then enters into an agreed judgment, the insurer is barred from challenging the reasonableness of the settlement amount."[83] The supreme court acknowledged that the instant case differed from *Block* in several respects, including the forms of the settlement and the policy claims.[84] First, the insurer in *Block* breached the duty to defend; conversely, although the insurer in *ATOFINA* had wrongfully denied coverage, no duty to defend was implicated.[85] Second, *Block* involved an agreed judgment between the insured and the underlying claimant; conversely, in *ATOFINA*, the insured and the underlying claimants used a contractual settlement agreement and nonsuit.[86] Despite these distinctions between the two cases, the supreme court determined that *Block* nevertheless governed because its rule derived not "from the nature of the violated policy term or the formality of agreed judgments," but rather from principles of estoppel and waiver.[87] As such, the key inquiry is whether the insurer received notice and had an opportunity to participate in the settlement discussions.[88] This inquiry is not altered by the particular source of the insurer's attack on the settlement amount, that is, a policy provision versus the common law reasonableness requirement.[89] So, "[h]ad [the insurer] not unconditionally denied coverage, it too would have been able to influence the amount of the settlement. For these reasons, the difference in policy claims and the absence of a formal judgment do not persuade us to abandon *Block* here."[90]

The supreme court also acknowledged that due to *Block*'s procedural posture of the underlying claimant suing the insurer as a judgment creditor, it previously expressed "some disapproval" of *Block* in *State Farm Fire & Casualty Co. v. Gandy*,[91] which held that "[i]n 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 defen-

81. *Id.* at 671-72.
82. 744 S.W.2d 940 (Tex. 1988).
83. *ATOFINA*, 256 S.W.3d at 671 (referencing *Block*, 744 S.W.2d at 943).
84. *Id.* at 671.
85. *Id.* at 671-72.
86. *Id.* at 672.
87. *Id.*
88. *Id.*
89. *Id.* (alteration in original).
90. *Id.*
91. 925 S.W.2d 696 (Tex. 1996).

dant's assignee."[92] Nevertheless, the supreme court reasoned that *Gandy* did not disrupt the application of *Block* to the instant case for two reasons.[93] First, because *Gandy*'s holding was "explicit and narrow, applying only to a specific set of assignments with special attributes," its "invalidation applies only to cases that present its five unique elements."[94] Since the insured in *ATOFINA* made no assignment of its claim against the insurer and sued the insurer directly, "*Gandy*'s key factual predicate is missing," thereby "remov[ing] this case from the formal bounds of *Gandy*."[95]

Second, the supreme court explained that *Gandy*'s reason for invalidating assignments was that they "made evaluating the merits of the plaintiff's claim difficult by prolonging disputes and distorting trial litigation motives;" if, however, this difficulty is not present in a particular case, it should not be a basis to invalidate a settlement.[96] The supreme court reasoned that the insurer's challenge in *ATOFINA* did not implicate *Gandy*'s concerns because: (1) "[p]reventing insurers from litigating the reasonableness of a settlement does not extend disputes; [but,] by definition, it shortens them; and (2) there was no "risk of distorting litigation or settlement motives" because the insured had settled without knowing whether coverage would exist, thus "leaving in place its motive to minimize the settlement amount in case it became solely responsible for payment."[97] The supreme court decided that application of the *Block* rule in this circumstance "will encourage early intervention by the insurers who are best positioned to evaluate the worth of claims during settlement discussions."[98] In the absence of "relevant factual differences or *Gandy* concerns to dissuade us from following *Block*," the supreme court held that the insurer's denial of coverage barred it from challenging the reasonableness of the settlement and that it was responsible for payment of the settlement.[99]

C. The Duty to Defend

1. *A Liability Insurer Has No Duty to Notify an Additional Insured That a Defense Is Available*

In *National Union Fire Insurance Co. v. Crocker*, the Texas Supreme Court held that "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."[100] Emeritus Corporation ("Emeritus") and Richard Morris ("Morris"), an

92. *ATOFINA*, 256 S.W.3d at 673 (quoting *Gandy*, 925 S.W.2d at 714).
93. *Id.*
94. *Id.*
95. *Id.* at 673.
96. *Id.* at 673-74.
97. *Id.* at 674.
98. *Id.*
99. *Id.*
100. Nat'l Union Fire Ins. Co. v. Crocker, 246 S.W.3d 603, 608 (Tex. 2008).

employee of Emeritus' nursing home, were sued by a resident who was allegedly injured by Morris. Emeritus tendered the lawsuit under a CGL policy issued by National Union Fire Insurance Company ("National Union"). As an employee at the time of the accident, Morris qualified for additional insurance coverage under the policy. Morris, however, was apparently unaware that he qualified for coverage, did not request a defense under the policy, and failed to file an answer in the lawsuit. National Union provided a defense to Emeritus, but did not defend Morris even though it was aware that he qualified for coverage and that he had been served with the lawsuit. The claims against Morris were severed, and a $1,000,000 default judgment was entered against Morris. The claimant then sued National Union as a third-party beneficiary under the policy in an effort to collect the judgment.[101]

National Union argued that the duty to defend was never trigged because Morris had not provided notice of the lawsuit nor requested a defense under the policy.[102] Conversely, the claimant argued that because National Union had actual notice of the lawsuit against Morris, it was not prejudiced by Morris' failure to comply with the policy's notice provisions and had a duty to notify Morris of his insured status. The district court concluded that Texas law required National Union to show prejudice to establish a notice-based policy defense and that National Union breached the duty to defend by failing to notify Morris that a defense was available under the policy.[103] On appeal, the Fifth Circuit certified the following three questions to the Texas Supreme Court:

> [(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?[104]
>
> [(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?[105]
>
> [(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?[106]

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101. *Id.* at 605.
102. *Id.*
103. *Id.*
104. *Id.* at 606.
105. *Id.* at 608.
106. *Id.* at 609.

Because the supreme court answered the first question "no," it did not answer the second question and answered the third question "no."[107]

On the first question, the supreme court stated that "[p]ut simply, there is no duty to provide a defense absent a request for coverage."[108] The supreme court relied on its decision in *Weaver v. Hartford Accident and Indemnity Co.*,[109] in which it 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."[110] Based on *Weaver*, the supreme court held that "[m]ere awareness of a claim or suit does not impose a duty on the insurer to defend under the policy; there is no unilateral duty to act unless and until the additional insured first *requests* a defense—a threshold duty that the insured fulfills under the policy by notifying the insurer that the insured has been served with process and the insurer is expected to answer on its behalf."[111] However, the supreme court did emphasize that "[o]f course, an insurer that is aware an additional insured has been sued may, and perhaps should, choose to inform the insured that a defense is available . . . ."[112]

As to the third question, the supreme court concluded that an insurer's actual knowledge that an additional insured has been served does not establish, as a matter of law, that the insurer was not prejudiced because an insurer has no duty to either inform the additional insured of available coverage or to voluntarily undertake a defense for the insured.[113] Absent a threshold duty to defend, the supreme court held that the insurer could not have liability to Morris or to the claimant derivatively.[114] In reaching this holding, the supreme court distinguished the instant case from other decisions addressing late notice by an insured, explaining that the additional insured's notice here "was not merely late; it was wholly lacking."[115]

2. *Whether There Is an Exception to the "Eight-Corners" Rule That Permits Consideration of Extrinsic Evidence in Determining the Duty to Defend*

An ongoing issue of debate in Texas has been whether an exception to the "eight-corners" rule exists to permit the consideration of extrinsic evidence in determining an insurer's duty to defend. In 2006, the Texas Supreme Court provided some guidance on this issue in *GuideOne Elite*

107. *Id.* at 604, 608-09.
108. *Id.* at 607.
109. 570 S.W.2d 367 (Tex. 1978).
110. *Crocker*, 246 S.W.3d at 606.
111. *Id.* at 608 (emphasis in original).
112. *Id.*
113. *Id.* at 609.
114. *Id.*
115. *Id.*

Insurance Co. v. Fielder Road Baptist Church, where it refused to adopt any exception to the "eight-corners" rule for "liability only" or "overlapping/mixed fact" scenarios.[116] The supreme court, however, did not expressly rule out the use of extrinsic evidence that is relevant solely to a discrete issue of coverage that does not overlap with the liability issues. Accordingly, Texas courts have continued to grapple with whether, and under what circumstances, extrinsic evidence can be admitted to determine the insurer's duty to defend.

The Fifth Circuit addressed this issue in *Liberty Mutual Insurance Co. v. Graham*.[117] There, an employee of the insured company was involved in an accident while driving a company vehicle for personal use and was sued as a result. The underlying pleading contained allegations indicating that the employee had the insured company's permission to use the vehicle for personal use. Accordingly, the employee sought coverage under his employer's policy, arguing that he was a permissive user and that the policy defined insured to include "[a]nyone else while using with your permission a covered auto you own, hire or borrow . . . ."[118] The insurer argued that the underlying pleading did not allege permissive use of the vehicle and that, even if it did, consideration of extrinsic evidence showing that the employee was not a permissive user was appropriate because the evidence related solely to a coverage determination.[119]

The Fifth Circuit reversed the district court's summary judgment in favor of the insurer, holding that the court's admission of extrinsic evidence on the duty to defend was improper after *GuideOne*.[120] The court explained that based on a liberal construction of the underlying pleading's allegations, it was "reasonable to infer that the plaintiffs assert that [the employee] was driving the vehicle with [the insured company's] permission at the time of the accident."[121] While the court acknowledged that there is the "limited exception to the eight corners rule applied by some Texas appellate courts and approved in the *GuideOne* decision's dicta," the court decided the exception was inapplicable for two reasons.[122] First, the underlying pleading was specific enough to determine coverage without resorting to extrinsic evidence.[123] Second, the court found that the coverage issue did not turn on the applicability of a specific-coverage exclusion, noting that the cases allowing extrinsic evidence "are distinguishable because they involved explicit policy coverage exclusion clauses, the applicability of which could not be established under the allegations of the complaint but rather required reference to unrelated but readily ascertainable facts."[124] Thus, while the Fifth Circuit acknowl-

116. 197 S.W.3d 305, 310-11 (Tex. 2006).
117. 473 F.3d 596 (5th Cir. 2006).
118. *Id.* at 598.
119. *Id.* at 599.
120. *Id.* at 602.
121. *Id.*
122. *Id.*
123. *Id.* at 603.
124. *Id.*

edged the possibility of using "coverage only" extrinsic evidence, it concluded that the exception to the "eight-corners" rule was inapplicable in the case before it.[125]

In *D.R. Horton-Texas, Ltd. v. Markel International Insurance Co.*, the Houston Court of Appeals for the Fourteenth District also refused to permit the use of extrinsic evidence to determine the duty to defend in the additional insured context.[126] The general contractor required all subcontractors to name it as an additional insured under their policies. The general contractor was sued in a construction defect case and sought additional insured coverage under the liability policies issued to its masonry subcontractor. The masonry subcontractor's liability insurers denied coverage for the general contractor because the underlying pleading did not name any subcontractors or refer to the subcontractors. The general contractor sued the insurers and sought to introduce extrinsic evidence that the alleged damages were caused by the masonry subcontractor. While recognizing that the general contractor had "produced a significant amount of summary judgment evidence that . . . links [the masonry subcontractor] to the injuries claimed," the court of appeals concluded that the extrinsic evidence related to both coverage and liability and therefore refused to permit the use of the extrinsic evidence.[127] The general contractor has filed a petition for review with the Texas Supreme Court, asking the court to expressly adopt a "coverage only" exception to the "eight corners" rule.

In *Roberts, Taylor & Sensabaugh, Inc. v. Lexington Insurance Co.*, the Federal District Court for the Southern District of Texas allowed the use of extrinsic evidence that did not "engage the truth or falsity of any facts alleged in the underlying case" or "affect the third party's right of recovery."[128] There, the general contractor hired a subcontractor for a construction project and required the subcontractor to procure liability insurance naming the general contractor as an additional insured for liability arising from the subcontractor's work on the project.[129] The subcontractor hired another contractor to perform part of the work, and an employee of that sub-subcontractor was injured and sued the general contractor. The subcontractor's insurer denied additional insured coverage for the general contractor because the pleading did not allege that the injured employee was performing work for the subcontractor or that the subcontractor was working for the general contractor.[130]

The general contractor sued the insurer for a declaration that a duty to defend existed and asked the court to consider extrinsic evidence of the subcontracts between the various parties, arguing that this evidence was

125. *Id.* at 602-03.
126. No. 14-05-00486-CV, 2006 Tex. App. LEXIS 9346, at *16 (Tex. App.—Houston [14th Dist.] Oct. 26, 2006, pet. filed).
127. *Id.*
128. No. H-06-2197, 2007 U.S. Dist. LEXIS 75075, *20 (S.D. Tex. Oct. 9, 2007).
129. *Id.* at *2.
130. *Id.* at *4.

necessary to determine whether its liability in the underlying suit arose from the subcontractor's work and to establish its status as an additional insured.[131] The court decided that extrinsic evidence of the parties' contracts was admissible because "[s]uch evidence shows the circumstances under which [the employee] was working when the incident at issue occurred, not whether, how, or why any injury occurred or who may be responsible," and evidence of the contracts would not engage the truth or falsity of the employee's allegations.[132]

D. Notice Provisions

1. *Late Notice Will Not Defeat Advertising Injury Coverage Under a CGL Policy if the Insurer Was Not Prejudiced by the Delay*

In *PAJ, Inc. v. Hanover Insurance Co.*, the Texas Supreme Court held that an insured's failure to timely notify its insurer of a claim or suit will not defeat advertising injury coverage under a CGL policy if the insurer was not prejudiced by delay.[133] The policy required the insured to notify the insurer of suits "as soon as practicable."[134] The insured was sued for copyright infringement but failed to provide notice of the lawsuit for four to six months. After the insurer's denial of coverage, the insured sought a judicial declaration that the insurer was contractually obligated to provide a defense and indemnification. The parties filed cross-motions for summary judgment, stipulating that the notice was not "as soon as practicable" and that the insurer was not prejudiced by the late notice.[135] The trial court granted summary judgment in favor of the insurer, holding that the insurer was not required to demonstrate prejudice to avoid coverage under the policy, which was affirmed by the court of appeals.[136]

At the Texas Supreme Court, the insurer argued that the policy's prompt notice requirement was a condition precedent to coverage, "the failure of which defeats coverage under the policy irrespective of prejudice to the insurer."[137] Conversely, the insured argued that the notice provision "creates a covenant, the breach of which excuses performance only if the breach is 'material,'" and that even if the provision was a condition precedent, Texas law required the insurer to prove that it was prejudiced by the untimely notice.[138]

Accepting the insured's position, the supreme court held that only a material breach of the timely notice provision would excuse the insurer's

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131. *Id.* at *4-5.

132. *Id.* at *20; *see also* Boss Mgmt. Servs., Inc. v. Acceptance Ins. Co., No. H-06-2397, 2007 U.S. Dist. LEXIS 69666, *38 (S.D. Tex. Sept. 19, 2007) (allowed use of extrinsic evidence to determine earliest date after which damage occurred).

133. 243 S.W.3d 630, 636-37 (Tex. 2008).

134. *Id.* at 631.

135. *Id.*

136. *Id.* at 631-32.

137. *Id.* at 632.

138. *Id.*

performance.[139] In reaching this holding, the supreme court relied on its prior decision in *Hernandez v. Gulf Group Lloyds*,[140] where the supreme court had applied "fundamental principle[s] of contract law" and, without distinguishing between covenants and conditions, concluded that the insured's breach of a settlement-without-consent provision was immaterial and did not relieve the insurer from liability.[141] The supreme court found that the policy language at issue in *Hernandez* was indistinguishable from the policy language presently before it.[142]

The supreme court further reasoned that the timely notice provision was not an essential part of the bargained-for exchange under this occurrence-based policy.[143] Noting prior Fifth Circuit decisions "aptly describ[ing] the critical distinction between 'occurrence' policies and 'claims-made' policies," the supreme court explained that "[i]n the case of an 'occurrence' policy, any notice requirement is subsidiary to the event that triggers coverage. Courts have not permitted insurance companies to deny coverage on the basis of untimely notice under an 'occurrence' policy unless the company shows actual prejudice from the delay."[144] Accordingly, the supreme court held that "only a material breach of the timely notice provision will excuse [the insurer's] performance under the policy," and that in the absence of prejudice here, the late notice did not preclude coverage.[145]

2. *Whether the Notice-Prejudice Rule Applies to Claims-Made Policies*

On the same day as its *PAJ, Inc.* decision, the Texas Supreme Court granted the petition for review in *Prodigy Communications, Inc. v. Agricultural Excess & Surplus Insurance, Co.*,[146] and accepted a certified question from the Fifth Circuit in *XL Specialty Insurance Co. v. Financial Industries Corp.*.[147] Both of these cases address the application of the notice-prejudice rule in the context of claims-made policies, as opposed to occurrence policies.

In *Prodigy Communications, Inc.*, the insured was served with a lawsuit alleging violations of federal securities laws on June 20, 2002, but "did not give written notice of the lawsuit" under its directors and officers liability policy "until June 6, 2003, nearly one year later."[148] The insurer denied the claim based on the policy's notice requirement, which required that the insureds,

139. *Id.* at 636.
140. 875 S.W.2d 691 (Tex. 1994).
141. *PAJ, Inc.*, 243 S.W.3d at 633.
142. *Id.* at 635.
143. *Id.* at 636.
144. *Id.*
145. *Id.* at 636-37.
146. 195 S.W.3d 764, 766 (Tex. App.—Dallas 2006, pet. granted).
147. 259 F. App'x 675, 675 (5th Cir. 2007).
148. *Prodigy Commc'ns*, 195 S.W.3d at 766.

> as a condition precedent to their rights under this Policy, give the Insurer notice, in writing, as soon as practicable of any Claim first made against the Directors and Officers during the Policy Period, or Discovery Period . . ., but in no event later than ninety (90) days after the expiration of the Policy Period or Discovery Period, and shall give the Insurer such information and cooperation as it may reasonably require.[149]

The insured argued that it gave timely notice because the phrase "but in no event later than ninety (90) days after the expiration of the Policy Period or Discovery Period" modified the phrase "as soon as practicable," thereby creating a safe harbor by allowing notice of a claim at any time before the end of the ninety-day period, regardless of when the claim was made or when the insured received notice of the claim.[150] The insurer countered that the policy required written notice to be given "as soon as practicable," and that "notice more than eleven months after service of the lawsuit was not 'as soon as practicable' as a matter of law."[151] The Dallas Court of Appeals determined that the insured's interpretation was contrary to the plain meaning of the words used in the policy and that the insurer was not required to prove it was prejudiced as a result of the untimely notice.[152] The supreme court heard oral argument in this case on April 1, 2008.

In *XL Specialty Insurance Co.*, the claims-made management liability policy required that notice of any claim be given to the insurer "as soon as practicable after it is first made" as a condition precedent to payment under the policy.[153] The insured provided notice of a lawsuit seven months after the suit was filed but within the policy's coverage period. The insurer denied coverage and sought a declaratory judgment that the policy did not provide coverage based on the insured's late notice. The district court granted summary judgment in favor of the insurer, concluding that "an insurer need not demonstrate prejudice from late notice to avoid coverage on a claims-made policy."[154]

The Fifth Circuit acknowledged that the Texas Supreme Court, in the context of a settlement without consent policy provision, had reasoned that "'[i]nsurance policies are contracts, and as such are subject to rules applicable to contracts generally.' Those rules direct that a breach must be material—*i.e.*, must cause prejudice—to excuse performance by the non-breaching party," and that the supreme court's "reasoning is arguably broad enough to encompass other clauses as well."[155] However, the Fifth Circuit also noted that the "Texas Courts of Appeals currently appear to take different positions on the prejudice requirement" and that

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149. *Id.*
150. *Id.* at 766-67.
151. *Id.* at 767.
152. *Id.*
153. XL Specialty Ins. Co. v. Fin. Indus. Corp., 259 F. App'x 675, 676 (5th Cir. 2007).
154. *Id.*
155. *Id.* at 676-77 (quoting Hernandez v. Gulf Group Lloyds, 875 S.W.2d 691, 691 (Tex. 1994)).

four cases involving the notice-prejudice rule were pending before the Texas Supreme Court.[156] Therefore, the Fifth Circuit declined to follow its earlier decisions holding that "prejudice is required in all occurrence policies, but that insurers need not provide prejudice in claims-made policies," and instead certified the following question to the Texas Supreme Court: "Must an insurer show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured's breach of the policy's prompt-notice provision, but the notice is nevertheless given within the policy's coverage period?"[157] The Texas Supreme Court heard oral argument in *XL Specialty Insurance Co.* on April 1, 2008.

E. The Made Whole Doctrine Does Not Limit a Contractual Subrogation Right

In *Fortis Benefits v. Cantu*, the Texas Supreme Court addressed whether the equitable "made whole" doctrine trumps an insurer's contract-based subrogation rights.[158] There, the medical insurer intervened in the insured's personal injury suit and asserted a subrogation claim to recover the amount of the medical benefits it had paid to the insured out of the insured's settlement with the tortfeasors. "A divided court of appeals upheld a trial court finding that because [the insured's] medical expenses exceeded the settlement amount plus the benefits [the insurer] had paid," the equitable made whole doctrine barred the insurer's subrogation claim.[159]

The supreme court first recognized the made whole doctrine in *Ortiz v. Great Southern Fire & Casualty Insurance Co.*, holding that "[a]n 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."[160] The supreme court explained that *Ortiz* would govern if the insurer had asserted only a claim for *equitable* subrogation; the insurer here, however, was relying on *contractual* rights of recovery specifically stated in the policy.[161] The supreme court reasoned that contractual subrogation clauses express the parties' intent that reimbursement should be controlled by agreed contract terms rather than external rules imposed by the courts. The supreme court emphasized that given this policy's plain language, it was "loathe to judicially rewrite the parties' contract by engrafting extra-contractual standards that neither the Legislature nor the Texas Department of Insurance has thus far decided to promulgate."[162] The supreme court therefore concluded that contractual subrogation rights "should be governed by the parties' express agreement and not

156. *Id.* at 677.
157. *Id.* at 677-78.
158. 234 S.W.3d 642, 644 (Tex. 2007).
159. *Id.*
160. *Id.* at 644-45 (quoting Ortiz v. Great S. Fire & Cas. Ins. Co., 597 S.W.2d 342, 343 (Tex. 1980)).
161. *Id.* at 645.
162. *Id.* at 647-49.

invalidated by equitable considerations that might control by default in the absence of an agreement."[163]

The specific policy language at issue stated that the insurer would be subrogated to "*all* rights" of recovery that the insured may have against "*any* person or organization," and that such right would extend to the proceeds of "*any* settlement or judgment."[164] The supreme court interpreted this language as giving the insurer an "unfettered right" of recovery and not suggesting that the insured must first be made whole before the insurer could recover.[165] The supreme court, therefore, concluded that the policy language controlled the insurer's right to subrogation, that the equitable defense of the made whole doctrine "must give way," and that the insurer was contractually entitled to recover out of the insured's settlement the full amount of the benefits it had paid.[166]

F. The Fortuity Doctrine Applies to Claims-Made Policies

In *Warrantech Corp. v. Steadfast Insurance Co.*, the Forth Worth Court of Appeals decided that the fortuity doctrine could be applied to a claims-made liability policy to bar coverage for an underlying suit against the insured.[167] This doctrine provides:

> Insurance is designed to protect against unknown, fortuitous risks, and fortuity is a requirement of all policies of insurance. An insured cannot insure against something that has already begun and which is known to have begun. The fortuity doctrine precludes coverage for two categories of losses: known losses and losses in progress. A "known loss" is one that the insured knew had occurred before the insured entered into the contract for insurance. A "loss in progress" involves those situations in which the insured knows, or should know, of a loss that is ongoing at the time the policy is issued.[168]

Attempting to defeat application of this doctrine, the insured argued that until rendition of judgment on the underlying claim, the loss is uncertain and cannot be "known." The court rejected this argument, finding that it was "fatally undermined" by the many Texas cases applying the fortuity doctrine "where the insured's liability was not yet fixed by judgment."[169] The insured next argued that the nature of a claims-made policy anticipates the possibility of losses occurring before the policy's inception and that applying the fortuity doctrine to this type of policy would render the contract of insurance illusory because there would never be coverage for losses occurring before the inception date.[170] Again rejecting the insured's position, the court explained that "fortuity

163. *Id.* at 650.
164. *Id.* (emphasis in original).
165. *Id.* at 650-51.
166. *Id.* at 651.
167. 210 S.W.3d 760, 766-68 (Tex. App.—Fort Worth 2006, pet. denied).
168. *Id.* at 766 (citations omitted).
169. *Id.*
170. *Id.* at 766-67.

is a requirement of *all* insurance policies" and that "it is not the existence of a loss but [rather] the insured's *knowledge* of the loss that triggers the fortuity doctrine."[171] As such, application of the doctrine to a claims-made policy precludes coverage for only those losses of which the insured knows, not "losses of which the insured is ignorant at the policy's inception."[172] The court therefore concluded that the "doctrine does not render claims-made insurance illusory but merely restricts coverage to unknown losses."[173]

In determining whether the doctrine applied in the instant case, the court emphasized that "application of the fortuity doctrine does not hinge on whether the insured knew a particular act was wrongful" but instead "on whether the insured knew before the inception of coverage that an act—knowingly wrongful or otherwise—resulted in a loss."[174] Viewed in this light, the facts showed that regardless of whether the insured had acted intentionally or merely negligently, it knew of the loss caused by its conduct long before the inception of the policy.[175] Accordingly, the court applied the fortuity doctrine and held that the insurer had no duty to defend.[176]

G. Commercial General Liability ("CGL") Policies

1. *The Texas Supreme Court Ruled That Construction Defect Claims May Allege an "Occurrence" and "Property Damage" Triggering Coverage under CGL Policies*

Answering certified questions from the Fifth Circuit, the Texas Supreme Court in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, resolved the split among Texas state and federal courts as to whether a claim for defective construction or faulty workmanship that injures only the insured's own work alleges an "occurrence" and "property damage" sufficient to trigger coverage under a CGL policy.[177] First addressing the requirement of an "occurrence," which the policy defined as an "accident," the supreme court explained that an "accident is generally understood to be a fortuitous, unexpected, and unintended event."[178] An "intentional tort is not an accident and thus not an occurrence regardless of whether the effect was unintended or unexpected," but a "deliberate act, performed negligently, is an accident if the effect is not the intended or expected result."[179]

Thus, a claim does not involve an accident or occurrence when either direct allegations purport that the insured intended the injury (which

171. *Id.* at 767.
172. *Id.*
173. *Id.*
174. *Id.* at 768.
175. *Id.* at 767-68.
176. *Id.* at 768.
177. 242 S.W.3d 1, 4-7 (Tex. 2007).
178. *Id.* at 8.
179. *Id.*

> is presumed in cases of intentional tort) or circumstances confirm that the resulting damage was the natural and expected result of the insured's actions, that is, was highly probable whether the insured was negligent or not.[180]

The supreme court emphasized that when applying these principles in the context of construction defect claims, the "determination of whether an insured's faulty workmanship was intended or accidental is dependent on the facts and circumstances of the particular case," which, with respect to the duty to defend governed by the eight-corners rule, "must generally be gleaned" from the claimant's pleading.[181] Because the pleading at issue asserted that the insured's defective construction was a product of its negligence and there was no allegation that the insured intended or expected its work or its subcontractors' work to damage the house, the court concluded that the pleading alleged an "occurrence."[182]

The supreme court next addressed the requirement of "property damage," which the policy defined as "[p]hysical injury to tangible property, including all resulting loss of use of that property."[183] The supreme court found that this definition did not, on its face, eliminate the insured's work because the home and its component parts were "tangible property," and the underlying allegations of cracking sheetrock and stone veneer were allegations of "physical injury" to "tangible property."[184] The federal district court had reasoned that "damage to the [insured] homebuilder's own work, the home, cannot be 'property damage' because CGL insurance exists not to repair or replace the insured's defective work" and that finding coverage for such damage would transform "CGL insurance into a performance bond."[185] The supreme court, however, rejected this reasoning as "irrelevant," stating, "[t]he CGL policy covers what it covers. No rule of construction operates to eliminate coverage simply because similar protection may be available through another insurance product."[186] The supreme court also rejected the insurer's reliance on the economic-loss rule, reasoning that the CGL policy makes no distinction between tort and contract damages and that "any preconceived notion that a CGL policy is only for tort liability must yield to the policy's actual language."[187]

The supreme court ultimately concluded that construction defect allegations may allege an "occurrence" and "property damage" sufficient to trigger the duty to defend under a CGL policy, summarizing its analysis as follows:

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180. *Id.* at 9.
181. *Id.*
182. *Id.*
183. *Id.* at 10 (alteration in original).
184. *Id.*
185. *Id.*
186. *Id.*
187. *Id.* at 12-13.

> The proper inquiry is whether an "occurrence" has caused "property damage," not whether the ultimate remedy for that claim lies in contract or in tort. An "occurrence" depends on the fortuitous nature of the event, that is, whether the damage was expected or intended from the standpoint of the insured . . . . "Property damage" consists of physical injury to tangible property and includes the loss of use of tangible property. Thus, we agree with the Fifth Circuit that "claims for damage caused by an insured's defective performance or faulty workmanship" may constitute an "occurrence" when "property damage" results from the "unexpected, unforeseen or undesigned happening or consequence" of the insured's negligent behavior.[188]

2. *The Fifth Circuit Certified the Issue of When Property Damage "Occurs"*

In *OneBeacon Insurance Co. v. Don's Building Supply, Inc.*, the Fifth Circuit asked the Texas Supreme Court to resolve the split among Texas courts concerning the proper rule to determine when property damage "occurs" under a CGL policy.[189] The insured sought coverage for twenty-two lawsuits filed against it by homeowners claiming damage to their homes due to defective Exterior Insulation and Finish Systems ("EIFS") sold by the insured. Each of the underlying petitions pleaded the discovery rule to avoid the application of the statute of limitations and alleged that although the damage remained undiscoverable until some point within two years of the filing of the suit, the damage actually began to occur at the time of the first moisture penetration, which was six months to one year after the application of the EIFS, and was continuous thereafter.[190] The district court reasoned that because the first suit was filed on August 13, 2003, "none of the petitions allege[d] damage that could have been discovered before August 13, 2001," which was after the expiration of the policy period in 1996, and therefore none of the suits alleged property damage that manifested during the policy period.[191]

On appeal, the Fifth Circuit explained that the Texas Supreme Court "has not yet adopted a particular rule for determining when property damage occurs and that the Texas courts of appeals "are split on the appropriate rule."[192] The Dallas, San Antonio, and Austin courts of appeals have adopted the "manifestation rule," holding "that property damage occurs at the time that the damage manifests, which . . . [is] defined as the time when the damage becomes apparent or identifiable."[193] Conversely, the Houston courts of appeals have "rejected this 'manifestation rule' and instead applied the 'exposure rule' to harms caused by continuous or re-

188. *Id.* at 16 (quoting Federated Mut. Ins. Co. v. Grapevine Excavation, Inc., 197 F.3d 720, 725 (5th Cir. 1999)).
189. 496 F.3d 361, 366 (5th Cir. 2007).
190. *Id.* at 363.
191. *Id.* at 363-64.
192. *Id.* at 364.
193. *Id.*

peated exposure to conditions during a policy period."[194] Although the Fifth Circuit had previously made an "*Erie* guess" and applied the manifestation rule, this ruling was based on the Dallas Court of Appeals' opinions and was made prior to the Houston Court of Appeals' adoption of the exposure rule.[195]

Given this split in authority among the Texas courts of appeals, the Fifth Circuit concluded that the appropriate rule would be better determined by the Texas Supreme Court.[196] Accordingly, the Fifth Circuit certified the following questions:

> 1. When not specified by the relevant policy, what is the proper rule under Texas law for determining the time at which property damage occurs for purposes of an occurrence-based commercial general liability insurance policy?
> 2. Under the rule identified in the answer to the first question, have the pleadings in lawsuits against an insured alleged that property damage occurred within the policy period of an occurrence-based commercial general liability insurance policy, such that the insurer's duty to defend and indemnify the insured is triggered, when the pleadings allege that actual damage was continuing and progressing during the policy period, but remained undiscoverable and not readily apparent for purposes of the discovery rule until after the policy period ended because the internal damage was hidden from view by an undamaged exterior surface?[197]

3. *Policy Language Affording Additional Insured Coverage with Respect to the Named Insured's Operations Requires Only a Causal Connection or Relation Between the Event and the Operations, Not Proximate or Legal Causation*

In addition to the issues discussed earlier in this article, the Texas Supreme Court's opinion in *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, also addressed "the interplay between a contractual indemnity provision and a service contract's requirement to name an additional insured." Specifically the case assessed whether a liability policy "purchased to secure the insured's indemnity obligation in a service contract with a third party also provide[d] direct liability coverage for the third party."[198] ATOFINA Petrochemicals, Inc. ("ATOFINA") contracted with Triple S Industrial Corporation ("Triple S") to perform maintenance and construction work at its refinery. Pursuant to the service contract, Triple S agreed to indemnify ATOFINA from all personal injuries and property losses sustained during the performance of the con-

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194. *Id.*
195. *Id.* at 364-65.
196. *Id.* at 365 (presenting the additional unresolved issue of "whether property damage can be deemed to have occurred under the governing rule during a time in which the pleadings state that the damage was undiscoverable for purposes of the discovery rule").
197. *Id.* at 366.
198. 256 S.W.3d 660, 662 (Tex. 2008).

tract, except to the extent that the loss was attributable to ATOFINA. Triple S was also required to procure a CGL policy and a following-form excess or umbrella policy indicating ATOFINA as an additional insured.[199] A Triple S employee who was working at the ATOFINA facility under the service contract drowned after he fell through the roof of a storage tank. The employee's survivors sued Triple S and ATOFINA for wrongful death. After the primary insurer tendered its policy limits, ATOFINA sought coverage as an additional insured under the Evanston Insurance Company's ("Evanston") umbrella policy. Evanston denied coverage on the ground that the loss was caused by ATOFINA's negligence.[200]

The supreme court explained that although the service contract precluded ATOFINA's indemnification by Triple S, if the loss was occasioned in any way by ATOFINA's negligence, ATOFINA was not seeking indemnity from Triple S; instead, ATOFINA's position was that it was entitled to indemnification from Evanston based on its status as an additional insured on the umbrella policy issued to Triple S.[201] Thus, contrary to the court of appeals' focus on the service contract's indemnity agreement, the supreme court focused on the terms of the umbrella policy itself, which included as an additional insured "[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."[202] Evanston argued that this language did not cover an additional insured for its own negligence, that because the employee's death "was caused solely by ATOFINA's negligence, the death did not 'respect' . . . operations performed by [Triple S]," and that ATOFINA therefore did not qualify as an additional insured.[203]

The supreme court noted that the courts of appeals had reached divergent results in addressing such additional insured provisions. Some courts adopted a fault-based interpretation of "arising out of operations," finding coverage only if the insured's wrongful act during the operation caused the injury.[204] Conversely, other courts have used "a more liberal causation theory," finding that the loss could be "with respect to liability arising out of" the named insured's operations, and thus covered even though the claimants alleged that the additional insured acted negli-

199. *Id.* at 662-63.
200. *Id.* at 663.
201. *Id.* at 664.
202. *Id.*
203. *Id.*
204. *Id.* (citing Granite Constr. Co. v. Bituminous Ins. Cos., 832 S.W.2d 427, 428 (Tex. App.—Amarillo 1992, no writ) ("[T]he claim did not 'aris[e] out of operations performed by' the insured because only the additional insured company was responsible for the injury.").

gently.[205] The supreme court adopted the second approach stated in *Admiral* and *McCarthy*:

> [R]egardless of the underlying service agreement's terms, we do not follow *Granite* because the fault-based interpretation of this kind of additional insured endorsement no longer prevails. Instead, we interpret "with respect to operations" under a broader theory of causation. Generally, an event "respects" operations if there exists "a causal connection or relation" between the event and the operations; we do not require proximate cause or legal causation. In cases in which the premises condition caused a personal injury, the injury respects an operation if the operation brings the person to the premises for purposes of that operation. The particular attribution of fault between insured and additional insured does not change the outcome.[206]

Appling these principles, the supreme court found that the injury respected operations performed by Triple S because the injured employee was employed by Triple S and was present at ATOFINA's facility for purposes of Triple S's operations when the accident occurred.[207] Accordingly, the supreme court concluded that even if ATOFINA's negligence alone caused the injury, the umbrella policy's additional insured provision afforded direct insurance coverage to ATOFINA.[208]

H. Auto Policies

In *Brainard v. Trinity Universal Insurance Co.*, the Texas Supreme Court resolved several issues regarding uninsured/underinsured motorist ("UIM") coverage.[209] First, the supreme court addressed whether UIM insurance covers prejudgment interest that the underinsured motorist would owe the insured in tort liability.[210] The UIM policy obligated the insurer to pay "damages" that the insured was legally entitled to recover from the underinsured motorist.[211] The supreme court explained that the purpose of prejudgment interest is to "fully compensate the injured party, not to punish the defendant," and that it has "consistently viewed prejudgment interest as falling within the common law meaning of damages."[212]

The insurer argued that the policy's requirement that the damages must be "'because of bodily injury or property damage'" negated coverage "for prejudgment interest because the essence of prejudgment interest is

205. *Id.* at 665 (citing McCarthy Bros. Co. v. Cont'l Lloyds Ins. Co., 7 S.W.3d 725, 727, 730-31 (Tex. App.—Austin 1999, no pet.); Admiral Ins. Co. v. Trident NGL, Inc., 988 S.W.2d 451, 453-55 (Tex. App.—Houston [1st Dist.] 1999, pet. denied)).
206. *Id.* at 666.
207. *Id.* at 667
208. *Id.*
209. 216 S.W.3d 809, 811 (Tex. 2006).
210. *Id.* at 812-15.
211. *Id.* at 812.
212. *Id.* at 812-13.

compensation for lost use of money, not damages from bodily injury."[213] The supreme court rejected this argument, reasoning:

> [The UIM statute's] compensatory purpose is well served when the insured obtains, in addition to actual damages, any prejudgment interest that the underinsured motorist would owe the insured. [The insurer's] attempt to give the phrase "because of bodily injury" an artificially literal meaning—so as to establish a nexus requirement that eliminates coverage for prejudgment interest—has no basis in the statute's history or our precedent, under which [the statute] is liberally construed to protect persons who are legally entitled to recover damages from underinsured motorists.[214]

The supreme court ultimately held that "UIM insurance covers prejudgment interest that the underinsured motorist would owe the insured."[215] Additionally, the court also held that: (1) any credits for settlements and personal injury protection should be applied in the prejudgment interest calculation using the "declining principal" formula, under which each credit is applied according to the date on which it was received; and (2) the insured may recover attorney's fees from the UIM insurer under chapter 38 of the Texas Civil Practice and Remedies Code only if the insurer does not tender UIM benefits within thirty days after the trial court signs a judgment establishing the liability and underinsured status of the other motorist.[216]

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213. *Id.* at 813.
214. *Id.* at 814 (citing TEX. INS. CODE ANN. art. 5.06-1(5) (Vernon 1981)).
215. *Id.* at 815.
216. *Id.* at 811, 815-19. *See also* Mid-Century Ins. Co. v. Daniel, 223 S.W.3d 586, 589 (Tex. App.—Amarillo 2007, pet. denied) (determining, based on *Brainard*, that the UIM insurer's payment within two days of the judgment against the motorist precluded an award of attorney's fees to the insured).