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Insurance Law

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I. EXTRA-CONTRACTUAL LIABILITY

A. THE PROMPT PAYMENT OF CLAIMS STATUTE¹

1. *The Statute Does Not Apply to a Liability Insurer’s Indemnity Obligations*

THE Statute authorizes an award of eighteen percent annual interest and attorney’s fees when an insurer wrongfully refuses or delays payment of a “claim.”² The Statute defines the term “claim” as a “first-party claim” that is “made by an insured” and that “must be paid by the insurer directly to the insured,” but does not separately define the term “first-party claim.”³ 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.⁴

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.⁵ The court explained that it “distinguish[es] first-party and third-party claims based on the claimant’s relationship to the loss. [A] first-party claim is stated when an insured seeks recovery for the insured’s own loss, whereas a third-party claim is stated when an insured seeks coverage for injuries to a third party.”⁶ Based on this distinction, the court reasoned that the insured’s payment of an amount to a third party pursuant to a settlement is not a loss to the insured.⁷ Characterizing the insured’s claim

1. TEX. INS. CODE ANN. §§ 542.051-.061 (Vernon 2009) (the Statute) (formerly codified as TEX. INS. CODE ANN. art. 21.55 (Vernon 1991) (Article 21.55)).

2. *Id.* § 542.060(a).

3. *Id.* § 542.051(2).

4. 51 Tex. Sup. Ct. J. 1018, 2008 Tex. LEXIS 575, at *38-40 (Tex. June 13, 2008).

5. *Id.* at *40.

6. *Id.* at *39 (internal quotations omitted).

7. *Id.*

for coverage of injuries sustained by a third party as a “classic third-party claim” and emphasizing that the Statute was intended to apply only to claims belonging to the insured, the court concluded that the insured was not entitled to damages or attorney’s fees under the Statute.⁸

2. *An Insured Cannot Recover Under the Statute in the Absence of Coverage*

The United States District Court for the Southern District of Texas confirmed that an insured cannot prevail under the Statute if the claim is not covered under the policy.⁹ The insured alleged that the insurers violated the Statute’s requirement of notifying the insured “in writing of the acceptance or rejection of a claim no later than the 15th business day after the date the insurer receives all items, statements, and forms required by the insurer to secure final proof of loss.”¹⁰ The court first explained that by its plain language, the Statute authorizes a private cause of action only where the insurer “is liable for a claim under an insurance policy.”¹¹ Second, the court noted that Texas Supreme Court had interpreted the prior statute, Article 21.55, as applying only where coverage existed.¹² Because the insurers were not liable for the insured’s claim for business interruption losses, the court determined that the insurers could not be liable for violating the Statute.¹³

B. THE UNFAIR OR DECEPTIVE ACTS OR PRACTICES STATUTE¹⁴

1. *The Absence of Coverage Does Not Preclude Recovery Under Chapter 541, but the Insured Must Show “Actual Damages”*

In contrast to its conclusion with respect to the Prompt Payment of Claims Statute, the United States District Court for the Southern District of Texas ruled that an insured may prevail on a Chapter 541 claim even in the absence of coverage.¹⁵ The insured here alleged “a violation of the ‘reasonable explanation’ provision of Section 541.060(a)(3).”¹⁶ Relying on other decisions holding that the prior statute, Article 21.21, imposed obligations on the insurer separate from its contractual duties under the policy and thus applied even in the absence of coverage, the court held

8. *Id.* at *39-40.

9. *S. Tex. Med. Clinics, P.A. v. CNA Fin. Corp.*, No. H-06-4041, 2008 U.S. Dist. LEXIS 11460, at *34-36 (S.D. Tex. Feb. 15, 2008).

10. *Id.* at *34 (quoting TEX. INS. CODE ANN. § 542.056(a) (Vernon 2009)).

11. *Id.* at *35 (quoting TEX. INS. CODE ANN. § 542.060).

12. *Id.* at *35-36 (relying on *Progressive County Mut. Ins. Co. v. Boyd*, 177 S.W.3d 919, 922 (Tex. 2005)).

13. *Id.* at *35.

14. TEX. INS. CODE ANN. §§ 541.001-454 (Chapter 541) (formerly codified at TEX. INS. CODE ANN. art. 21.21 (Vernon 1991) (Article 21.21)).

15. *S. Tex. Med. Clinics*, 2008 U.S. Dist. LEXIS 11460, at *34, *36-39.

16. *Id.* at *34, *36 (referencing TEX. INS. CODE ANN. § 541.060(a)(3) (defining an unfair or deceptive act or practice in the business of insurance as the insurer’s “failing to promptly provide to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer’s denial of a claim or offer of a compromise settlement of a claim”)).

that “[a] lack of coverage under the insurance policy does not automatically bar recovery for a violation” of the reasonable explanation provision of Chapter 541.¹⁷

The court next addressed whether the insured had adequately proven the “actual damages” required to prevail on a Chapter 541 claim.¹⁸ Because the policy did not cover the insured’s business interruption losses, the insurers did not wrongfully deny payment, and therefore, the insured was not damaged by the denial of coverage.¹⁹ Further, the insured failed to show any other “actual damages” caused by the insurers’ alleged failure to explain the basis for the denial.²⁰ Accordingly, the court determined that a fact issue existed as to whether the insured could recover for the alleged statutory violation and denied the insured’s and the insurers’ motions for summary judgment on the Chapter 541 claim.²¹

2. Chapter 541 Claims Against Adjusters

Two decisions during this Survey period addressed the level of specificity required to adequately plead a claim against an insurance adjuster under Chapter 541.²² In *First Baptist Church*, the insured church sought coverage for damages sustained from Hurricane Rita. The insurer retained an independent insurance adjuster to adjust the claim. The insurer eventually denied the claim, and the church sued the insurer (a citizen of Iowa) and the adjuster (a citizen of Texas) in Texas state court. The insurer removed the action to federal court. In response to the insured’s motion to remand the action to state court, the insurer argued that the adjuster was fraudulently joined and that the claims asserted against him were invalid.²³

In analyzing the validity of the claims against the adjuster, the United States District Court for the Eastern District of Texas explained that under Texas law a Chapter 541 claim may be asserted against adjusters and agents in addition to insurers.²⁴ However, a pleading’s mere reference to Chapter 541 is not sufficient to state a claim against an adjuster; rather, the pleading must set forth specific facts detailing the alleged improper conduct of the adjuster.²⁵ The pleading at issue identified the individual as the adjuster and noted that an adjuster may be liable under Chapter 541, but did not detail any specific statutory violations by the individual.²⁶ The court determined that there was no “factual fit” be-

17. *Id.* at *36-37.

18. *Id.* (quoting TEX. INS. CODE ANN. § 541.151).

19. *Id.* at *38-39 n.6.

20. *Id.* at *37.

21. *Id.* at *37-39.

22. *First Baptist Church v. GuideOne Mut. Ins. Co.*, No. 1:07-CV-988, 2008 U.S. Dist. LEXIS 75961 (E.D. Tex. Sept. 29, 2008); *Warren v. State Farm Mut. Auto. Ins. Co.*, No. 3:08-CV-0768-D, 2008 U.S. Dist. LEXIS 68646 (N.D. Tex. Aug. 29, 2008).

23. *First Baptist Church*, 2008 U.S. Dist. LEXIS 75961, at *1-4.

24. *Id.* at *16.

25. *Id.* at *13.

26. *Id.* at *19.

tween the conclusory allegations and the theory of recovery.²⁷ Because the pleading did not allege valid state law claims against the adjuster, the court denied the motion to remand.²⁸

Applying the same standard under a similar procedural background, the United States District Court for the Northern District of Texas reached a different result in *Warren*.²⁹ Following the insurer's denial of a claim for underinsured motorist benefits, the insured sued the insurer and Todd J. Dauper, the adjuster who handled the claim, for violation of Chapter 541.³⁰ After recognizing that Texas permits a private cause of action against an adjuster for violation of Chapter 541, the court noted it was a "close question" as to whether the petition, assessed under Texas's notice pleading standard, sufficiently pleaded facts to state a Chapter 541 claim against Dauper.³¹ The court reasoned that because the claim against Dauper was based on the processing and denial of the claim, the allegation that Dauper was the adjuster responsible for the claim "does implicate Dauper in the alleged misconduct in the processing and denial of [the insured's] claim for benefits."³² Even though certain of the factual allegations did not name Dauper, the court determined that the pleading was nevertheless adequate when these allegations were considered in conjunction with the allegations that Dauper was the person handling the claim and that he violated specified parts of Chapter 541.³³ Accordingly, the court concluded that the factual allegations were sufficient to state a claim against Dauper individually for violations of Chapter 541, that the insurer failed to establish that Dauper was improperly joined, and therefore, remand was warranted.³⁴

C. COMMON LAW BAD FAITH

In *State Farm Lloyds v. Hamilton*, the Dallas Court of Appeals addressed the sufficiency of the evidence to support a jury finding of bad faith for the insurer's denial of the homeowners' claim for foundation damage.³⁵ The insurer based its denial on a report from an engineer concluding that the foundation damage was not caused by a plumbing leak under the house. The insureds retained their own engineer who concluded that the plumbing leak did cause the foundation damage.³⁶

The court first emphasized that the mere erroneous denial of claim does not equate to bad faith.³⁷ Rather, "an insurer breaches its duty of

27. *Id.*

28. *Id.* at *21.

29. *Warren v. State Farm Mut. Auto. Ins. Co.*, No. 3:98-OV-0768, 2008 U.S. Dist. LEXIS 68646, at *9-15 (N.D. Tex. Aug. 29, 2008).

30. *Id.* at *2-3, *9-10.

31. *Id.* at *7-8, *10.

32. *Id.* at *13.

33. *Id.* at *14.

34. *Id.* at *12, *21.

35. 265 S.W.3d 725, 727, 729 (Tex. App.—Dallas 2008, pet. dismissed).

36. *Id.*

37. *Id.* at 734.

good faith and fair dealing when the insurer fails to settle a claim if the insurer knew or should have known that it was reasonably clear that the claim was covered.”³⁸ Even where the insurer’s coverage decision is based on an expert report, the insurer may still be liable for bad faith “‘if there is evidence that the report was not objectively prepared or the insurer’s reliance on the report was unreasonable.’”³⁹

In assessing the sufficiency of the evidence, the court noted that the jury was free to disbelieve the testimony offered by the insurer about the engineer’s independence and how the insurer did not track the outcomes of the engineer’s opinions.⁴⁰ Further, there was evidence that the engineer was on the insurer’s list of approved engineers, that more than fifty percent of the engineer’s business came from this insurer, that the insurer had retained the engineer on 1,440 claims and had paid him more than \$3 million over five years, and that the engineer had never testified against this insurer’s interests.⁴¹ To the extent that the engineer was not independent, it would have been reasonable for the jury to find that the engineer’s report was not objective and, therefore, that the insurer could not reasonably rely on the report.⁴² Additionally, the jury may have found that the report contained conflicts, did not state adequate grounds for its conclusions, or failed to address alternative causes of the water damage.⁴³ As such, the jury could have determined that the insurer’s investigation or its reliance on the engineer’s report was not reasonable.⁴⁴ Viewing the evidence in the light most favorable to the insureds, the court concluded that the evidence was legally and factually sufficient to support the imposition of extra-contractual liability.⁴⁵

II. CONTRACTUAL LIABILITY

A. THE TEXAS SUPREME COURT REJECTS THE “WILKINSON EXCEPTION”

In *Ulico Casualty Co. v. Allied Pilots Ass’n*, the Texas Supreme Court addressed whether the doctrines of waiver and estoppel can be applied to expand the scope of a policy’s coverage.⁴⁶ The insured was sued a few days before the expiration of the claims-made liability policy but did not notify the insurer of the suit until after the policy had expired. Nevertheless, the insurer acknowledged the claim, told the insured the claim was being reviewed for coverage, and advised that no defense costs could be incurred or settlements made without the insurer’s consent. A few months later, the insurer issued a letter stating that the policy provided

38. *Id.*

39. *Id.* (quoting *State Farm Lloyds v. Nicolau*, 951 S.W.2d 444, 448 (Tex. 1997)).

40. *Id.* at 735.

41. *Id.*

42. *Id.*

43. *Id.* at 736-37.

44. *Id.* at 737.

45. *Id.*

46. 262 S.W.3d 773, 775 (Tex. 2008).

for defense costs but that the insurer was reserving its rights to deny coverage. Thirteen months later the insurer sent a letter to the insured agreeing to reimburse the insured for defense costs. At that point the insured had defended the suit and moved for summary judgment without any reports or further contact with the insurer and without obtaining the insurer's approval for actions or authorization to incur defense costs. After the underlying case was resolved in its favor, the insured sought reimbursement of \$635,000 in defense costs.⁴⁷

The insurer sued for a declaration of noncoverage. The trial court entered judgment for the insured based on jury findings that the insurer had waived, or was barred from asserting, the coverage defense of late notice.⁴⁸ The court of appeals affirmed, relying on the so-called "*Wilkinson* exception," which holds that "if an insurer assumes the insured's defense without obtaining a reservation of rights or a non-waiver agreement and with knowledge of the facts indicating noncoverage, all policy defenses, including those of noncoverage, are waived, or the insurer may be estopped from raising them."⁴⁹

Emphasizing that waiver and estoppel are distinct concepts, the supreme court explained that waiver is "the intentional relinquishment of a right actually known, or intentional conduct inconsistent with claiming that right," while estoppel "prevents one party from misleading another to the other's detriment or to the misleading party's own benefit."⁵⁰ The supreme court then identified the following problems with the *Wilkinson* decision: (1) it does not indicate whether it is based on waiver or estoppel, (2) there was no finding of prejudice against the insured, and (3) the court held that "an 'apparent' conflict of interest that 'might' arise sufficiently justified judicial rewriting of the insurance contract to include a risk not agreed to by the parties to the contract."⁵¹ The supreme court also disagreed with *Wilkinson's* suggestion that noncoverage is a right that can be waived:

An insurer's actions can result in it being estopped from refusing to make its insured whole for prejudice the insured suffers because the insurer assumed the insured's defense, but estoppel does not work to create a new insurance contract that covers a risk not agreed to by the contracting parties. Thus there is no "right" of noncoverage that is subject to being waived by the insurer, even by assumption of the insured's defense with knowledge of facts indicating noncoverage and without obtaining a valid reservation of rights or non-waiver agreement.⁵²

47. *Id.* at 776.

48. *Id.*

49. *Id.* at 776, 781 (quoting *Farmers Tex. County Mut. Ins. Co. v. Wilkinson*, 601 S.W.2d 520, 521-22 (Tex. Civ. App.—Austin 1980, writ ref'd n.r.e.)).

50. *Id.* at 778.

51. *Id.* at 781.

52. *Id.* at 781-82 (internal citations omitted).

After setting forth why the cases cited in *Wilkinson* do not support that case's conclusion, the supreme court addressed the justification typically given for the *Wilkinson* exception, that is, the "apparent conflict of interest that *might* arise when the insurer represents the insured in a lawsuit against the insured and simultaneously formulates its defense against the insured for noncoverage."⁵³ Rejecting this justification, the supreme court emphasized that while an insurer should be prevented from denying benefits where the insured has been actually prejudiced by the insurer's conduct, "the possibility that an apparent conflict of interest might arise under these circumstances is insufficient justification for judicially rewriting the parties' agreement."⁵⁴ The court explained that its application of estoppel in its prior *Tilley* decision turned on the fact that there was an undisclosed conflict of interest between the insurer and the insured that had actually prejudiced the insured.⁵⁵ Because the *Tilley* rule and the ethics rules governing attorneys clearly require the disclosure to the insured of any conflict of interest irrespective of the insurer's reservation of rights, insureds are adequately protected "without the necessity of remolding the doctrines of waiver and estoppel to create an anomaly in the law by judicially rewriting agreements between insurers and insureds."⁵⁶

The supreme court ultimately rejected the *Wilkinson* rule because it "would afford the insured more contractual coverage than the policy provided, even if the insurer provides a perfect defense at no cost to the insured and the insured suffers no prejudice."⁵⁷ Rather, the key inquiry is whether the insured was prejudiced by an undisclosed conflict of interest or other conduct on the part of the insurer.⁵⁸ The supreme court therefore adopted the following rule:

[I]f an insurer defends its insured when no coverage for the risk exists, the insurer's policy is not expanded to cover the risk simply because the insurer assumes control of the lawsuit defense. But, if the insurer's actions prejudice the insured, the lack of coverage does not preclude the insured from asserting an estoppel theory to recover for any damages it sustains because of the insurer's actions.⁵⁹

B. THE INSURABILITY OF PUNITIVE OR EXEMPLARY DAMAGES

In *Fairfield Insurance Co. v. Stephens Martin Paving, L.P.*, 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

53. *Id.* at 785 (quoting *Wilkinson*, 601 S.W.2d at 522).

54. *Id.*

55. *Id.* at 785-86 (citing *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552, 561 (Tex. 1973)).

56. *Id.* at 786.

57. *Id.*

58. *Id.* at 786-87.

59. *Id.* at 787.

because of gross negligence?”⁶⁰ The court adopted a two-part analysis for resolving this issue.⁶¹ First, the court determines whether the punitive damages are covered under the policy’s plain language.⁶² Second, if such coverage exists, the court decides if Texas public policy permits coverage, looking first to express statutory provisions.⁶³ In the absence of a legislative directive, the “general public policies of Texas” are considered.⁶⁴

In deciding whether to invalidate an insurance contract on public policy grounds, a court must weigh “Texas’ general policy favoring freedom of contract” against “the extent to which the agreement frustrates important public policy.”⁶⁵ This analysis considers the underlying purpose of exemplary damages, which is gleaned from the common law and legislative developments.⁶⁶ The recent legislative enactments show that the goal of such damages is punishment, as opposed to compensation or deterrence.⁶⁷ Viewed in this light, insurance may be permissible in the circumstance of an insured corporation or business which is paying exemplary damages due to the conduct of one employee, but the other employees and management were not aware of or involved in the conduct.⁶⁸ Conversely, extreme circumstances may warrant the invalidation of coverage to the extent that such coverage defeats the punitive purpose of exemplary damages.⁶⁹

Accordingly, responding to the certified question, the supreme court answered that Texas public policy does not prohibit coverage for exemplary damages in the context of workers’ compensation.⁷⁰ 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.”⁷¹ Consequently, while *Fairfield* provides some guidance regarding insurability of exemplary damages, this issue has not been finally resolved and will likely continue to be litigated.

For example, in *American International Specialty Lines Insurance Co. v. Res-Care Inc.*, the Fifth Circuit Court of Appeals applied the *Fairfield* two-step framework to hold that Texas public policy barred coverage for punitive damages under the circumstances of that case.⁷² The insured entity, which operated a group home for mentally disabled individuals, was

60. 246 S.W.3d 653, 654 (Tex. 2008).

61. *Id.* at 655.

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.* at 663-64.

66. *Id.* at 666.

67. *Id.*

68. *Id.* at 670.

69. *Id.*

70. *Id.*

71. *Id.*

72. 529 F.3d 649, 653 (5th Cir. 2008).

insured under a primary hospital professional liability and commercial general liability policy as well as a commercial umbrella policy. The umbrella policy excluded coverage for punitive or exemplary damages.⁷³ The insured was sued in a wrongful death and survival suit arising out of injuries to and the death of a patient with cerebral palsy on whom an employee at the home had poured bleach. The insured and the insurer entered into a non-waiver agreement which authorized the insurer to settle the underlying suit and then seek recoupment from the insured of any sums paid on uncovered claims. The underlying suit settled for \$9 million. In the subsequent coverage litigation, the district court allocated \$4 million to covered actual damages and \$5 million to uncovered punitive damages and entered judgment against the insured for \$5 million.⁷⁴

In analyzing whether the punitive damages were covered, the Fifth Circuit first considered the plain language of both policies. Because the umbrella policy specifically excluded coverage for punitive damages, the insurer could recover any amounts that it had paid under the umbrella policy for punitive damages.⁷⁵ However, because the primary policy was silent as to punitive damages, the court decided it was "prudent to presume" that punitive damages were covered under the primary policy.⁷⁶ Then examining legislative policy, the court explained that although the legislature had generally prohibited "health care providers" from obtaining insurance for punitive damages, the insured was an "Intermediate Care Facility for the Mentally Retarded," which was not included in the Insurance Code's definition of "health care providers."⁷⁷ The court determined that the legislature had not explicitly prohibited entities like the insured from purchasing punitive damages coverage.⁷⁸

In the absence of a legislative directive, the Fifth Circuit considered general public policy.⁷⁹ Analogizing its situation to the example given in *Fairfield*, the insured argued that insurance was permissible here because none of its officers, directors, or shareholders knew about or was involved in the conduct.⁸⁰ Rejecting this argument, the court emphasized that the *Fairfield* court had expressed concern about insuring punitive damages in situations of "'extreme and avoidable conduct that causes injury.'"⁸¹ The court found that this case presented such a situation based on the allegations that all of the defendants, including the entity, and not just a single employee, were grossly negligent, and that state reports from other facilities showed a pattern of poor conduct by the insured.⁸² The court deter-

73. *Id.* at 653-54.

74. *Id.* at 653-56.

75. *Id.* at 660-61.

76. *Id.* at 661.

77. *Id.* at 661-62.

78. *Id.* at 662.

79. *Id.*

80. *Id.* at 663.

81. *Id.* (quoting *Fairfield Ins. Co. v. Stephens Martin Paving, L.P.*, 246 S.W.3d 653, 670 (Tex. 2008)).

82. *Id.* at 663-64.

mined that the circumstances of the injury and death were “so extreme that the purposes of punishment and deterrence of conscious indifference outweigh the normally strong public policy of permitting the right to contract between insurer and insured.”⁸³ Accordingly, the court concluded that this case typified the situation recognized in *Fairfield* where public policy required that the insured pay the punitive damages itself rather than escaping punishment by shifting the burden to the insurer.⁸⁴

C. A LIABILITY INSURER’S ERRONEOUS DENIAL OF COVERAGE PROHIBITS IT FROM CHALLENGING THE REASONABLENESS OF THE INSURED’S SETTLEMENT

In *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.⁸⁵ 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 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.⁸⁶

The supreme court explained that its last occasion to address this issue was in *Employers Casualty Co. v. Block*,⁸⁷ 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.”⁸⁸ The supreme court acknowledged that the instant case differed from *Block* in several respects, including the forms of the settlements and the policy claims.⁸⁹ 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.⁹⁰ Second, *Block* involved an agreed judgment between the insured and the underlying claimant; conversely, *ATOFINA*, involved a settlement contract between the insured and the underlying claimants.⁹¹ Despite these distinctions, the supreme court determined that *Block* nevertheless governed because its rule was based on principles of waiver and estoppel and did not turn on the type of duty the insurer breached or the presence of a judgment.⁹² As such, the key inquiry is whether the

83. *Id.* at 664.

84. *Id.*

85. 51 Tex. Sup. Ct. J. 1018, 2008 Tex. LEXIS 575, at *27-37 (Tex. June 13, 2008).

86. *Id.* at *2-4, *29.

87. 744 S.W.2d 940 (Tex. 1988).

88. *ATOFINA*, 2008 Tex. LEXIS 575, at *27 (referencing *Block*, 744 S.W.2d at 943).

89. *Id.* at *27-29.

90. *Id.* at *29-30.

91. *Id.* at *30.

92. *Id.*

insurer received notice and could have participated in the settlement negotiations.⁹³ This inquiry is not altered by the particular source of the insurer's attack on the settlement amount, i.e., a policy provision versus the common law reasonableness requirement.⁹⁴ "Had [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."⁹⁵

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*,⁹⁶ 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 defendant's assignee."⁹⁷ Despite this holding in *Gandy*, the supreme court reasoned that *Block* nevertheless governed the instant case.⁹⁸ 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."⁹⁹ 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*."¹⁰⁰

Second, the supreme court explained that *Gandy's* reason for invalidating assignments was that they made it difficult to evaluate the merits of the underlying claim 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.¹⁰¹ The insurer's reasonableness challenge in *ATOFINA* did not implicate these issues because: (1) prohibiting such challenges does not prolong disputes, but rather shortens them, and (2) there was no risk of distorting motives because the insured had settled without knowing whether coverage would exist.¹⁰² 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."¹⁰³ In the absence of "relevant factual differences or *Gandy* concerns to dissuade us from following *Block*," the supreme court held that

93. *Id.*

94. *Id.* at *32.

95. *Id.* at *32-33.

96. 925 S.W.2d 696 (Tex. 1996).

97. *ATOFINA*, 2008 Tex. LEXIS 575, at *34-35 (quoting *Gandy*, 925 S.W.2d at 714).

98. *Id.* at *35.

99. *Id.*

100. *Id.*

101. *Id.* at *35-36.

102. *Id.* at *36-37.

103. *Id.* at *37.

the insurer's denial estopped it from contesting the reasonableness of the settlement and that the insurer was bound to pay the settlement.¹⁰⁴

D. THE DUTY TO DEFEND

1. *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 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.¹⁰⁵ The *GuideOne* 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 Texas Supreme Court had another opportunity to address this issue in *Zurich American Insurance Co. v. Nokia, Inc.*¹⁰⁶ The insurers sought consideration of extrinsic evidence in the form of briefs filed by the plaintiffs in the underlying suit.¹⁰⁷ The insured argued that the extrinsic evidence could not be considered because it went to the merits of the underlying case.¹⁰⁸ The supreme court initially explained that although some states have allowed exceptions to the eight-corners rule in limited circumstances, "Texas has not."¹⁰⁹ The supreme court further explained that in *GuideOne*, it "declined to recognize an exception to the eight-corners rule for 'overlapping' evidence that implicated both coverage and the merits of the claim."¹¹⁰ Furthermore, the court recognized that in *GuideOne* it had acknowledged that the Fifth Circuit has opined that if the supreme court were to recognize exceptions to the eight-corners rule, it would likely do so in cases "'when it is initially impossible to discern whether coverage is potentially implicated and when the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case.'"¹¹¹

104. *Id.*

105. 197 S.W.3d 305, 310 (Tex. 2006).

106. 268 S.W.3d 487, 497-98 (Tex. 2008).

107. *Id.* at 497.

108. *Id.* at 498.

109. *Id.* at 497.

110. *Id.*

111. *Id.* (quoting *GuideOne Elite Ins. Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305, 309 (Tex. 2006)) (quoting *Northfield Ins. Co. v. Loving Home Care Inc.*, 363 F.3d 523, 531 (5th Cir. 2004)).

The supreme court decided that it did not need to reach this issue, however, because the insured had alleged damages for bodily injury in the underlying suit.¹¹² Thus, according to the supreme court, this was not a situation where it was “initially impossible to determine whether coverage is potentially implicated”¹¹³ The supreme court then concluded that even if it were to recognize the *Northfield* exception to the eight-corners rule, “this case would not fit within its parameters. Accordingly, we decline to do so.”¹¹⁴

With the Texas Supreme Court again passing on the opportunity to resolve this issue, courts have continued to reach varying results when faced with extrinsic evidence, as demonstrated by three opinions issued during this Survey period by the United States District Court for the Southern District of Texas. First, in *Trinity Universal Insurance Co. v. Employers Mutual Casualty Co.*, the insurer sought to use extrinsic evidence to show that the insured was aware of the property damage to the underlying claimant’s building before the policy took effect and that coverage was therefore barred by the fortuity doctrine and the policy’s known loss exclusion.¹¹⁵ While acknowledging that the supreme court “has not iterated any exception to the eight-corners rule,” the Southern District did note the exception articulated by the Fifth Circuit in *Northfield*.¹¹⁶ The court, however, determined that the proffered extrinsic evidence did not fit within this “presumed narrow exception” for two reasons. First, the evidence the insurers sought to rely upon was produced by the insured during discovery in the underlying suit and obtained from the insured’s defense counsel.¹¹⁷ Under Texas law, “facts developed during [the] litigation of [an] underlying suit do not affect [the] duty to defend.”¹¹⁸ “Second, the timing and nature of the alleged property damage overlap[ped] at least in part with the merits of [the underlying] claims.”¹¹⁹ Consequently, the court concluded that the extrinsic evidence could not be considered and that, in the absence of any facts in the pleading suggesting that the insured was aware of any property damage before the effective date of the policy, the allegations potentially supported a covered claim, thereby triggering the duty to defend.¹²⁰

In *Willbros RPI, Inc. v. Continental Casualty Co.*, Willbros RPI, Inc. (Willbros) sought coverage as an additional insured under a policy in which it was not named as an additional insured but that did contain a blanket endorsement that provided additional insured coverage to any organization whom the named insured agreed to add as an insured.¹²¹

112. *Id.*

113. *Id.* at 498.

114. *Id.*

115. 586 F. Supp. 2d 718, 725-26 (S.D. Tex. 2008).

116. *Id.* at 726.

117. *Id.*

118. *Id.*

119. *Id.* at 726-28.

120. *Id.* at 728.

121. No. H-07-2479, 2008 U.S. Dist. LEXIS 99851, at *10-11 (S.D. Tex. Aug. 27, 2008).

Willbros argued that a master service agreement (MSA) it had with the named insured allowed it to acquire status as an additional insured because the MSA required that Willbros and its successors be added as an additional insured under all liability policies.¹²² The insurer argued that the MSA was outside the eight-corners rule and could not be considered.

The Southern District explained that while the insurer correctly argued that reference to the usual documents (the pleading and the policy) could not alone determine coverage here, the insurer's "contention that Texas forbids extrinsic evidence does not reflect current Texas law."¹²³ The court characterized *GuideOne* as "recogniz[ing] a narrow exception to the eight corners rule" stated by the Fifth Circuit in *Northfield*.¹²⁴ The court reasoned that consideration of the MSA "fit[] neatly within this exception" because: (1) a coverage determination was "initially impossible" by only reference to the policy and the pleading, (2) use of the MSA addressed the "fundamental issue of coverage" regarding whether Willbros qualified as an insured, and (3) no danger existed for overlapping or "questioning the truth or falsity of the facts alleged" in the underlying suit.¹²⁵

The court further reasoned that even without use of the *Northfield* exception, consideration of the MSA was justified because the policy permitted and required the parties to "go beyond its four corners to determine whether [Willbros qualified as] an additional insured."¹²⁶ Stated differently, incorporation of a "blanket endorsement 'effectively incorporates' any written agreement under which [the named insured] agreed to add a person or organization as an insured."¹²⁷ The court therefore concluded that it would consider the MSA "both [for] extrinsic evidence, for which an exception applies, and as part of the [policy] itself."¹²⁸

Lastly, in *Insurance Corp. of Hannover v. Skanska USA Building, Inc.*, the Southern District stated that the *GuideOne* court "appeared to approve of the [*Northfield*] exception, but made no ruling explicitly recognizing the exception as such a holding was not necessary to resolve the issues before the court."¹²⁹ The policy at issue excluded coverage for work performed by the insured related to the construction of condominiums. The insureds submitted extrinsic evidence in the form of affidavits averring that the buildings included in the project did not contain condominiums.¹³⁰ The court reasoned that the extrinsic evidence regarding the type of buildings involved did not address the merits of the underlying claims regarding whether actual damage to the buildings occurred, but

122. *Id.* at *11.

123. *Id.* at *11-12.

124. *Id.* at *12-13.

125. *Id.* at *13.

126. *Id.*

127. *Id.*

128. *Id.*

129. No. B-05-304, 2008 U.S. Dist. LEXIS 51520, at *13 (S.D. Tex. July 3, 2008).

130. *Id.* at *18-20.

instead “went to the fundamental issue of coverage,” specifically “whether the damage[s] alleged [fell] within the coverage of the policy.”¹³¹ The court therefore concluded that under *Northfield*, it could review the affidavits to the extent they provided evidence on the fundamental coverage issue.¹³²

E. COMMERCIAL GENERAL LIABILITY (CGL) POLICIES

1. *The Texas Supreme Court Adopts the “Actual Injury” Rule to Determine When Property Damage “Occurs”*

In *Don’s Building Supply, Inc. v. OneBeacon Insurance Co.*, the Texas Supreme Court, answering certified questions from the Fifth Circuit Court of Appeals, resolved a split among Texas courts by adopting the “actual injury” rule to determine when property damage “occurs” under an occurrence-based commercial general liability (CGL) policy, stating that “the key date is when injury happens, not when someone happens upon it.”¹³³

The insured sought coverage for several lawsuits filed against it by homeowners claiming damage to their homes due to defective Exterior Insulation and Finish Systems (EIFS) sold by the insured. The homeowners alleged that the defective EIFS allowed moisture to seep into wall cavities behind the siding and caused wood rot and other damages. The homeowners asserted that the damage began at the time of the first water penetration, but pled the discovery rule seeking to avoid the statutes of limitations and argued that the damage was hidden from view and not discoverable or readily apparent until after the policy period ended.¹³⁴ In the insurer’s declaratory judgment action, the district court ruled that the duty to defend does not arise until the damage becomes identifiable.¹³⁵ On appeal, the Fifth Circuit certified the following coverage trigger-date questions to the Texas Supreme Court:

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?

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

131. *Id.* at *21.

132. *Id.*

133. 267 S.W.3d 20, 22, 24 (Tex. 2008).

134. *Id.* at 22-23.

135. *Id.* at 23

because the internal damage was hidden from view by an undamaged exterior surface?¹³⁶

Focusing on the plain meaning of the policy provisions, the supreme court held the property damage occurred when actual physical damage to the property occurred.¹³⁷ “The policy says as much, defining property damage as ‘[p]hysical injury to tangible property,’ and explicitly stating that coverage is available if and only if ‘property damage’ occurs during the policy period.”¹³⁸ As applied to the instant case, property damage occurred when a home suffered “wood rot or other physical damage”; the date that the insured could or would have discovered the physical damage is irrelevant under the policy.¹³⁹

In reaching this holding, the supreme court noted that the issue of when property damage occurs had not been uniformly resolved, resulting in courts adopting varying approaches.¹⁴⁰ Many courts agreed that the actual injury or “injury-in-fact” approach should apply,¹⁴¹ while others, including several Texas appellate courts, adopted the “manifestation rule[, which] imposes a duty to defend only if the property damage became evident or discoverable during the policy term.”¹⁴² Other courts adopted the “exposure rule,” which provides that coverage is triggered “if the plaintiff is exposed to whatever agent ultimately results in personal injury or property damage during the policy period.”¹⁴³ Still other courts adopted varying approaches, including multiple trigger rules or rules that examined the allegations of the date of the alleged negligent conduct rather than the date of actual injury.¹⁴⁴

Noting that it was again being asked “to construe a widely used CGL policy where ‘unfortunately there is no consensus on the policy’s meaning under the circumstances posed here,’” the supreme court explained its reasoning for rejecting the other approaches and adopting the actual injury rule.¹⁴⁵ Notably, the policy language itself made no provision for the manifestation or exposure rules given the straightforward wording of the policy providing coverage if the property damage “‘occurs during the policy period’” and defining property damage as “‘[p]hysical injury to tangible property.’”¹⁴⁶

The supreme court ultimately reasoned that the policy “asks when damage happened, not whether it was manifest, patent, visible, apparent, obvious, perceptible, discovered, discoverable, capable of detection, or

136. *Id.* at 23, 30-31.

137. *Id.* at 24.

138. *Id.*

139. *Id.*

140. *Id.* at 24-25.

141. *Id.* at 25.

142. *Id.* at 25-26.

143. *Id.* at 27-28.

144. *Id.* at 28.

145. *Id.* at 28-30.

146. *Id.* at 28-29.

anything similar.”¹⁴⁷ Furthermore, “[o]ccurred means when *damage* occurred, not when *discovery* occurred.”¹⁴⁸ The supreme court, however, did acknowledge that the duty to defend is driven by the policy language itself, and given the language varies from policy to policy, it was not adopting a universal rule “for determining when an insurer’s duty to defend a claim is triggered.”¹⁴⁹

Turning to the second certified question, and in light of its answer to the first certified question, the supreme court recognized that under the actual injury rule, a plaintiff’s claim that an insured’s allegedly defective product caused actual physical damage to tangible property would trigger the insurer’s duty to defend.¹⁵⁰ The supreme court continued, “[t]his duty is not diminished because the property damage was undiscoverable, or not readily apparent or ‘manifest,’ until after the policy period ended. Nor does it depend on . . . a valid limitations defense. The parties could have conditioned coverage on identifiability, but the contract imposes no such limitation.”¹⁵¹

2. *Whether Claims for Biological Injuries or Effects from Radiation from Wireless Phones Allege “Damages Because of Bodily Injury” Under a CGL Policy*

In *Zurich American Insurance Co. v. Nokia, Inc.*, the insured wireless telephone manufacturer was sued in a number of class actions in which claimants alleged that wireless phones emitted radio frequency radiation (RFR) that caused “biological injury.”¹⁵² The insured tendered the defense to its CGL carrier, which agreed to defend the suits under a reservation of rights. In the insurers’ declaratory judgment action, the trial court granted the insurer’s motion for summary judgment. The court of appeals reversed with respect to all of the underlying claims except one, holding that the claimants had alleged “bodily injury” and sought “damages because of bodily injury” as required under the CGL policy.¹⁵³ The court of appeals affirmed that the insurer did not have a duty to defend one underlying claim that had disclaimed personal injuries and sought only economic damages and equitable relief.¹⁵⁴

The policy language required the insurer to pay all sums which the insured became legally obligated to pay “‘as damages because of . . . bodily injury’” and defined bodily injury as “‘bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.’”¹⁵⁵ The supreme court, therefore, had to determine if “biological

147. *Id.* at 30.

148. *Id.*

149. *Id.*

150. *Id.* at 31.

151. *Id.* at 31-32.

152. 268 S.W.3d 487, 488-89 (Tex. 2008).

153. *Id.* at 488-90.

154. *Id.* at 490.

155. *Id.* at 491.

injury” or “biological effects” qualified as “bodily injury,” which “requires an injury to the physical structure of the human body.”¹⁵⁶

In the underlying complaints, plaintiffs alleged they “were exposed to RFR from their phones and thus subjected to ‘RFR’s biological effects and the risk to human health arising [from RFR].’”¹⁵⁷ Relying upon dictionary definitions and similar decisions from the Fourth and Ninth Circuits, the court of appeals concluded that the plaintiffs had sufficiently alleged “bodily injury” under the policies.¹⁵⁸ Agreeing with that analysis, the supreme court concluded that “the biological injuries alleged by the plaintiffs potentially state a claim for bodily injuries under the policies, much like the subclinical injuries alleged by plaintiffs who have been exposed to asbestos.”¹⁵⁹

Having resolved the “bodily injury” issue, the supreme court turned to whether the plaintiffs sought “damages.”¹⁶⁰ The insurers argued that the plaintiffs sought only headsets, and not damages, thereby removing the claims from coverage, whereas the insured argued that the plaintiffs sought damages including, but not limited to, the headsets.¹⁶¹ Agreeing with the insured, the supreme court reasoned that plaintiffs asserted that they had been injured and sought damages based on their physical exposure to radiation in addition to compensation for the cost of the headsets.¹⁶² The supreme court therefore concluded that the underlying cases sought “damages.”¹⁶³

Lastly, the supreme court addressed the policy’s requirement that the damages be “because of” bodily injury.¹⁶⁴ The insurers argued that including future purchasers in the putative class negated the duty to defend because it was impossible for those future purchasers to have suffered damages due to bodily injury.¹⁶⁵ Stating that the insurers’ argument misconstrued the nature of the duty to defend, the court explained that the duty to defend is triggered by the inclusion of potentially covered claims and not negated by the inclusion of uncovered claims.¹⁶⁶

156. *Id.* at 492 (quoting *Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 823 (Tex. 1997)).

157. *Id.*

158. *Id.* at 492-93.

159. *Id.* at 493.

160. *Id.*

161. *Id.* at 493-94.

162. *Id.* at 494.

163. *Id.* at 494-95.

164. *Id.* at 495-96.

165. *Id.* at 495.

166. *Id.* at 495-96. On the same day the *Zurich* decision was handed down, the Texas Supreme Court issued two additional opinions addressing other insurers’ obligations with respect to the same underlying cases at issue in *Zurich*, concluding that *Zurich* was dispositive and required the other insurers to defend those cases. *Trinity Universal Ins. Co. v. Cellular One Group*, 268 S.W.3d 505, 505 (Tex. 2008); *Fed. Ins. Co. v. Samsung Elecs. Am.*, 268 S.W.3d 506, 506 (Tex. 2008).

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 whether a liability policy purchased to secure the insured's indemnity obligation in a service contract with a third party also provided direct liability coverage for the third party.¹⁶⁷ 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 contract, 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 showing ATOFINA as an additional insured.¹⁶⁸ A Triple S employee who was working at the ATOFINA facility pursuant to 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 Evanston Insurance Company's (Evanston) umbrella policy. Evanston denied coverage on the ground that the loss was caused by ATOFINA's negligence.¹⁶⁹

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.¹⁷⁰ 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."¹⁷¹ Evanston argued that this language did not provide coverage to an additional insured for its own negligence, that because the employee's

167. 51 Tex. Sup. Ct. J. 1018, 2008 Tex. LEXIS 575, at *1 (Tex. June 13, 2008).

168. *Id.* at *2-3.

169. *Id.* at *4.

170. *Id.* at *6.

171. *Id.* at *7.

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.¹⁷²

The supreme court noted that the courts of appeals had reached divergent results in addressing such additional insured provisions, with some adopting a fault-based interpretation where an insurer must defend only if the insured's wrongful act during the operation caused the injury.¹⁷³ Conversely, other courts have adopted a more liberal causation theory, finding that the loss could be "with respect to liability arising out of" the named insured's operations, and therefore covered, notwithstanding allegations that the additional insured acted negligently.¹⁷⁴ 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.¹⁷⁵

Applying these principles, the 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.¹⁷⁶ Accordingly, the 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.¹⁷⁷

III. INSURERS' USE OF "CAPTIVE COUNSEL" TO DEFEND INSURED

In *Unauthorized Practice of Law Committee v. American Home Assurance Co.*, the Texas Supreme Court addressed whether it is proper for a liability insurer to use its "captive counsel" to defend an insured and

172. *Id.* at *7-8.

173. *Id.* at *8 (citing *Granite Constr. Co. v. Bituminous Ins. Cos.*, 832 S.W.2d 427, 428 (Tex. App.—Amarillo 1992, no writ) (determining that the claim did not "aris[e] out of operations performed" by the insured because only the additional insured company was responsible for the injury)).

174. *Id.* at *10-11 (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)).

175. *Id.* at *12.

176. *Id.* at *15-16.

177. *Id.* at *16.

whether such practice constitutes the unauthorized practice of law.¹⁷⁸ The supreme court explained that liability insurance policies commonly require that an insurer indemnify its insured from liability for covered claims, and that the insurer has the duty and the right to defend such claims, which, in turn, gives the insurer exclusive control over the defense.¹⁷⁹ An insurer will usually retain an attorney in private practice to represent its insured against such claims. However, for decades insurers have also used staff attorneys, i.e., salaried employees of the insurer, to assist in the defense.¹⁸⁰

Furthermore, the supreme court explained that a corporation may employ in-house attorneys to represent its own interests, but that the in-house attorneys cannot engage in the practice of law by providing legal representation or advice to others with dissimilar interests.¹⁸¹ Because an insurer faces potential indemnity obligations, it has a direct and substantial financial interest in defending the claims against its insured.¹⁸² Although the insurer's and the insured's interests are often aligned toward defeating the plaintiff's claims, the insurer's and the insured's interests can diverge, e.g., when the insured submits a noncovered or partially-covered claim under the policy.¹⁸³ The propriety of the insurer's use of staff attorneys turns on whether the insurer "is representing its own interests, which is permitted, or engaging in the unauthorized practice of law, which is not."¹⁸⁴ Noting that several other states permit the use of staff attorneys, the supreme court held that an insurer "may use staff attorneys to defend a claim against its insured if the insurer's interest and the insured's interest are congruent, but not otherwise."¹⁸⁵ Congruent interests exist when there are no conflicts of interest and the insured and insurer are aligned in defeating the claims against the insured.¹⁸⁶ The supreme court further held that a staff attorney must fully disclose his or her affiliation with the insurer to the insured.¹⁸⁷

In reaching this holding, the supreme court noted that whether the claim is covered and within the policy limits is the most common conflict between an insurer and an insured.¹⁸⁸ When a coverage issue exists, the insurer usually issues a reservation of rights letter, agreeing to defend the insured without waiving its right to later deny coverage.¹⁸⁹ The supreme court emphasized that a reservation of rights letter, by itself, does not ordinarily create a conflict of interest between the insurer and the in-

178. 261 S.W.3d 24, 26 (Tex. 2008).

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

184. *Id.*

185. *Id.* at 26-27.

186. *Id.* at 27.

187. *Id.*

188. *Id.* at 42-43.

189. *Id.* at 43.

sured, but rather simply recognizes the possibility that such a conflict may arise in the future.¹⁹⁰ Therefore, while instructing that “[d]eclining representation is the safer course,” the supreme court decided it “cannot say as a blanket rule that a staff attorney can never represent an insured under a routine reservation of rights.”¹⁹¹

IV. INSURER’S RIGHT OF REIMBURSEMENT FROM A CO-INSURER

The United States District Court for the Southern District of Texas extended the Texas Supreme Court’s decision in *Mid-Continent Insurance Co. v. Liberty Mutual Insurance Co.*¹⁹² to the duty to defend, holding that *Mid-Continent* barred an insurer’s claim for reimbursement from a co-insurer of amounts the insurer incurred to defend their common insured when the co-insurer wrongfully refused to contribute to the defense.¹⁹³ First addressing the insurer’s contribution claim, the Southern District explained that when seeking contribution, a party must show that it has made a compulsory payment or other discharge of its fair share of the several insurers’ common obligation or burden.¹⁹⁴

Like the policies in *Mid-Continent*, the policies here contained “other insurance” or “pro rata” clauses which provided that the insurers’ respective “obligations [were limited] to an equal share of a covered loss, or a proportion of such loss based on a ratio of the limit of insurance under the policy to the total limits of coverage under all policies.”¹⁹⁵ Pursuant to *Mid-Continent*, these clauses render the contractual obligations of [the respective insurers] “several and independent of each other, not joint.”¹⁹⁶ The court determined that the “independence of these contractual obligations affects not only the duty to indemnify, as discussed in *Mid-Continent*, but necessarily applies with equal force to the duty to defend.”¹⁹⁷ The court, therefore, concluded that by including the “other insurance” clauses, the policies defeated the paying insurer’s contribution claim because the otherwise shared contractual obligations, including the duty to defend, became independent duties that could be enforced only by the insured.¹⁹⁸ Accordingly, the court ruled that the non-paying insurer was entitled to summary judgment on the paying insurer’s contribution claim.¹⁹⁹

190. *Id.*

191. *Id.* at 44; *see also* *Unauthorized Practice of Law Comm. v. Nationwide Mut. Ins. Co.*, 264 S.W.3d 742, 743 (Tex. 2008).

192. 236 S.W.3d 765 (Tex. 2007).

193. *Trinity Universal Ins. Co. v. Employers Mut. Cas. Co.*, 586 F. Supp. 2d 718, 728-30 (S.D. Tex. 2008).

194. *Id.* at 729.

195. *Id.* at 729-30.

196. *Id.* at 730.

197. *Id.*

198. *Id.*

199. *Id.*

Turning to the insurer's subrogation claim, the court explained that its holding from *Mid-Continent* "forecloses contractual and equitable subrogation claims between co-insurers when the insured has been fully compensated" based on "the principle that an insured cannot obtain more than a single recovery for any loss, and that an insurer asserting rights in subrogation stands in the shoes of its insured."²⁰⁰ An impermissible double recovery would therefore result if the court allowed an insured to recover a portion of the costs paid by another insurer.²⁰¹ The court reasoned that the insured had not incurred any loss, notwithstanding the non-paying insurer's breach of the duty to defend, because the paying insurer had borne all costs associated with the insured's defense.²⁰² The court therefore concluded that under *Mid-Continent*, if the insured incurred no loss, the paying insurer's subrogation claim is precluded.²⁰³

200. *Id.* at 730-31.

201. *Id.* at 731.

202. *Id.*

203. *Id.*; see also *Lexington Ins. Co. v. Chicago Ins. Co.*, No. H-06-1741, 2008 U.S. Dist. LEXIS 60629 (S.D. Tex. Aug. 8, 2008) (applying *Mid-Continent* to bar insurer's contribution and subrogation claims against co-insurer).