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I. INTRODUCTION

DURING this Survey period, courts addressed various important issues related to Texas insurance law, including the effect of notice provisions in claims-made policies, the scope of certain "business risk" exclusions in commercial general liability (CGL) policies, and the scope of standard appraisal clauses that appear in most property policies. Additionally, courts continued to interpret and apply holdings from recent Texas Supreme Court cases relating to the "property damage" coverage trigger, reimbursement rights between co-insurers, and exceptions to the "eight-corners" rule when determining an insurer's duty to defend.

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II. NOTICE PROVISIONS

During this Survey period, the Texas Supreme Court issued two significant decisions in cases of first impression concerning the consequences of an insured's failure to provide timely notice in compliance with a notice condition under a claims-made policy. For over twenty years, the law in Texas has been evolving regarding the effect of an insured's failure to comply with a condition precedent requiring notice of a claim or suit "as soon as practicable." In 1972, the Texas Supreme Court held in *Members Mutual Insurance Co. v. Cutaia* that a notice provision in an automobile policy was a condition precedent to coverage, regardless of whether the insurer was harmed or prejudiced by the late notice.[1] The supreme court recognized the "apparent injustice" created but nonetheless relied upon the "plain wording of the contract" in making its determination.[2] In response to *Cutaia*, the State Board of Insurance (THE Board) issued an order requiring that insurers include a mandatory endorsement in Texas general liability and automobile policies that an insured's failure to provide notice does not bar coverage unless the insurer has been prejudiced.[3]

Given the limited authority of the Board and the decision from *Cutaia*, litigation ensued over the next several years regarding whether companies and policies beyond the reach of the Board's authority were subject to a prejudice requirement.[4] For example, in *Hanson Production Co. v. Americas Insurance Co.*, a surplus lines carrier denied coverage for its insured based on late notice.[5] The surplus lines carrier argued it was not required to show prejudice. Although it recognized that *Cutaia* had not yet been overruled and that the Board's order did not apply to policies issued by surplus lines carriers, the Fifth Circuit, relying on *Hernandez v. Gulf Group Lloyds*,[6] nevertheless opined that that the supreme court would likely adopt a "uniform rule of construction" and require prejudice under the circumstances.[7] In *Hernandez*, the supreme court held that an insurer was required to show prejudice to escape liability on the basis of a violation of the settlement-without-consent exclusion.[8] The supreme court in *Hernandez* focused on the fact that when an insurer is not prejudiced by an insured's breach of the insurance contract, the insurer should not be relieved of its obligations, because the breach was not material and the insurer had not been denied the benefit of the bargain.[9]

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1. 476 S.W.2d 278, 280-81 (Tex. 1972).
2. *Id.*
3. Tex. State Bd. of Ins., *Revision of Texas Standard Provision For General Liability Policies—Amendatory Endorsement–Notice*, Order No. 23080 (Mar. 13, 1973).
4. *See, e.g.*, Hanson Prod. Co. v. Americas Ins. Co., 108 F.3d 627 (5th Cir. 1997) (surplus lines policy); Chiles v. Chubb Lloyds Ins. Co., 858 S.W.2d 633, 635 (Tex. App.—Houston [1st Dist.] 1993, writ denied) (homeowners' policy).
5. *Hanson*, 108 F.3d at 628.
6. 875 S.W.2d 691, 692, 694 (Tex. 1994).
7. *Hanson*, 108 F.3d at 630.
8. *Hernandez*, 875 S.W.2d at 693.
9. *Id.*

In 2008, the Texas Supreme Court issued its opinion in *PAJ, Inc. v. Hanover Insurance Co.* and definitively answered the question of whether an insured's failure to provide notice as soon as practicable, in violation of a notice condition in an occurrence-based liability policy, precludes coverage in the absence of a showing of prejudice by the insurer.[10] As the Fifth Circuit had done in *Hanson*, the supreme court in *PAJ* adopted the *Hernandez* analysis and focused on the "fundamental principle of contract law" that an immaterial breach of contract by one party does not relieve the other party from performance.[11] According to the supreme court, because the timely notice provision is not an essential part of the bargained-for exchange in an "occurrence" policy, an insurer must show prejudice—or that the insured committed a material breach of the policy—before it can deny coverage.[12]

In *PAJ*, the supreme court noted that a key difference between occurrence and claims-made policies is that, in occurrence policies, "any notice requirement is subsidiary to the event that triggers coverage," whereas in claims-made policies, notice itself constitutes the event that triggers coverage.[13] Additionally, the majority in *PAJ* specifically recognized a distinction in the effect of a notice provision in an occurrence policy and claims-made policy, going so far as to criticize the dissent for "focusing on the type of coverage rather than the type of *policy*" at issue.[14] Thus, the supreme court left the issue open regarding whether the same notice–prejudice rule would apply in the context of late notice under a claims-made policy.

Notice Under a Claims-Made Policy

Prior to this Survey period, the Texas Supreme Court had not addressed the issue of late notice under a claims-made policy. However, other Texas federal and state courts had nearly uniformly held that an insurer need not show prejudice to deny coverage based on late notice under a claims-made policy.[15] Particularly, in *Federal Insurance Co. v.*

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10. 243 S.W.3d 630, 636-37 (Tex. 2008).

11. *Id.* at 634 (citing Hernandez v. Gulf Group Lloyds, 875 S.W.2d 691, 692 (Tex. 1994)).

12. *Id.* at 633, 636-37.

13. *See generally id.* at 636 (citing Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co., 174 F.3d 653, 658 (5th Cir. 1999); Hirsch v. Tex. Lawyers' Ins. Exch., 808 S.W.2d 561, 563 (Tex. App.—El Paso 1991, writ denied)).

14. *Id.*

15. *See, e.g.*, Singleentry.com, Inc. v. St. Paul Fire & Marine Ins. Co., 117 F. App'x 933, 936 (5th Cir. 2004) (noting the distinction in occurrence and claims-made policies and that insurers need not show prejudice to deny coverage based on late notice); *Matador*, 174 F.3d at 658-59 (same); EmCode Reimbursement Solutions, Inc. v. Nutmeg Ins. Co., 512 F. Supp. 2d 603, 609 (N.D. Tex. 2007) ("Under Texas law, an insurer is not required to show prejudice by late notice under a claims-made policy."); Precis, Inc. v. Fed. Ins. Co., 2005 U.S. Dist. LEXIS 13985, at *18-19 (N.D. Tex. July 12, 2005), *aff'd* 184 F. App'x 439 (5th Cir. 2006); Fed. Ins. Co. v. CompUSA, Inc., 239 F. Supp. 2d 612, 617 (N.D. Tex. 2002), *aff'd* 319 F.3d 746 (5th Cir. 2003) (same); Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Willis, 139 F. Supp. 2d 827, 832 (S.D. Tex. 2001) (same); Int'l Ins. Co. v. RSR Corp., 2001 U.S. Dist. LEXIS 16569, at *26 (N.D. Tex. Oct. 11, 2001) (same); *Hirsch*, 808 S.W.2d at 565 ("To

CompUSA, Inc., the Northern District of Texas noted that the effect of an insured's noncompliance with a notice provision "depends on whether . . . a 'claims-made' [policy] or occurrence 'policy' is at issue."[16] According to the court, under a claims-made policy, notice itself constitutes the event that triggers coverage. Because the policy provided that, "as a condition precedent" to coverage, the insured was to provide notice to the insurer "as soon as practicable," the court found that the insured's eleven-month delay in providing notice constituted a breach of the notice provision and failure of the condition precedent to coverage.[17] Therefore, the insurer was not required to show prejudice to deny coverage. The Fifth Circuit adopted the district court's opinion in its entirety.[18]

In 2007, the Fifth Circuit was again faced with the issue of "whether an insurer must show prejudice to deny [coverage under] a claims-made policy."[19] The Fifth Circuit initially noted that the supreme court's reasoning from *Hernandez* was "arguably broad enough" to require that a breach of an insurance contract must be material, i.e., "must cause prejudice[,] to excuse performance by the non-breaching party."[20] The Fifth Circuit also noted that under the facts, it was reluctant to apply its prior holdings as a uniform rule due to the cases pending at the time before the supreme court addressing the late-notice issue.[21] Therefore, the Fifth Circuit 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?"[22]

One of those pending cases was *Prodigy Communications Corp. v. Agricultural Excess & Surplus Insurance Co.*[23] In that case, the supreme court extended the rationale from *PAJ* to a claims-made policy and held that an insured's breach of a notice condition must result in a material breach of the policy for the insurer to deny coverage.[24] The supreme court limited the ruling to the facts of the case, however, specifically rec-

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require a showing of prejudice for late notice would defeat the purpose of '**claims-made**' policies, and in effect, change such policy into an '**occurrence**' policy."); Komatsu v. U.S. Fire Ins. Co., 806 S.W.2d 603, 607 (Tex. App.—Fort Worth 1991, writ denied); Yancey v. Floyd West & Co., 755 S.W.2d 914, 921 (Tex. App.—Fort Worth 1988, writ denied).

16. 239 F. Supp. 2d at 617.

17. *Id.* at 616, 618.

18. Fed. Ins. Co. v. CompUSA, Inc., 319 F.3d 746, 750 (5th Cir. 2003).

19. XL Specialty Ins. Co. v. Fin. Indus. Corp., 259 F. App'x 675 (5th Cir. 2007).

20. *Id.* at 676-77.

21. *Id.* at 677-78. The following late notice cases were pending before the Texas Supreme Court at that time: Coastal Ref. & Mktg., Inc. v. U.S. Fid. and Guar. Co., 218 S.W.3d 279 (Tex. App.—Houston [14th Dist.] 2007, pet. denied); Lennar Corp. v. Great Am. Ins. Co., 200 S.W.3d 651 (Tex. App.—Houston [14th Dist.] 2006, pet. denied); Prodigy Commc'ns Corp. v. Agric. Excess & Surplus Ins. Co., 195 S.W.3d 764 (Tex. App.—Dallas 2006), *rev'd* 288 S.W.3d 374 (Tex. 2009); PAJ, Inc. v. Hanover Ins. Co., 170 S.W.3d 258 (Tex. App.—Dallas 2005), *rev'd* 243 S.W.3d 630 (Tex. 2008).

22. *XL*, 259 F. App'x at 678; *see infra* text accompanying notes 38-42.

23. 288 S.W.3d 374 (Tex. 2009).

24. *See id.* at 382.

ognizing that although notice was late, the insured had provided it within the extended reporting deadline. *Prodigy* involved a directors and officers liability policy issued by Agricultural Excess & Surplus Insurance Company (AESIC) to FlashNet Communications (FlashNet) that provided coverage for "claims first made during the [March 16, 2000 to May 31, 2003] policy period."[25] The policy's notice provision required that the insured, "as a condition precedent," give notice of any claim "as soon as practicable . . . but in no event later than ninety (90) days after the expiration of the Policy Period, or Discovery Period."[26] A lawsuit naming FlashNet as a defendant was filed and served upon Prodigy Communications (Prodigy) on June 20, 2002, but Prodigy did not provide notice of the lawsuit to AESIC within the ninety-day period after the end of the policy period.[27] AESIC denied coverage based on the insured's breach of the policy's notice condition. Prodigy responded that notice was timely because it was within ninety days of the expiration of the policy's discovery period.[28]

The issue before the Texas Supreme Court was:

> [W]hether, under a claims-made policy, an insurer can deny coverage based on its insured's alleged failure to comply with a policy provision requiring that notice of a claim be given "as soon as practicable," when (1) notice of the claim was provided before the reporting deadline specified in the policy; and (2) the insurer was not prejudiced by the delay.[29]

Although the notice provision in the policy specifically required Prodigy to provide notice to AESIC as a condition precedent to coverage, the supreme court noted that its decision in *PAJ* was not based on the differences between conditions and covenants, but instead on "fundamental principle[s] of contract law" that only a material breach of contract will excuse a party's performance.[30] The supreme court then turned its focus to the key distinctions and similarities between occurrence and claims-made policies and the notice requirements associated with each. According to the supreme court, claims-made policies "provide[ ] unlimited retroactive coverage and no prospective coverage, while an 'occurrence' policy provides unlimited prospective coverage and no retroactive coverage."[31] Additionally, the Texas Supreme Court acknowledged that requiring an insured to report a claim during the policy period or within a specified time period is essential to coverage under a claims-made-and-reported policy.[32] Under those circumstances, an insurer need not

25. *Id.* at 387. In May 2000, Prodigy Communications merged with FlashNet. It appears that the surviving entity was Prodigy Communications. *See id.* at 375-76.
26. *Id.* at 376.
27. *Id.*
28. *Id.* at 377.
29. *Id.*
30. *Id.* at 378.
31. *Id.* at 379.
32. *Id.*

demonstrate prejudice when the insured fails to give notice of a claim within such a policy's policy period or other specified time period.[33]

However, the supreme court then determined that an insured's failure to provide notice "as soon as practicable" under a claims-made policy is not a material breach of the policy when notice is given during the policy period or other reporting period, as receiving notice "as soon as practicable" is not an essential part of the bargained-for exchange under the policy.[34] Specifically, the supreme court found that Prodigy's failure to provide notice "as soon as practicable" was not a material breach of the policy because "AESIC was not denied the benefit of the claims-made nature of its policy as it could not 'close its books' on the policy until ninety days after the discovery period expired."[35] Accordingly, the Texas Supreme Court held that AESIC could not deny coverage unless it was prejudiced by Prodigy's noncompliance with the notice provision.[36] As AESIC had admitted it was not prejudiced, the supreme court reversed the judgment of the court of appeals and remanded the case to the trial court.[37]

On the same day the supreme court issued *Prodigy*, it also answered the Fifth Circuit's certified question in *Financial Industries Corp. v. XL Specialty Insurance Co.*[38] In that case, XL Specialty Insurance Company (XL) issued a claims-made policy to Financial Industries Corporation (FIC) with a policy period of March 12, 2005 to March 12, 2006. The policy provided that as a condition precedent, FIC "shall give written notice to [XL] of any Claim as soon as practicable after it is first made."[39] FIC was sued in a Texas state court on June 5, 2005, but it did not notify XL until seven months later. FIC did provide notice, however, to XL during the policy period.[40]

In answering the certified question, the supreme court noted *Prodigy* and reiterated that an insured's failure to give notice "as soon as practicable" is not a material breach of the policy when notice is received during the policy period. Specifically, because FIC provided notice of the suit within the policy period and before XL could "close its books" on the policy, XL was not denied any benefits provided by the nature of the claims-made policy.[41] Thus, the supreme court held that "an insurer must 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 pro-

33. *Id.* at 380-81.
34. *Id.* at 382-83.
35. *Id.* at 382.
36. *Id.* at 382-83.
37. *Id.*
38. 285 S.W.3d 877, 879 (Tex. 2009). *See supra* text accompanying notes 19-22.
39. *Id.* at 878. Whereas *Prodigy* involved a claims-made-and-reported policy, at issue in *XL* was a claims-made policy requiring the insured provide notice "as soon as practicable." Compare *Prodigy*, 288 S.W.3d 374, 376, 380 n.7 (Tex. 2009), with *XL*, 285 S.W.3d at 878.
40. *XL*, 285 S.W.3d at 878.
41. *Id.* at 878-79.

vision, but the notice is given *within* the policy's coverage period."[42]

After *PAJ*, *Prodigy*, and *XL*, it is settled that an insurer must show prejudice to deny coverage for late notice under an occurrence-based liability policy. It is also clear that an insurer must show prejudice to deny coverage for an insured's breach of a notice condition under a claims-made policy if notice is provided late, but before the expiration of the policy period or other specified reporting deadline. Insurers can arguably infer from *Prodigy* and *XL* that no prejudice requirement exists under a claims-made policy when an insured provides notice *after* the policy period or other specified reporting deadline. This is consistent with the holdings from *CompUSA* and other cases that have addressed this issue, which are still good law as of the date of this Article.[43] Policyholders, however, could argue that because the supreme court has not directly addressed the issue, *Prodigy* and *XL* represent a trend toward the imposition of a uniform late-notice rule under Texas law, regardless of whether the insured provides notice during or after the policy period or other reporting deadline. Policyholders might point to the Fifth Circuit's recent decision in *East Texas Medical Center Regional Healthcare System v. Lexington Insurance Co.* to support their position.[44]

In that case, the late-notice issue came before the Fifth Circuit again, this time in the context of a claims-made excess medical malpractice insurance policy.[45] Lexington Insurance Company (Lexington) issued a one-year claims-made policy to East Texas Medical Center Regional Healthcare System (the Medical Center) that provided excess liability coverage for claims above the $2 million self-insured retention. Per the terms of the policy, the Medical Center was required to provide Lexington written notice of any claims or lawsuits that it believed would exceed that self-insured retention and "immediately" forward copies of all claim- or suit-related demands.[46]

The Medical Center received a claim letter in March 2003 stating that a patient had sustained unspecified personal injuries at one of the Medical Center's facilities. The information from that claim letter was entered into a computer-generated spreadsheet known as a "loss run" and forwarded to Lexington. On May 27, 2003, the patient's mother sued the Medical Center in state court. Because it was responsible for processing, monitoring, and defending claims it believed were below the self-insured retention, the Medical Center initially appointed defense counsel to file an answer and defend the suit.[47] The policy expired on June 8, 2003, approximately two weeks after the lawsuit was filed. At the end of the policy period, the notation of the claim letter on the loss run represented the only notice of the claim that the Medical Center had provided to Lex-

42. *Id.* at 879 (emphasis added).
43. *See supra* notes 15-18 and accompanying text.
44. *See* 575 F.3d 520, 532 (5th Cir. 2009).
45. *Id.* at 523.
46. *Id.*
47. *Id.* at 523-24.

ington.[48] In January 2004—seven months after the policy expired—the Medical Center first gave written notice of the lawsuit to Lexington. After Lexington denied coverage based on late notice, the Medical Center brought a coverage action against Lexington in federal court.

One issue before the Fifth Circuit was whether Lexington was required to show prejudice by the Medical Center's failure to provide prompt notice of the lawsuit.[49] Initially, the Fifth Circuit noted that the policy required the Medical Center to provide Lexington with notice of the claim *and* notice of the lawsuit, and that notice of one would not suffice for the other.[50] The Fifth Circuit acknowledged that the initial claim letter was reported to Lexington via the "loss runs" within the policy period. However, notice of the lawsuit was not reported to Lexington until seven months after the policy expired. Nevertheless, the Fifth Circuit held that because the notice of the initial claim was provided within the policy period, Lexington would be unable to "close its books" until it knew whether a suit would actually be filed.[51] Thus, the Fifth Circuit held that "[a]s long as notice of the underlying claim had been timely given, coverage would exist under either a claims-made or claims-made and reported policy."[52]

Although policyholders might argue that *Lexington* represents an erosion of the rule from *CompUSA* that an insurer may deny coverage for notice received after the policy period or other reporting deadline, the facts from *Lexington* show that it can be easily reconciled with *Prodigy*, *XL*, and *CompUSA*. Specifically, the Medical Center *did* provide notice of the claim during the policy period, like in *Prodigy* and *XL*. Thus, notwithstanding the fact that the insured did not provide notice of the lawsuit until after the policy period, the insurer could not "close its books" on the policy and was not denied the "inherent benefit" of the claims-made policy. Additionally, the Fifth Circuit did not overrule *CompUSA*, thus implying that its decision was meant to be read in light of that opinion.[53] Therefore, while insurers and policyholders will likely debate the significance of *Lexington* in disputes over late notice, it appears that the decision does not provide new guidance on the issue. Accordingly, we expect litigation over the applicability of the notice–prejudice rule to continue in the future.

III. INSURER'S RIGHT OF REIMBURSEMENT

In its 2007 opinion in *Mid-Continent Insurance Co. v. Liberty Mutual Insurance Co.*, the Texas Supreme Court restricted the rights of co-insurers to seek reimbursement or contribution from each other pursuant to

48. *Id.* at 524.
49. *Id.* at 527-28.
50. *Id.* at 527 (citing Members Mut. Ins. Co. v. Cutaia, 476 S.W.2d 278, 279-80 (Tex. 1972)).
51. *Id.* at 530.
52. *Id.*
53. *See id.* at 532.

their pro rata clauses after payments made on behalf of mutual insureds.[54] The supreme court specifically noted that any "direct claim for contribution between co-insurers disappears when the insurance policies contain 'other insurance' or 'pro rata' clauses."[55] Thus, if one co-insurer pays more than it is legally obligated to pay, without a contractual right of contribution, there is no right to contribution.[56] Additionally, because the right of subrogation is based upon the insurer "stepping into the shoes" of its insured, if the insured is fully indemnified, it will have no right to pass its rights to the insurer for it to enforce.[57]

During the Survey period, the Fifth Circuit again had the opportunity to address whether an insurer has a subrogation right against a co-insurer that refused to participate or contribute to a settlement involving its insured.[58] In *Nautilus*, EOG Resources, Incorporated (EOG) had primary coverage as an additional insured under policies issued by Nautilus Insurance Company (Nautilus) and Pacific Employers Insurance Company (Pacific). Just as in *Mid-Continent*, the Nautilus and Pacific policies contained identical pro rata clauses, which stated that if other primary coverage were available, each insurer would pay a pro rata share of any settlement or judgment against the insured.[59] Several homeowners sued EOG, alleging that its seismic surveying and blasting activities caused their homes to suffer foundation defects. EOG sought coverage for the lawsuits from Pacific and Nautilus.[60]

As the litigation progressed, Nautilus and the other insurance companies involved settled some of the lawsuits for $3.5 million, which included a voluntary $1.5 million payment by Nautilus within its $2 million limit. However, Pacific refused to contribute to the settlement and the remaining lawsuits went to trial. In the end, none of the homeowners' suits were successful. "Thus, Pacific did not contribute to the settlement and did not pay anything in the underlying state court cases."[61] Asserting that it was "contractually and equitably subrogated to the rights of EOG" under its policy, Nautilus sued Pacific seeking to recover the amount it claimed that Pacific should have paid on behalf of EOG.[62] After the Texas Supreme Court's opinion in *Mid-Continent*, the district court granted summary judgment for Pacific. Nautilus appealed.[63]

The issue on appeal involved whether the district court had appropri-

54. 236 S.W.3d 765, 768, 777 (Tex. 2007). For a detailed discussion, please see the 2007 Insurance Law Survey. J. Price Collins, Ashley E. Frizzell & Omar Galicia, *Insurance Law*, 61 SMU L. REV. 877, 879-81 (2008).

55. *Id.* at 772.

56. *Id.*

57. *See id.* at 777.

58. Nautilus Ins. Co. v. Pac. Employers Ins. Co, 303 F. App'x 201, 203 (5th Cir. 2008).

59. *Id.* at 202.

60. *Id.*

61. *Id.* at 202-203.

62. *Id.* at 203.

63. *Id.*

ately applied the holding from *Mid-Continent*.[64] Nautilus made several arguments attempting to distinguish *Mid-Continent*. First, it argued that the Texas Supreme Court had intended *Mid-Continent* to be "narrow" and apply "only when an insurer settles a case to 'protect its own coffers.'"[65] Specifically, Nautilus argued that because Liberty Mutual provided the insured in *Mid-Continent* with an excess policy, it had a "self-serving motive to settle" the case to avoid liability under that policy.[66] Therefore, according to Nautilus, the supreme court's ruling was simply "that an insurer cannot recover from a co-insurer based . . . [on] . . . subrogation when the insurer pays a claim to protect its own financial interests."[67] In rejecting this argument, the Fifth Circuit noted that Nautilus itself may have been concerned with additional liability, as it had settled the homeowners' claims for $500,000 less than its limit.[68] Additionally, according to the Fifth Circuit, the supreme court mentioned excess insurance in *Mid-Continent* only to distinguish that opinion from a prior opinion in which it had recognized an excess insurer's equitable subrogation rights.[69] Thus, simply because Liberty Mutual acted as a primary and excess insurer in *Mid-Continent* had no effect on the case at bar.

Second, Nautilus argued that if the court ruled that it had no subrogation rights, several policy concerns would be implicated. In particular, Nautilus "assert[ed] that an insurer will be less likely to settle a suit if it cannot recover the money it pays to settle a case[,]" and "a broad reading of *Mid-Continent* will lead to the elimination of the right of subrogation."[70] Nautilus also suggested that the elimination of subrogation would cause "unfair distribution of losses among insurers."[71] The Fifth Circuit found these arguments unavailing and noted that whether the supreme court's "decision in *Mid-Continent* will have these policy effects . . . is within the province of the Texas Supreme Court to decide."[72] To the contrary, the Fifth Circuit noted, as Pacific "bore the risk" by refusing to settle the claims and then prevailing at trial, it would be inequitable to make it contribute under the circumstances.[73] Accordingly, the Fifth Circuit held that because EOG had been fully indemnified by its insurers and therefore had no rights to enforce against Pacific, Nautilus therefore had no right of subrogation against Pacific.[74]

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64. *Id.*
65. *Id.* at 205.
66. *Id.*
67. *Id.*
68. *Id.* at 206.
69. *Id.* (citing Am. Centennial Ins. Co. v. Canal Ins. Co., 843 S.W.2d 480, 483 (Tex. 1992)).
70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.*
74. *Id.* at 207.

In 2008, the United States District Court for the Southern District of Texas in *Trinity Universal Insurance Co. v. Employers Mutual Casualty Co.* extended *Mid-Continent* to the duty to defend, holding that an insurer could not seek reimbursement of defense costs, through contribution or subrogation, from a co-insurer that wrongfully refused to contribute to the defense of their common insured.[75] The Fifth Circuit, however, reversed this holding subsequent to the Survey period, finding that the district court had "mischaracterized" the supreme court's holding from *Mid-Continent*.[76] Specifically, the Fifth Circuit found that the Texas Supreme Court in *Mid-Continent* addressed only the question of whether a co-insurer could seek reimbursement under its "other insurance" clause through contribution or subrogation from a non-paying co-insurer for amounts paid to *indemnify* their common insured.[77]

According to the Fifth Circuit, "*Mid-Continent* left open the separate question of whether a co-insurer that pays more than its share *of defense costs* may recover such costs from a co-insurer who violates its duty to defend a common insured."[78] The Fifth Circuit focused on the fact that the "other insurance" clauses address only "an insured's loss" but do not implicate a similar proration of defense costs incurred during the defense.[79] Importantly, the Fifth Circuit reiterated the long-standing principle that, although an insurer may owe only a portion of the costs associated with the defense of the insured, it has a complete duty to defend the insured that is "'equally and concurrently due' by all . . . insurers."[80] The Fifth Circuit therefore held that the insurer seeking contribution established that it had paid a compulsory payment of more than its proportionate share of defense costs and was therefore entitled to contribution from the non-participating insurer.[81]

In reaching its conclusion, the Fifth Circuit recognized existing Texas law that when two insurers owe concurrent defense obligations to a mutual insured, one carrier's agreement to provide a defense does not alleviate the other from its contractual duties.[82] If this principle were ignored and the holding from *Mid-Continent* were applied to the duty to defend, this would effectively penalize a carrier that recognizes and assumes its

75. Trinity Universal Ins. Co. v. Employers Mut. Cas. Co., 586 F. Supp. 2d 718, 728-30 (S.D. Tex. 2008). For a detailed discussion, please refer to the 2008 Insurance Law Survey. J. Price Collins, Ashley E. Frizzell & Blake H. Crawford, *Insurance Law*, 62 SMU L. REV. 1267, 1289 (2009).

76. Trinity Universal Ins. Co. v. Employers Mut. Cas. Co., 592 F.3d 687, 694, 696 (5th Cir. 2010).

77. *Id.* at 694-95.

78. *Id.*

79. *Id.*

80. *Id.* at 695 (citing Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co., 236 S.W.3d 765, 772 (Tex. 2007)); *see also* Indian Harbor Ins. Co. v. Valley Forge Ins. Group, 535 F.3d 359, 363 (5th Cir. 2008) (recognizing that insurers must provide a complete defense under Texas law); Tex. Prop. & Cas. Ins. Guar. Ass'n v. Sw. Aggregates, Inc., 982 S.W.2d 600, 606 (Tex. App.—Austin 1998, no pet.) (noting that if one claim potentially falls within coverage, the insurer must defend the entire suit).

81. *Trinity Universal*, 592 F.3d at 695-96.

82. *See Tex. Prop. & Cas. Ins. Guar. Ass'n*, 982 S.W.2d at 606.

duty to defend, while rewarding a carrier that delays in assuming its obligations. This would likely create situations where carriers would be hesitant to step up and assume their contractual duties, which would in turn severely impair the rights of insureds. It appears that the insurer in *Nautilus* made this type of policy argument, but the Fifth Circuit took the position that the supreme court had already conclusively decided the issue. Interestingly, the Fifth Circuit, only a year later in *Trinity Universal*, found that the holding from *Mid-Continent* was in fact limited to the duty to indemnify—even though the supreme court never made that statement in its opinion. Future litigation of issues related to contribution and subrogation will likely revolve around determining the scope of the holding from *Mid-Continent*, as this will affect both insureds and insurers in the context of defense and settlement negotiations.

IV. CONTRACTUAL LIABILITY

A. THE DUTY TO DEFEND

Extrinsic Evidence and the "Eight-Corners" Rule

The issue of whether extrinsic evidence may be used to determine whether the duty to defend exists has been a heavily debated topic in Texas over the past several years. The Texas Supreme Court again had the opportunity to address this ongoing issue in *Pine Oak Builders, Inc. v. Great American Lloyds Insurance Co.*[83] In that case, five separate homeowners sued Pine Oak Builders, Incorporated (Pine Oak) alleging that their homes suffered from water damage resulting from Pine Oak's defective construction. In four of the underlying suits, there were specific allegations that subcontractors performed the defective work. However, in one of the underlying lawsuits (the *Glass* suit), the plaintiffs attributed all the defective work to Pine Oak and made no allegations that subcontractors performed any work on the home.

Pine Oak submitted the lawsuits for coverage to its insurers, Great American Lloyds Insurance Company (Great American) and Mid-Continent Casualty Company (Mid-Continent). The insurers denied coverage for all the lawsuits. Particularly, Great American denied coverage for the *Glass* suit based on "Exclusion 'l'" (the "your work" exclusion), which excludes coverage for property damage to the insured's completed work unless "the damaged work or the work out of which the damage [arose] was performed on [Pine Oak's] behalf by a subcontractor."[84] After that, Pine Oak sued both insurers alleging that they had breached their defense obligations. The insurers sought declaratory relief that they owed no defense or indemnity to Pine Oak.[85] Pine Oak sought to introduce extrinsic evidence that subcontractors had performed the allegedly defective work in the *Glass* suit. The trial court granted the insurers' motions

83. 279 S.W.3d 650, 653 (Tex. 2009).
84. *Id.*
85. *Id.* at 652.

for summary judgment in their entirety. The court of appeals affirmed the summary judgment relating to the *Glass* suit based on the "your work" exclusion, but concluded that Great American had a duty to defend Pine Oak in the four other underlying suits.[86] Both parties appealed.

One of the issues before the supreme court was "whether evidence extrinsic to the eight corners of the policy and the underlying lawsuit may be used to establish the insurer's duty to defend."[87] Specifically, the supreme court focused on whether Pine Oak could introduce extrinsic evidence in the coverage action illustrating that subcontractors actually performed the allegedly defective work that was the subject of the *Glass* suit.[88] If Pine Oak could introduce this evidence, the exception to the "your work" exclusion would apply, and Great American would have a duty to defend Pine Oak in the *Glass* suit.

To resolve the issue, the supreme court began by reciting one of the most basic principles in Texas insurance law: The duty to defend is determined by the "eight corners" of the underlying pleading and the terms of the policy.[89] The supreme court further acknowledged that although it has never officially recognized an exception to the eight-corners rule, any exception "would not extend to evidence that was relevant to both insurance coverage and the factual merits of the case as alleged by the third-party plaintiff."[90] Here, the extrinsic evidence that Pine Oak sought to introduce to establish the duty to defend clearly contradicted the allegations in the underlying petition of the *Glass* suit. As such, it would overlap with both the coverage and liability aspects of the underlying lawsuit and would not fit within the guidelines established in *GuideOne*.

Specifically, the allegations in the *Glass* suit were that Pine Oak alone constructed the columns, "failed to . . . seal seams," "failed 'to perform work in a good and workmanlike manner,'" and failed to make repairs.[91] These claims, according to the supreme court, would be excluded in their entirety pursuant to the "your work" exclusion. Additionally, there was neither any reference to work performed by a subcontractor nor any allegation that Pine Oak was responsible "under any theory for the conduct or work of a subcontractor."[92] The supreme court held that extrinsic evidence that contradicts the allegations of the underlying petition, whether from an insurer or an insured, should not be considered in determining the duty to defend.[93] Because the evidence Pine Oak sought to

86. *Id.* With respect to Mid-Continent, the court of appeals affirmed the trial court's summary judgment in its entirety based on an EIFS exclusion. *Id.*

87. *Id.* at 653.

88. *Id.* at 651-54.

89. *Id.* at 654 (citing Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Merchs. Fast Motor Lines, Inc., 939 S.W.2d 139, 141 (Tex. 1997)).

90. *Id.* (citing GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church, 197 S.W.3d 305, 309 (Tex. 2006)).

91. *Id.*

92. *Id.* at 655.

93. *Id.*

introduce would have contradicted the allegations in the petition, it was therefore inadmissible.[94]

Likewise, in *Accufleet, Inc. v. Hartford Fire Insurance Co.*, the Houston First Court of Appeals rejected an argument that it should look to extrinsic evidence in the form of deposition testimony, correspondence from the insured's attorney, and the insured's responsive pleadings to determine whether the insurer had a duty to defend.[95] The court of appeals declined to recognize an exception to the eight-corners rule, noting that the Texas Supreme Court has never expressly recognized any such exception.[96]

Additionally, just after the Survey period, in *D.R. Horton–Texas, Ltd. v. Markel International Insurance Co., Ltd.*, the Texas Supreme Court had the opportunity to decide whether it would recognize a "coverage only" exception to the eight-corners rule.[97] In that case, homeowners sued their general contractor for various alleged construction defects related to the construction of their home. The general contractor sought coverage from one of its subcontractor's insurers, who refused to defend because its insured–subcontractor was not named in the homeowners' petition.[98] The general contractor sued the subcontractor's insurer and sought to introduce evidence that the subcontractor had performed the allegedly defective work. The court of appeals refused to allow the general contractor to introduce the extrinsic evidence, citing that the evidence related to both coverage and liability issues.[99] On appeal, the supreme court refused to decide whether there is a coverage-only exception to the eight-corners rule, stating that the general contractor waived the issue by not raising the argument until its second motion for rehearing at the court of appeals.[100] The supreme court also held that even if an insurer has no duty to defend, it may still have a duty to indemnify its insured based on the actual facts.[101] This represents a shift from the belief that if an insurer had no duty to defend, it also had no duty to indemnify. Thus, if an insurer has no duty to defend based on the allegations, it must still examine extrinsic evidence to determine if it may have a duty to indemnify its insured.

Though the supreme court again did not recognize an "official" exception to the eight-corners rule, it again gave the indication that any such exception would be for coverage-only evidence. Clearly, if the supreme court had allowed Pine Oak to introduce evidence that subcontractors

94. *See id.* at 656.

95. No. 01-08-00684-CV, 2009 Tex. App. LEXIS 7313, at *16-17 (Tex. App.—Houston [1st Dist.] Sept. 17, 2009, no pet.).

96. *Id.* at *17.

97. 300 S.W.3d 740, 742-43 (Tex. 2009).

98. *Id.* at 741-42.

99. D.R. Horton–Tex., Ltd. v. Markel Int'l Ins. Co., 300 S.W.3d 773, 781 (Tex. App.—Houston [14th Dist.] 2006), *rev'd on other grounds*, 300 S.W.3d 740, 745 (Tex. 2009).

100. *D.R. Horton*, 300 S.W.3d at 742-43.

101. *See id.* at 744-45. As this case was outside the Survey period, please look for a detailed discussion regarding its affect in the 2011 Insurance Law Article.

performed work in the *Glass* suit, this would have set a precedent requiring insurers to perform possibly unnecessary investigation regarding issues not addressed in the pleadings. This would likely undermine the purpose of the eight-corners rule under Texas law.

B. Binding Effect of Default Judgment Against Insured After Insurer Breaches Duty to Defend

In 2008, the Texas Supreme Court issued its opinion in *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.* and held that a liability insurer that wrongfully denies coverage to its insured cannot later challenge the reasonableness of the amount of the insured's settlement with a third-party claimant.[102] In the process, the supreme court provided clarification regarding the scope of *State Farm Fire & Casualty Co. v. Gandy*[103] and *Employers Casualty Co. v. Block*,[104] which involved issues of whether an insurer is bound by an insured's settlement.[105]

Based on the guidance from the supreme court in *ATOFINA*, the Fifth Circuit addressed in *Mid-Continent Casualty Co. v. JHP Development, Inc.* whether a liability insurer that breaches its duty to defend is bound by a default judgment against its insured.[106] In *Mid-Continent*, the insurer refused to defend its insured in a lawsuit arising out of the insured's allegedly defective construction of a condominium project. The insurer's position was that there was no "occurrence" or "property damage," and, to the extent those requirements were satisfied, various exclusions precluded coverage under the policy.[107] The third-party claimant subsequently obtained a default judgment against the insured for approximately $1.5 million.[108]

The insurer sought declaratory relief, arguing, among other things, that, pursuant to *Gandy*, it was not bound by the default judgment, because the default judgment was not the result of a fully adversarial proceeding.[109] The Fifth Circuit stated that the Texas Supreme Court had recently explained that the *Gandy* holding was "narrow, applying only to a specific set of assignments with special attributes," and that *Gandy* only applies in cases involving the five unique elements outlined in that case.[110] Noting that the case before it did not involve a suit against the insurer by a plaintiff acting as the insured's assignee or any other unique element, the Fifth Circuit held that *Gandy* did not apply.[111] Instead, the Fifth Circuit, relying on *Block*, held that because the insurer breached its

102. 256 S.W.3d 660, 674-75 (Tex. 2008).
103. 925 S.W.2d 696 (Tex. 1996).
104. 744 S.W.2d 940 (Tex. 1988).
105. *ATOFINA*, 256 S.W.3d at 671-75.
106. 557 F.3d 207, 218 (5th Cir. 2009).
107. *Id.* at 210.
108. *Id.*
109. *Id.* at 217 (citing State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696, 714 (Tex. 1996)).
110. *Id.* at 218 (quoting *ATOFINA*, 256 S.W.3d 660, 673 (Tex. 2008)).
111. *Id.*

duty to defend, it was bound by the amount of the default judgment against its insured in the underlying suit.[112]

V. EXTRA-CONTRACTUAL LIABILITY

A. THE PROMPT PAYMENT OF CLAIMS STATUTE

The Prompt Payment of Claims Statute (the Statute) in the Texas Insurance Code authorizes that an insured may receive an award of eighteen percent annual interest and reasonable attorneys' fees if its insurer wrongfully refuses or delays payment of a "claim."[113] The Statute defines the term "claim" as a first-party claim by an insured that the insurer must pay directly to the insured or beneficiary.[114] Another provision within the Statute provides that "if an insurer, after receiving all items, statements, and forms reasonably requested and required . . . delays payment of the claim for a period exceeding . . . more than 60 days, the insurer shall pay damages and other items as provided by Section 542.060."[115] In *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, the Texas Supreme Court settled a heavily debated issue regarding the applicability of the statute in third-party liability claims, holding that an insured's right to a defense constitutes a first-party claim, and therefore the Statute applies if the insurer wrongfully refuses to provide the defense owed.[116] However, in *Evanston Insurance Co. v. ATOFINA Petrochemicals, Inc.*, the Texas Supreme Court held that the Statute does *not* extend to an insured's claim under a liability policy for indemnification of a third-party claim.[117]

In *Trammell Crow Residential Co. v. Virginia Surety Co.*, the Northern District of Texas addressed issues relating to when the damages authorized by the Statute become payable and how those damages are calculated.[118] In that case, Trammell Crow Residential Company (Trammell Crow) sought coverage from its insurer, Virginia Surety Company, Incorporated (Virginia Surety), for a lawsuit in which it was alleged that Trammell Crow discriminated against people with disabilities in violation of federal law. After Virginia Surety denied coverage, Trammel Crow sued, alleging that Virginia Surety violated the Statute by failing to provide a defense.[119]

Trammell Crow contended that from the day on which Virginia Surety denied coverage, it had incurred significant defense costs relating to the underlying lawsuit. Trammell Crow further contended that Virginia Surety wrongfully refused to pay these defense costs, and that because it

112. *Id.*
113. TEX. INS. CODE ANN. § 542.060(a) (Vernon 2009).
114. *Id.* § 542.051(2).
115. *Id.* § 542.058(a) (Vernon Supp. 2009).
116. 242 S.W.3d 1, 20 (Tex. 2007). *See also* Pine Oak Builders, Inc. v. Great Am. Lloyds Ins. Co., 279 S.W.3d 650, 652 (Tex. 2009) (reiterating that the Statute applies to an insurer's breach of its duty to defend under a liability policy).
117. 256 S.W.3d 660, 674-75 (Tex. 2008).
118. 643 F. Supp. 2d 844, 856-60 (N.D. Tex 2008).
119. *Id.* at 848-49.

delayed more than sixty days in paying the defense costs, Virginia Surety had violated the Statue.[120] Virginia Surety responded that it could not be liable under the Statute because Trammell Crow had not submitted any legal bills or invoices for the expenses incurred in defending the underlying lawsuit. Virginia Surety argued that "[t]he legal fee statements or invoices are necessary last pieces of information needed to put a value on the insured's loss."[121] In essence, Virginia Surety argued that its liability under the Statute would not be triggered until Trammell Crow submitted the invoices demonstrating its actual loss.

The district court rejected Virginia Surety's argument, noting that neither the supreme court's *Lamar Homes* opinion nor § 542.060 refers to "submitted" defense costs.[122] Instead, the court concluded "that *Lamar Homes* is best understood as holding that an insurer becomes liable under the [S]tatute when it wrongfully rejects its defense obligation, but that attorney's fees cannot be awarded, and prejudgment interest does not begin accruing, until the insured actually incurs the defense costs."[123] Thus, the court continued, "there can be a determination of liability without a calculation of damages."[124] The court, therefore, granted Trammell Crow's motion for summary judgment on its claim that Virginia Surety had violated the Statute and found that the exact amount of damages, fees, and prejudgment interest would be determined at trial.[125]

After *Lamar Homes*, many believed that the supreme court had established that an insurer's responsibility to pay the defense costs did not begin until the insured actually submitted bills for payment. This assumption was based on the following statement from that case regarding the triggering event for the penalty under the Statute: "[W]hen 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.* These statements or invoices are the last piece of information needed to put a value on the insured's loss."[126] Nevertheless, the federal district court in *Trammel Crow* suggests that an insurer's liability under the Statute is not dependent upon when it receives the bills, but instead triggers as soon as it wrongfully

120. *Id.* at 858.

121. *Id.*

122. *Id.* at 858-59.

123. *Id.*

124. *Id.*

125. *Id.* at 859-60.

126. Lamar Homes, Inc. v. Mid-Continent Cas. Co., 242 S.W.3d 1, 19 (Tex. 2007) (emphasis added) (citing TEX. INS. CODE ANN. § 542.056(a) (Vernon 2007)). *See also* Primrose Operating Co. v. Nat'l Am. Ins. Co., 382 F.3d 546, 565 (5th Cir. 2004) (holding prejudgment interest accrues from the date the insured paid the bills rather than the day when the insurer denied coverage); TIG Ins. Co. v. Dallas Basketball, Ltd., 129 S.W.3d 232, 241 (Tex. App.—Dallas 2004, pet. denied) (querying whether an insured would have "to continually submit his legal bills" to be entitled to extra-contractual penalties under the Statute).

rejects its insured's request for a defense.[127] Whether this suggestion is what the supreme court intended in *Lamar Homes* is yet to be determined.

B. The Unfair or Deceptive Acts or Practices Statute and Common-Law Bad Faith

In *Spicewood Summit Office Condominiums Ass'n v. America First Lloyd's Insurance Co.*, the insured claimed that the insurer breached the common-law duty of good faith and fair dealing and violated Chapter 541 of the Texas Insurance Code (Chapter 541) by wrongfully withholding insurance benefits.[128] In that case, the insured sought coverage for wind and hail damage to five two-story commercial buildings. After the insurer performed an initial evaluation of the property and provided an estimate of the damages and repair costs, the insured retained its own roof consultant. The insured's roof consultant estimated the damages and repair costs to be much higher than the insurer's estimate. The insurer subsequently had the property reinspected by independent adjusters three additional times. The insurer also had an engineering company investigate the property and prepare a detailed report regarding the damage.[129] During each reinspection and during the engineer's investigation, the roof and siding of the property were found to need no additional repair or replacement. Nevertheless, after each reinspection, the insurer made supplemental payments to the insured.[130] The insured subsequently sued the insurer, claiming that the payments made by the insurer for the loss under the policy were insufficient and that the insurer had violated Chapter 541.[131] The trial court granted the insurer's motion for summary judgment, ruling that the insured's "extra-contractual claims were precluded because 'there was, at most, a *bona fide* dispute regarding the extent of damage and valuation of [the insured's] loss.'"[132] The insured appealed.

The insured's argument on appeal, according to the Austin Court of Appeals, appeared to be that the evidence that the insurer engaged in bad faith came from the fact that it agreed to perform additional assessments of damage at the insured's property, which, after each inspection, resulted in the insurer issuing supplement payments to the insured.[133] The court of appeals disagreed, noting that in agreeing to the additional assessments of damage, the insurer demonstrated good faith in attempting to settle the claim.[134] The court of appeals further noted that "[t]o

127. Tramell Crow Residential Co. v. Va. Sur. Co., 643 F. Supp. 2d 844, 858-60 (N.D. Tex. 2008).

128. 287 S.W.3d 461, 463, 468 (Tex. App.—Austin 2009, pet. denied). Chapter 541 of the Texas Insurance Code is commonly referred to as the "Unfair or Deceptive Acts or Practices Statute."

129. *Id.* at 469.

130. *Id.*

131. *Id.* at 464.

132. *Id.*

133. *Id.* at 470.

134. *Id.*

find otherwise might encourage insurers to stand by their initial assessments for fear that their willingness to consider new evidence and issue supplemental payments would indicate their initial assessments were made in bad faith."[135]

The court of appeals held that the insured failed to produce any evidence demonstrating that there was more than a bona fide dispute regarding the amount of the loss.[136] To support its conclusion, the court noted that the insured was not arguing that the insurer should have paid the full amount at the time of the initial assessment, but instead, that the insured argued that the amount paid by the insurer was insufficient.[137] Additionally, the insured's requesting several assessments of the damage to the property, was not evidence that the insurer's final assessment of damage was unreasonable.[138] Finally, the court of appeals determined that the insurer's making payments over time was not evidence that the amount paid to the insured was insufficient.[139] The court of appeals therefore affirmed the trial court's judgment regarding the insured's common-law bad faith and Chapter 541 claims.[140]

VI. COMMERCIAL GENERAL LIABILITY POLICIES

A. The "Property Damage" Trigger of Coverage

Until the Texas Supreme Court issued its opinion in *Don's Building Supply, Inc. v. OneBeacon Insurance Co.*,[141] Texas courts were split regarding the coverage trigger applicable in the context of a CGL policy.[142] In *Don's Building*, the supreme court adopted the "actual injury" (or "injury in fact") rule, which states that "property damage" occurs when actual physical damage to the property occurs.[143] Because most of the courts have applied the "manifestation" theory and some courts had applied the "exposure" theory in the past,[144] this newly adopted rule may lead to circumstances where courts struggle to interpret and apply the holding from *Don's Building*. In fact, the supreme court itself recognized in *Don's Building* that "[p]inpointing the moment of injury retrospec-

135. *Id.*
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.* at 470-71.
141. 267 S.W.3d 20 (Tex. 2008).
142. Compare Guar. Nat'l Ins. Co. v. Azrock Indus., 211 F.3d 239, 245-48 (5th Cir. 2000); Summit Custom Homes, Inc. v. Great Am. Lloyds Ins. Co., 202 S.W.3d 823, 827 (Tex. App.—Dallas 2006, pet. withdrawn); State Farm Fire & Cas. Co. v. Rodriguez, 88 S.W.3d 313, 322 (Tex. App.—San Antonio 2002, pet. denied); State Farm Mut. Auto. Ins. Co. v. Kelly, 945 S.W.2d 905, 910 (Tex. App.—Austin 1997, writ denied) (following the "manifestation" theory), with Pine Oak Builders, Inc. v. Great Am. Lloyds Ins. Co., 292 S.W.3d 48, 58-59 (Tex. App.—Houston [14th Dist.] 2006), *rev'd* 279 S.W.3d 650 (Tex. 2009) (applying the "exposure" theory); Pilgrim Enters., Inc. v. Md. Cas. Co., 24 S.W.3d 488, 497-98 (Tex. App.—Houston [1st Dist.] 2000, no pet.).
143. *Don's Bldg.*, 267 S.W.3d at 22-24.
144. *See supra* note 142.

tively is sometimes difficult, but we cannot exalt ease of proof or administrative convenience over faithfulness to the policy language."[145]

The supreme court again addressed the property damage trigger in *Pine Oak Builders, Inc. v. Great American Lloyds Insurance Co.*, but did not provide any further guidance on how one determines when "actual physical damage" occurs.[146] In that case, Great American insured Pine Oak with consecutive one-year CGL policies from April 5, 1993 to April 5, 2001. The underlying suits involved homes that were alleged to have been built during 1996 and 1997 and that had suffered extensive water damage due to Pine Oak's alleged negligence. One issue in the case was whether the allegations triggered the Great American policies.[147] Focusing on its decision in *Don's Building*, the supreme court again reiterated that the date when the injury occurs is not "when someone happens upon it," but 'when the damage comes to pass."[148] The supreme court then instructed the trial court to apply the actual-injury rule to determine when any of the homes that were the subjects of the underlying suit suffered wood rot or other physical damage.[149]

In *Wilshire Insurance Co. v. RJT Construction, LLC*, the Court of Appeals for the Fifth Circuit applied *Don's Building* in its analysis of whether there was an occurrence during the policy period.[150] In that case, Wilshire Insurance Company (Wilshire) provided RJT Construction, LLC (RJT) with CGL coverage for the period of June 2004 to June 2006. In 1999, RJT repaired the foundation of a home damaged by the discharge of water. The homeowner sued RJT, alleging, in part, "that cracks in the walls and ceilings suddenly appeared in his home" due to the foundation not being level.[151] During the coverage litigation, Wilshire argued that because there was no allegation that property damage occurred during the policy period, it had no duty to defend. In rejecting this argument, the Fifth Circuit noted that the alleged "cracks in the wall and ceilings" themselves constituted the "physical damage."[152] The homeowner had alleged that the cracks "first" appeared in 2005 during Wilshire's policy period. Thus, pursuant to the rule in *Don's Building*, because the actual physical damage was alleged to have begun in 2005, coverage was triggered under the policy.[153]

As the supreme court recognized in *Don's Building*, determining the "moment of injury" continues to be a difficult—if not impossible—task, as the issue of when the injury actually occurred may not be resolved during the underlying litigation.[154] It is arguable that the "actual injury"

145. *Don's Bldg.*, 267 S.W.3d at 29.
146. 279 S.W.3d 650, 652-53 (Tex. 2009).
147. *Id.* at 651-52.
148. *Id.* at 653 (quoting *Don's Bldg.*, 267 S.W.3d at 22).
149. *Id.*
150. 581 F.3d 222, 225 (5th Cir. 2009).
151. *Id.* at 224.
152. *Id.* at 225.
153. *Id.*
154. Don's Bldg. Supply, Inc. v. One Beacon Ins. Co., 267 S.W.3d 20, 29-30 (Tex. 2008).

could occur between the time when the insured begins its work until the day that the damage becomes apparent or identifiable. The supreme court has not yet offered any specific suggestions or recommendations for making this determination. Therefore, litigation regarding when and what policies may be triggered by allegations of property damage will likely continue until courts have an opportunity to provide better guidance on the issue.

B. The Scope of the j(5) and j(6) Exclusions

During the Survey period, the Fifth Circuit issued its opinion in *Mid-Continent Casualty Co. v. JHP Development, Inc.*, analyzing the scope of the j(5) and j(6) exclusions in the standard CGL insurance policy form.[155] JHP Development, Incorporated (JHP) and TRC Condominiums, Limited (TRC) entered into a contract whereby JHP agreed to construct a condominium project consisting of five separate units for TRC. Four of the units were to be partially unfinished until sold to give the purchaser the option to finish out the unit to his or her particularities.[156] In 2001 and prior to the completion of the project, water intrusion problems arose due to JHP's alleged failure to water-seal the exterior finishes. This water intrusion caused various damage to the exterior finishes and retaining walls of the units, including damage to the interior drywall, stud framing, electrical wiring, and wood flooring.[157] JHP refused to repair the damage and complete its work on the units; thus, TRC hired another contractor to repair and complete the condominiums.

Upon finishing the repairs and construction of the units, the new contractor attributed $438,466.77 of the project costs towards "investigating, demolishing, repairing, and replacing the non-defective interior finishes and wiring that were damaged by the water intrusion."[158] JHP sought coverage for this claim from its insurer, Mid-Continent Casualty Company (Mid-Continent). Mid-Continent, however, denied coverage. After TRC filed suit, JHP tendered the lawsuit to Mid-Continent for defense. Again, Mid-Continent denied coverage and refused to provide a defense. TRC subsequently took a default judgment against JHP for $1.5 million.[159] Mid-Continent then filed a declaratory judgment against JHP and TRC, arguing that various exclusions within the policy barred coverage for JHP, and therefore JHP was not entitled to defense or indemnity.[160] TRC answered and filed a counterclaim seeking a declaration

155. *See* 557 F.3d 207 (5th Cir. 2009).
156. *Id.* at 210.
157. *Id.*
158. *Id.*
159. *Id.*
160. *Id.* at 210-11. Mid-Continent originally asserted that based on the allegations of defective construction and faulty workmanship, there was no "occurrence" or "property damage" as contemplated by the CGL policy. However, Mid-Continent abandoned this position after the Texas Supreme Court's 2007 opinion in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, 242 S.W.3d 1 (Tex. 2007). *See Mid Contintent Cas. Co. v. JHP Dev., Inc.*, 557 F.3d at 212 n.1.

that no exclusions applied. Both Mid-Continent and TRC moved for summary judgment. The district court denied Mid-Continent's motion and granted TRC's motion. Mid-Continent appealed to the Fifth Circuit, arguing that exclusions j(5) and j(6) applied to bar coverage for the alleged damages.[161]

Exclusion j(5) provides that insurance does not apply to property damage to "[t]hat particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the 'property damage' arises out of those operations."[162] The parties agreed that this exclusion applies only to property damage that occurred during JHP's ongoing operations; however, they disagreed on whether JHP was "performing operations" within the meaning of the exclusion when the water damage occurred. TRC argued that JHP was not performing operations because it had suspended its operations pending the sale of the units to the individual owners. Mid-Continent argued that construction was ongoing because JHP was still responsible for the finish-out work on the units.

After examining the dictionary meaning of "performing operations" and the allegations of the underlying suit, the Fifth Circuit held "that JHP was not actively engaged in construction activities at the time the water intrusion occurred."[163] Specifically, the Fifth Circuit concluded that because JHP refused to complete the construction on the four unfinished units, these "prolonged, open-ended, and complete suspension of construction activities" did not fit into the ordinary meaning of "performing operations," i.e., "the active performance of work."[164] Additionally, the Fifth Circuit stated that "[a]lthough JHP intended to eventually complete construction work once the units were sold, an actor is not actively performing a task simply because he has not yet completed it but plans to do so at some point in the future."[165] Thus, exclusion j(5) did not apply, because "JHP was not actively engaged in construction activities" when the property damage occurred.[166]

The Fifth Circuit then analyzed the applicability of exclusion j(6). This exclusion provides that insurance does not apply to property damage to "[t]hat particular part of any property that must be restored, repaired or replaced because 'your work' was incorrectly performed on it."[167] TRC argued that the "[t]hat particular part" language limited the exclusion to bar coverage only for the portion of the project that was the subject of JHP's defective work. Mid-Continent argued that the exclusion in fact provided a bar for coverage for all the damages resulting from the in-

161. *Id.* at 211-12.
162. *Id.* at 211.
163. *Id.* at 213.
164. *Id.*
165. *Id.*
166. *Id.* at 213-14.
167. *Id.* at 215.

sured's work.[168] The Fifth Circuit postured the issue:

> whether the exclusion bars recovery for damage to any part of a . . . contractor's defective work, including damage to parts of the property that were the subject of only nondefective work, or whether the exclusion only applies to property damage to parts of the property that were themselves the subject of the defective work.[169]

The Fifth Circuit noted that the "plain meaning of the exclusion" is that damage "only to parts of the property that were themselves the subjects of the defective work is excluded."[170] According to the Fifth Circuit, when broken down into its distinct parts, the limiting language in the exclusion meant that there is coverage for damaged property that was the subject of the insured's nondefective work and for damaged property that the insured itself did not work on.[171] Accordingly, the Fifth Circuit held:

> [E]xclusion j(6) bars coverage only for property damage to parts of a property that were themselves the subject of defective work by the insured; the exclusion does not bar coverage for damage to parts of a property that were the subject of only nondefective work by the insured and were damaged as a result of defective work by the insured on other parts of the property.[172]

Turning to the case at bar, the Fifth Circuit found that the damage to the interior portions of the condominiums was not due to JHP's defective work, but was instead due to JHP's failure to water-seal the exterior finishes and retaining walls. Thus, exclusion j(6) barred coverage for the damage to the exterior finishes and retaining wall, but did not bar coverage for the damage to the interior parts of the units, including the drywall, stud framing, electrical wiring, and wood flooring.[173]

C. Allegations of Faulty Workmanship

Another issue addressed in *Pine Oak Builders, Inc. v. Great American Lloyds Insurance Co.* was whether allegations of faulty workmanship constitute "property damage" caused by an "occurrence" as contemplated in a standard-form CGL policy.[174] In that case, the insurer argued that the allegations made by the homeowners in the underlying suits against the insured relating to improper design and faulty construction did not satisfy the "property damage" or "occurrence" requirements of the relevant insurance policy.[175] Noting that it had previously addressed and answered this exact issue in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*,[176]

168. *Id.* at 214 (citing Sw. Tank & Treater Mfg. Co. v. Mid-Continent Cas. Co., 243 F. Supp. 2d 597 (E.D. Tex. 2003)).
169. *Id.*
170. *Id.* at 215.
171. *See id.*
172. *Id.*
173. *Id.* at 217.
174. 279 S.W.3d 650, 652 (Tex. 2009).
175. *See id.*
176. 242 S.W.3d 1, 4-5, 16 (Tex. 2007).

the supreme court rejected the insurer's position and held that the underlying pleadings contained allegations of "property damage" caused by an "occurrence."[177]

VII. APPRAISAL CLAUSES

Despite the fact that standard appraisal clauses appear in most forms of property policies, the supreme court had addressed the clause in only five cases since 1888, and in those cases, the issues revolved around waiver or enforceability of the clause itself.[178] *State Farm Lloyds v. Johnson* presented the supreme court with an issue of first impression regarding the scope of the appraisal clause.[179] In that case, the insured filed a claim with the insurer after the roof on her home was damaged by a hailstorm. The insured's inspector found that the hail had damaged only the ridgeline of the roof and estimated the repairs to be $499.50. The insured's roofing contractor, however, determined that the entire roof required replacement at a cost of over $13,000.[180] The insured demanded an appraisal of the "amount of loss" pursuant to her policy, but the insurer refused, stating that the dispute was over causation and not the "amount of loss."[181] The insured sued the insurer, seeking a judgment to compel the insurer to submit to the appraisal. The trial court found that no appraisal was warranted, and the court of appeals reversed, holding that an appraisal was required. The insurer appealed to the supreme court to determine whether the dispute fit within the scope of the appraisal clause.[182]

Initially, the supreme court examined the scope of the appraisal clause with respect to damages versus liability. In 1888, the supreme court first noted in *Scottish Union & National Insurance Co. v. Clancy* that a distinction exists between damage questions, which are for appraisers, and lia-

177. *Pine Oak*, 279 S.W.3d at 652.

178. *See* State Farm Lloyds v. Johnson, 290 S.W.3d 886, 888-89 (Tex. 2009) (referencing In re Allstate County Mut. Ins. Co., 85 S.W.3d 193, 195 (Tex. 2002); Glens Falls Ins. Co. v. Peters, 386 S.W.2d 529, 532 (Tex. 1965); Del. Underwriters v. Brock, 211 S.W. 779, 781 (Tex. 1919); Am. Cent. Ins. Co. v. Bass, 38 S.W. 1119, 1120 (Tex. 1897); Scottish Union & Nat'l Ins. Co. v. Clancy, 18 S.W. 439, 441 (Tex. 1892); Scottish Union & Nat'l Ins. Co. v. Clancy, 8 S.W. 630, 631-32 (Tex. 1888)).

179. *State Farm Lloyds*, 290 S.W.3d at 889.

180. *Id.* at 887.

181. *Id.* at 887-88. The appraisal clause in the insured's policy read as follows:

> APPRAISAL. If you and we fail to agree on the amount of loss, either one can demand that the amount of the loss be set by appraisal. If either makes a written demand for appraisal, each shall select a competent, disinterested appraiser. Each shall notify the other of the appraiser's identity within 20 days of receipt of the written demand. The two appraisers shall then select a competent, impartial umpire .... The appraisers shall then set the amount of the loss. If the appraisers submit a written report of an agreement to us, the amount agreed upon shall be the amount of the loss. If the appraisers fail to agree within a reasonable time, they shall submit their differences to the umpire. Written agreement signed by any two of these three shall set the amount of the loss.

Id.

182. *Id.* at 888.

bility questions, which are for the courts.[183] Noting that the ordinary meaning of the term "appraisal" is "[t]he determination of what constitutes a fair price; valuation; [or] estimation of worth," the supreme court again concluded that limiting the scope of appraisals to questions regarding damages is proper.[184] Thus, although the appraiser decides the "amount of loss" under the policy, the policy itself determines whether the insurer should pay that loss.[185]

With that in mind, the supreme court turned to the issue of whether appraisers can decide issues of causation.[186] The insurer argued in its brief that the dispute centered not on whether the shingles were damaged, but on whether the shingles were actually damaged by hail.[187] Thus, according to the insurer, an appraisal was not necessary, because the dispute revolved around whether it was actually liable for the damages. However, the supreme court noted that the insurer put forth no evidence demonstrating that the insured's roof was damaged by anything other than hail, nor did the insurer attempt to establish that the dispute involved how much of the roof was damaged as opposed to how much of the roof required replacement.[188] Thus, according to the supreme court, the trial court could not have determined if the dispute was about causation or something else.[189]

The supreme court further noted that a dispute over causation would not resolve issues relating to questions of damages or liability, because causation connects and relates to both aspects of liability and damages.[190] Thus, appraisers must always initially consider causation "because setting the 'amount of loss' requires appraisers to decide between damages for which coverage is claimed and damages caused by everything else."[191] Appraisers, however, cannot rewrite the coverage provided by the terms of the policy, as an insured would not be responsible for paying repairs for noncovered damages. However, to determine if appraisers have exceeded their rightful ability to determine the amount of damages depends "on the nature of the damage, the possible causes, the parties' dispute, and the structure of the appraisal award."[192] Thus, an insurer cannot avoid an appraisal simply because there may be a causation issue that exceeds the scope of the appraisal.[193]

183. *Id.* at 889-90; *see Scottish Union & Nat'l Ins. Co.*, 8 S.W. at 631.

184. *State Farm Lloyds*, 290 S.W.3d at 890 (quoting BLACK'S LAW DICTIONARY 110 (8th ed. 2004)).

185. *Id.*

186. *Id.* at 891.

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.* at 891-92.

191. *Id.* at 893.

192. *Id.*

193. *Id.*

VIII. CONCLUSION

Over the past several years, the Texas Supreme Court has issued many opinions that have significantly changed the landscape of Texas insurance jurisprudence, at times surprising both sides of the insurance bar with its analysis. Opinions issued by the supreme court during this Survey period continued to challenge established paradigms. Additionally, this Survey period saw other Texas courts issue opinions in an attempt to apply and interpret the recent changes to Texas insurance law established by the Texas Supreme Court.

The coming years will be interesting as we observe how the courts react to the apparent paradigm shift by the Texas Supreme Court. We anticipate that the supreme court will issue clarifying opinions in the near future and will finally squarely address some unanswered questions. Such issues may include: whether an insurer must demonstrate prejudice to deny coverage under a claims-made policy based on an insured's breach of the notice condition when the insurer does not receive notice until after the expiration of the policy, whether Texas law recognizes any exceptions to the "eight-corners" rule in determining the duty to defend, and how carriers insuring a mutual insured over multiple consecutive policy years will determine what policy provides indemnification for latent property damage under the "actual injury" coverage trigger.