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INSURANCE LAW

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I. INSURER'S RIGHT OF REIMBURSEMENT

IN probably the most anticipated insurance decision of this Survey period, *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.*, the Texas Supreme Court revisited the issue of whether an insurer is entitled to reimbursement from its insured for amounts it paid to settle third-party claims against the insured when it is subsequently determined that those claims are not covered.[1] The court first addressed this issue in 2000 in *Matagorda County*, holding that "when coverage is disputed and the insurer is presented with a reasonable settlement demand within policy limits, the insurer may fund the settlement and seek reimbursement only if it obtains the insured's clear and unequivocal consent to the settlement and the insurer's right to seek reimbursement."[2]

While not expressly overruling *Matagorda County*, the *Frank's Casing* decision clearly expanded the insurer's right of reimbursement:

> To the extent *Matagorda County* indicated that the *only* circumstances under which an insurer may obtain reimbursement from an insured for settlement payments when there is no coverage is when there is an express agreement that there is a right to seek reimbursement, we clarify that there are additional circumstances that will give rise to a right of reimbursement.[3]

Such additional circumstances include: (1) when an insured has demanded that its insurer accept a settlement offer that is within policy limits, or (2) when an insured expressly agrees that the settlement offer should be accepted. In these situations, the insurer is entitled to reimbursement "if it has timely asserted its reservation of rights, notified the insured it intends to seek reimbursement, and paid to settle claims that were not covered."[4]

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1. No. 02-0730, 2005 Tex. LEXIS 418, at *1 (Tex. May 27, 2005).
2. Tex. Ass'n of Counties County Gov't Risk Mgmt. Pool v. Matagorda County, 52 S.W.3d 128, 135 (Tex. 2000).
3. *Frank's Casing*, 2005 Tex. LEXIS 418, at *23-24 (emphasis in original).
4. *Id.* at *11.

As the basis for its determination, the court explained that "once an insured asserts that a settlement offer has triggered a *Stowers* duty, and the insurer then accepts that settlement offer or a lower one, the insured is estopped from asserting that the settlement is too financially burdensome for the insured to bear if it turns out the claims are not covered."[5] This is because the reasonableness of a settlement offer is judged objectively by an assessment of the insured's potential liability, not by whether the insured has assets to pay a judgment or whether the limits of insurance coverage greatly exceed the potential damages for which the insured may be liable.[6] As the court explained, "When there is a coverage dispute and an insured demands that its insurer accept a settlement offer within policy limits, the insured is deemed to have viewed the settlement offer as a reasonable one. If the offer is one that a reasonable insurer should accept, it is one that a reasonable insured should accept if there is no coverage."[7]

The court emphasized that insurance coverage should not be created merely because an insured could not afford to pay a judgment or fund a settlement demand. Rather, the insurer should be entitled to settle with the injured third party for an amount that the insured has agreed is reasonable and to seek recoupment from the insured if the claims were not covered. This does not affect the position of the insured, as it is in the same situation that it would have been in without insurance. The only difference is that the insured now owes money to the insurer rather than the injured third party. Therefore, requiring an insured to reimburse its insurer for settlement payments if it is later determined that there was no coverage does not prejudice the insured.[8] The court determined that, under these circumstances, an agreement to reimburse the insurer is implied in law and quasi-contractual.[9] Consequently, the court concluded that the insurers were entitled to reimbursement and remanded the case to the trial court to enter judgment in favor of the insurers.[10]

Notably, only three of the justices who were on the court when *Matagorda County* was decided remained on the court when *Frank's Casing* was decided—Justice Owen, Justice Hecht, and Justice O'Neill. The majority opinion was authored by Justice Owen, who has since left the court to assume her appointment to the Fifth Circuit Court of Appeals. Four justices joined in the majority opinion in its entirety, two justices joined in parts, and two justices did not participate in the decision. Three justices also filed concurring opinions, but no dissenting opinions were filed.[11] In his concurring opinion, Justice Hecht stated that while distinctions could

5. *Id.* at *12 (citing G.A. Stowers Furniture Co. v. Am. Indem. Co., 15 S.W.2d 544 (Tex. Comm'n App. 1929, holdings approved)).
6. *Id.* at *12-13.
7. *Id.* at *14.
8. *Id.* at *14-15.
9. *Id.* at *19.
10. *Id.* at *28.
11. *Id.* at *1.

be made between this case and *Matagorda County*, those distinctions were immaterial, and "the rule in *Matagorda County* cannot survive today's decision for the reasons *Matagorda County* was wrongly decided."[12] However, the majority opinion does not go so far as overruling *Matagorda County*; it merely "clarif[ies]" *Matagorda County*.[13]

Regardless of how the holding is classified, this decision represents a significant shift in the court's views concerning, and a clear expansion of, an insurer's right to reimbursement. The court has granted rehearing, so the case is still pending before the supreme court. Given the importance of this issue to both insurers and insureds and the continuing changes in the court's makeup, this case is certainly one to keep watching.

The ultimate decision in *Frank's Casing* will likely influence litigation on a related issue—whether an insurer is entitled to reimbursement from the insured of costs paid to defend the insured if it is determined that the insurer had no duty to defend the underlying action. While this issue was hinted at by Justice Owen and Justice Hecht in their dissent in *Matagorda County*,[14] it was not addressed by the Texas Supreme Court in either *Matagorda County* or *Frank's Casing* and has not been squarely decided by any Texas court. However, a federal district court in another jurisdiction has relied on *Frank's Casing* and "suggest[ions]" in the court of appeals' decision in *Matagorda County*[15] to conclude that the Texas Supreme Court would apply the doctrine of quantum meruit and would permit reimbursement of defense costs if the insurer reserves its rights and notifies the insured of its intent to seek reimbursement in the event that it is later determined that there was no duty to defend.[16]

II. EXTRACONTRACTUAL LIABILITY

A. ARTICLE 21.55[17]

1. When an Insurer Tenders Partial Payment on a Disputed Claim, It Avoids the Article 21.55 Penalty on the Paid Amount

In *Republic Underwriters Insurance Co. v. Mex-Tex, Inc.*, the Texas Supreme Court addressed whether an insurer's partial payment of the claim avoided, on that amount, the 18% per annum penalty imposed by Article 21.55.[18] Mex-Tex, Inc. submitted a claim to its commercial property insurer, Republic Underwriters Insurance Company, for hail damage to the

12. *Id.* at *28 (Hecht, J., concurring).
13. *Id.* at *24.
14. *Matagorda County*, 52 S.W.3d at 140-41 (Owen, J., dissenting, joined by Hecht, J.).
15. Matagorda County v. Tex. Ass'n of Counties County Gov't Risk Mgmt. Pool, 975 S.W.2d 782, 784-85 (Tex. App.—Corpus Christi 1998), *aff'd*, 52 S.W.3d 128 (Tex. 2000).
16. St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp., 377 F. Supp. 2d 719, 722-25 (D. Minn. 2005).
17. TEX. INS. CODE ANN. art. 21.55 (Vernon 1991). Effective April 1, 2005, Article 21.55 was repealed and recodified, without any substantive change, as Subchapter B of Chapter 542 of the Texas Insurance Code, entitled "Prompt Payment of Claims." TEX. INS. CODE ANN. §§ 542.051-.061 (Vernon 2005).
18. 150 S.W.3d 423 (Tex. 2004).

roof of a shopping center that it owned. Mex-Tex retained a contractor to replace the roof at a cost of $179,000. Republic sent Mex-Tex a check for $145,460, the amount that Republic's engineer determined was the cost of replacing the roof with an identical one. After twice rejecting the check, Mex-Tex accepted the check as partial payment of its claim and then sued Republic for breach of the policy. The trial court awarded Mex-Tex the difference of $33,540, along with an 18% penalty on the entire $179,000 from seventy-five days after Republic tendered the partial payment to the date Mex-Tex accepted the partial payment, and on the $33,540 difference from the date of the partial payment to the date of judgment. The court of appeals affirmed.[19]

In reversing the judgment, the supreme court explained that Article 21.55 defines a "claim" as a first-party claim made by an insured "that must be paid by the insurer directly to the insured."[20] This definition limits a claim to the amount ultimately determined to be owed, which would exclude any partial payments that the insurer made before that determination. The insurer's partial payment, however, cannot be conditioned on a release of the entire claim. This approach encourages insurers to pay the undisputed portion of a claim early, which is consistent with the statute's purpose of obtaining prompt payment of claims.[21] Applying this reasoning, the court concluded that Mex-Tex was entitled to the penalty only on the $33,540 difference from seventy-five days after the partial payment to the date of the judgment.[22]

2. *Whether Article 21.55 Applies to a Claim for Defense Costs under a Liability Policy*

An ongoing issue of debate in Texas is whether Article 21.55 applies to an insured's claim for a defense under a liability policy. Federal district courts in Texas have generally held that an insured's demand for a defense is a first-party claim that is subject to Article 21.55 and continued to do so during this Survey period.[23] However, the San Antonio Court of Appeals concluded that Article 21.55 does not apply to claims for defense costs because such claims are not first-party claims as that term is used in Article 21.55.[24] In reaching this conclusion, the court stated that it agreed with the rationale enunciated by the Dallas Court of Appeals—that a request for a defense is not a first-party claim for money to be paid directly to the insured, that damages for refusing to defend are breach of contract damages not subject to Article 21.55, and that the structure of Article 21.55 makes it unworkable when applied to an insured's demand for a

19. *Id.* at 424-25.
20. *Id.* at 426 n.8 (quoting TEX. INS. CODE ANN. art. 21.55, § 1(3) (Vernon 1991)).
21. *Id.* at 426.
22. *Id.* at 427-28.
23. Rx.com Inc. v. Hartford Fire Ins. Co., 364 F. Supp. 2d 609, 620 (S.D. Tex. 2005).
24. Service Lloyd's Ins. Co. v. J.C. Wink, Inc., 182 S.W.3d 19, 34 (Tex. App.—San Antonio 2005, pet. filed).

defense.[25] These decisions are essentially irreconcilable, and thus, there exists a split in authority on this issue between the federal district courts and the state appellate courts. To date, the Texas Supreme Court has declined to resolve the issue.

The Fifth Circuit also weighed in on this issue, explaining that under Article 21.55, "a first-party claim is an immediate direct diminution of the insured's assets, in contrast to a third-party claim, which goes through the first-party as a conduit."[26] The court determined that a claim for defense costs by the assignee of the insured was not a first-party claim for damage suffered directly by the insured and that the assignee was not the holder of the policy or a named beneficiary. The court therefore concluded that Article 21.55 did not apply to the claim.[27] In a subsequent opinion, however, the Fifth Circuit recognized the split in authority and certified the following issue to the Texas Supreme Court: "[D]oes Article 21.55 of the Texas Insurance Code apply to a CGL insurer's breach of the duty to defend?"[28] Although the supreme court has accepted the case, it will most likely address the question only if it first determines that the insurer breached the duty to defend. Thus, there is a chance that this issue will remain unresolved, in which case the conflict between federal and state courts will likely continue.

B. ARTICLE 21.21[29]

1. Article 21.21 Does Not Apply to Sureties

The Texas Supreme Court addressed whether Article 21.21 applied to a dispute over commissions to be paid under an agreement between an insurer and an agency, which provided that the agency would issue surety, performance, and bid bonds on behalf of the insurer.[30] Article 21.21 provides a private cause of action for unfair or deceptive acts or practices "in the business of insurance."[31] The court previously held that the term "the business of insurance," as used in Article 21.21, does not include suretyship.[32] The court of appeals read this prior decision narrowly as applying only to disputes between sureties and their bondholders, not between sureties and their sales agents. In rejecting the court of appeals' analysis,

25. *Id.* at 31 (citing TIG Ins. Co. v. Dallas Basketball, Ltd., 129 S.W.3d 232, 239-40 (Tex. App.—Dallas 2004, pet. denied)).

26. Singleentry.com, Inc. v. St. Paul Fire & Marine Ins. Co., 117 F. App'x 933, 938 (5th Cir. 2004).

27. *Id.*

28. Lamar Homes, Inc. v. Mid-Continent Cas. Co., 428 F.3d 193, 199-201 (5th Cir. 2005).

29. TEX. INS. CODE ANN. art. 21.21 (Vernon 1991). Effective April 1, 2005, Article 21.21 was repealed and recodified without any substantive change as Chapter 541 of the Texas Insurance Code, entitled "Unfair Methods of Competition and Unfair or Deceptive Acts or Practices." TEX. INS. CODE ANN. § 541.001 *et seq.* (Vernon 2005).

30. Dallas Fire Ins. Co. v. Tex. Contractors Sur. & Cas. Agency, 159 S.W.3d 895, 896 (Tex. 2004).

31. TEX. INS. CODE ANN. art. 21.21, § 16(a) (Vernon 2005).

32. Great Am. Ins. Co. v. N. Austin Util. Dist. No. 1, 908 S.W.2d 415, 424 (Tex. 1995).

the supreme court explained that its prior holding in *Great American* was not limited to parts of the business of suretyship and that by limiting the scope of Article 21.21 to "the business of insurance," the legislature "intended it to apply to a species of economic enterprise, not to particular contracts on a piecemeal basis."[33] Because the claims at issue arose in the business of suretyship, not the business of insurance, the supreme court concluded that Article 21.21 did not apply and therefore reversed the court of appeals' judgment.[34]

2. *Class Actions Brought by the Attorney General Must Comply with the Procedural Requirements of Article 21.21*

The Austin Court of Appeals addressed whether the Attorney General may maintain a class action under Article 21.21 without satisfying the Article's procedural requirements.[35] Section 17 of Article 21.21 authorizes the Attorney General, at the request of the Texas Department of Insurance, to institute a class-action suit to recover from an insurer damages for injuries done to the insurance-buying public.[36] Section 18 sets out the procedural requirements for class actions, specifically requiring the appointment of a class representative.[37] The Attorney General initiated a class action under Section 17 against Farmers Group, Inc. and its related insurance providers, alleging that Farmers failed to adequately disclose its rating practices and the use of credit scoring and that some of its rating practices were unfairly discriminatory. The Attorney General, however, did not appoint a class representative as required by Section 18. The trial court found that "strict compliance with Section 18 was unnecessary because the Attorney General was qualified through his capacity as *parens patriae* to adequately represent the interests of the potential class members without the appointment of a class representative."[38] Based on the language of the statute, the court determined that a class-action suit brought by the Attorney General should be treated the same as those brought by insurance purchasers. In other words, when the Attorney General brings a class-action suit under Section 17, he must comply with the procedural requirements in Section 18. The court therefore reversed the trial court's order certifying the class.[39]

33. *Dallas Fire Ins. Co.*, 159 S.W.3d at 896-97.
34. *Id.* at 897.
35. Lubin v. Farmers Group, Inc., 157 S.W.3d 113 (Tex. App.—Austin 2005, pet. filed).
36. *Id.* at 115 (citing TEX. INS. CODE ANN. art. 21.21, § 17(a) (Vernon 2005)).
37. *Id.* (citing TEX. INS. CODE ANN. art. 21.21, § 18 (Vernon 2005)).
38. *Id.* at 115-16.
39. *Id.* at 116, 124, 129.

C. The Duty of Good Faith and Fair Dealing

1. *A Federal District Court Held That a Claim for Indemnity under a D&O Policy Is a First-Party Claim Subject to the Duty of Good Faith and Fair Dealing*

In *Westcott Holdings, Inc. v. Monitor Liability Managers, Inc.*, the insured corporation sued its insurer for breach of contract and bad faith in failing to pay costs that it incurred in two underlying lawsuits under a directors' and officers' liability policy, which provided coverage for "wrongful acts" committed by the corporation's directors and officers to the extent that the corporation indemnified the directors and officers.[40] The court acknowledged that the Texas Supreme Court rejected application of the duty of good faith and fair dealing to third-party insurance cases.[41] Further, in a prior concurrence, four Texas Supreme Court justices had noted that many courts have imposed a duty of good faith in first-party, but not third-party, cases because "'an insurer's and an insured's interests are not aligned when the insured is claiming on his own behalf as they are or should be in third-party cases where insurer and insured face a common opponent.'"[42] Thus, the determination of whether a duty of good faith exists depends on whether the claim at issue is a third-party or a first-party claim. In this case, the court determined that the interests of the insured corporation and the insurer were not aligned. Before the insurer had any obligation under the policy to indemnify the insured corporation, the insured corporation had to first indemnify its directors and officers. Thus, the loss for which the insured sought recovery (the indemnification of its directors and officers) was its own, not that of a third party. Under these circumstances, the court found that there was no "adversarial relationship" between the insured and its directors and officers, as exists in cases in which a third party sues an insured.[43] Because the insurer's duty to pay ran directly to the insured and because the insurance protected the insured "against loss actually paid (the insured's own loss) rather than loss arising from liabilities (injuries to a third party)," the court concluded that the insurance coverage at issue was first party, thus making the insurer subject to a cause of action for bad faith.[44]

2. *An Insurer Who Denies Coverage Based on Reasonable Reliance on an Objectively Prepared Expert Report Is Not Liable for Bad Faith*

The Dallas Court of Appeals has reiterated that a bona fide dispute about the insurer's liability on an insurance contract does not rise to the

40. No. H-05-1945, 2005 U.S. Dist. LEXIS 20149, at *2-3 (S.D. Tex. 2005).
41. *Id.* at *18 (citing Md. Ins. Co. v. Head Indus. Coatings & Servs., Inc., 938 S.W.2d 27 (Tex. 1996)).
42. *Id.* at *22 (citing Universe Life Ins. Co. v. Giles, 950 S.W.2d 48, 60 (Tex. 1997)).
43. *Id.* at *23.
44. *Id.* at *23.

level of bad faith.[45] In this case, the insured homeowners alleged that the insurer hired a biased engineer to investigate their foundation problems and thus failed to reasonably investigate their claim for foundation repairs. The jury awarded contractual and extra-contractual damages to the homeowners, and the insurer appealed.[46]

Even though the court of appeals upheld the finding of breach of contract and the award of contractual damages, it concluded that the evidence was legally insufficient to support the finding of bad faith. The court explained that "the common-law duty of good faith and fair dealing is breached when an insurer denies or delays payment of a claim after its liability has become reasonably clear."[47] The court elaborated on what constitutes bad faith. First, there must be more evidence than just that of a bona fide coverage dispute. Second, the insurer must have done more than rely on an expert's report, unless it is shown that the report was not objectively prepared or that the insurer's reliance on the report was unreasonable.[48]

Considering the evidence in light of this standard, the court noted that, after receipt of the claim, the insurer immediately sent an adjuster and plumbers to the house to repair the leak and hired an engineer to assess the damages from the leak. Further, based on objective factors, such as elevation measurements, the home's history, and test results, along with four inspections of the house, the engineer concluded that the structure of the foundation had not been compromised by the leak. The court concluded that this evidence was sufficient to show that the engineer's report was objectively prepared and that the insurer's reliance on the report was reasonable. Emphasizing that "an insurer has the right to deny questionable claims without being subject to liability for the erroneous denial of a claim," the court reversed the finding of a breach of the duty of good faith and fair dealing.[49]

D. *Stowers* Duties Between Co-Primary Insurers

The Fifth Circuit addressed the obligations under *Stowers*[50] owed between two liability insurers with respect to a common insured.[51] Liberty Mutual Insurance Company and Mid-Continent Insurance Company both insured Kinsel Industries under respective $1 million comprehensive general liability ("CGL") policies. Both insurers defended Kinsel against a third-party claim. When the case ultimately settled for $1.5 million, Mid-Continent paid only $150,000. Liberty Mutual, which also had a $10 million umbrella excess policy covering Kinsel, paid the remaining $1.35

45. United Servs. Auto Ass'n v. Croft, 175 S.W.3d 457 (Tex. App.—Dallas 2005, pet. denied).
46. *Id.* at 462.
47. *Id.* at 469.
48. *Id.* at 469-70.
49. *Id.* at 469-71.
50. 15 S.W.2d 544 (Tex. Comm'n App. 1929, holdings approved).
51. Liberty Mut. Ins. Co. v. Mid-Continent Ins. Co., 405 F.3d 296 (5th Cir. 2005).

million. Both CGL policies included "other insurance" clauses, which provided for pro rata sharing up to policy limits. Both policies also contained "voluntary payment" and subrogation clauses. Based on these provisions, Liberty Mutual sued Mid-Continent for $600,000, the unpaid portion of Mid-Continent's pro rata share of the $1.5 million settlement.[52]

On appeal, Mid-Continent argued that, because it timely acknowledged policy coverage of and defended Kinsel, it was entitled to determine how much it would pay or offer to pay in settlement and owed no duty in that respect to Liberty Mutual. Mid-Continent claimed that its only duty was to indemnify Kinsel for an adverse judgment up to the policy limits and, under *Stowers*, to pay an excess judgment if its refusal of a settlement offer within policy limits was unreasonable. Mid-Continent asserted that because it did not breach any duty under its policy or *Stowers*, there were no claims to which Liberty Mutual could be subrogated.[53] After examining several appellate decisions, the Fifth Circuit concluded that there was no controlling Texas Supreme Court precedent addressing the duties owed between co-primary insurers under *Stowers*. Accordingly, the Fifth Circuit certified the following questions to the Texas Supreme Court:

> 1. Two insurers, providing the same insured applicable primary insurance liability coverage under policies with $1 million limits and standard provisions (one insurer also providing the insured coverage under a $10 million excess policy), cooperatively assume defense of the suit against their common insured, admitting coverage. The insurer also issuing the excess policy procures an offer to settle for the reasonable amount of $1.5 million and demands that the other insurer contribute its proportionate part of that settlement, but the other insurer, unreasonably valuing the case at no more than $300,000, contributes only $150,000, although it could contribute as much as $700,000 without exceeding its remaining available policy limits. As a result, the case settles (without an actual trial) for $1.5 million funded $1.35 million by the insurer which also issued the excess policy and $150,000 by the other insurer.
>
> In that situation is any actionable duty owed (directly or by subrogation to the insured's rights) to the insurer paying the $ 1.35 million by the underpaying insurer to reimburse the former respecting its payment of more than its proportionate part of the settlement?
>
> 2. If there is potentially such a duty, does it depend on the underpaying insurer having been negligent in its ultimate evaluation of the case as worth no more than $300,000, or does the duty depend on the underpaying insured's evaluation having been sufficiently wrongful to justify an action for breach of the duty of good faith and fair dealing for denial of a first party claim, or is the existence of the duty measured by some other standard?

52. *Id.* at 298-99.
53. *Id.* at 301-02.

3. If there is potentially such a duty, is it limited to a duty owed the overpaying insurer respecting the $ 350,000 it paid on the settlement under its excess policy?[54]

E. Severance or Bifurcation of Extra-Contractual Claims from Contractual Claims

In *In re Allstate Texas Lloyd's*, the insurer sought mandamus relief from the trial court's denial of its motion to sever the insured homeowners' extra-contractual claims of bad faith from their breach-of-contract claims.[55] The court of appeals explained that "insurance coverage claims and bad faith claims are, by their nature, independent claims . . . [and that] . . . an insured usually may not prevail on an extra-contractual claim without first proving the insurer breached the contract."[56] The court then provided examples of when severance would be proper, such as when the insurer has made a settlement offer on the disputed contract claim. In this case, following a pretrial mediation, the insurer had made an offer to the insureds to settle all the disputed breach-of-contract claims, which the insureds rejected. Based on this settlement offer, the court of appeals concluded that the trial court abused its discretion in denying the motion for severance and granted mandamus relief directing the trial court to grant the motion for severance.[57]

III. CONTRACTUAL LIABILITY

A. The Duty to Defend

1. The "Eight-Corners" Rule

The Fifth Circuit reiterated the standards to be applied in determining whether the allegations against the insured are sufficient to trigger the insurer's duty to defend.[58] In Texas, this determination is governed by the eight-corners rule, under which the four corners of the pleading are compared to the four corners of the insurance policy. For a duty to defend to exist, the pleadings, liberally interpreted and presumed true, must allege facts within the scope of coverage. If coverage exists for any part

54. *Id.* at 310, *amended by* 407 F.3d 683 (5th Cir. 2005) (clarifying that the settlement of the claims against Kinsel occurred before Mid-Continent's settlement of other claims pending against its named insured and that when it settled, the limits of the Mid-Continent policy had not been reduced and were still subject to the unresolved claims against the named insured).

55. No. 14-05-00762-CV, 2005 Tex. App. LEXIS 7333, at *1-2 (Tex. App.—Houston [14th Dist.] Sept. 2, 2005, orig. proceeding).

56. *Id.* at *3.

57. *Id.* at *3-11. *Cf. In re* Allstate Ins. Co., No. 06-05-00051-CV, 2005 Tex. App. LEXIS 3610, at *6-7 (Tex. App.—Texarkana May 12, 2005, orig. proceeding) (concluding that the trial court acted within its discretion in denying severance because the insurer provided no evidence of what specific settlement offers, if any, were actually tendered, what the nature of these offers were, or whether the insured rejected the offers, and that the parties would be adequately protected by simply bifurcating the contractual and extra-contractual issues into two trials before the same jury).

58. Allstate Ins. Co. v. Disability Servs. of the Sw. Inc., 400 F.3d 260 (5th Cir. 2005).

of a suit, the insurer must defend the entire suit. However, if a covered cause is related and interdependent to the excluded cause of injury, there is no duty to defend. Any doubt as to whether the allegations state a cause of action within coverage will be resolved in the insured's favor.[59]

The San Antonio Court of Appeals further emphasized that, although the eight-corners rule requires the court to give a liberal interpretation to the allegations, the court may not "read facts into the pleadings, look outside the pleadings, or imagine factual scenarios that might trigger coverage."[60] In that case, the insurer argued that no duty to defend existed because the petition alleged only that the plaintiffs had purchased used cars after October 1, 1993 and did not allege that the insured harmed the plaintiffs during the policy period of September 1997 to September 2000. In rejecting this argument, the court explained that, while the petition did not give specific dates for the disputed transactions, it did allege that all the sales occurred between October 1993 and September 2002, which encompassed the policy period. Construing the factual allegations liberally, the court concluded that the petition potentially alleged damages from conduct occurring during the policy period and, therefore, that the insurer had to defend.[61]

While acknowledging that Texas applies the eight-corners rule, a decision from the Northern District of Texas stated that a court may look at evidence outside the pleadings under certain circumstances.[62] For example, whether a person is insured or not should be determined by true facts, not false, fraudulent, or otherwise incorrect facts, that might be alleged by a claimant.[63] In this case, the business-auto policy defined the term "insured" to include anyone using the covered auto with the named insured's permission.[64] Because the underlying pleading did not allege that the defendant was using a covered auto with the named insured's permission, the court concluded that the defendant did not qualify as an insured and that the insurer, therefore, did not have a duty to defend.[65]

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59. *Id.* at 263-64. *See also* Huffhines v. State Farm Lloyds, 167 S.W.3d 493, 496-97 (Tex. App.—Houston [14th Dist.] 2005, no pet.) (stating that the insurer "is obligated to defend if *potentially* there is a case under the complaint within the coverage") (emphasis in original); Archon Invs., Inc. v. Great Am. Lloyds Ins. Co., 174 S.W.3d 334 (Tex. App.—Houston [1st Dist.] 2005, pet. filed) (explaining that, as a general rule, the insurer is obligated to defend if there is, potentially, an action alleged within the policy coverage, even if the allegations do not clearly show that there is coverage).

60. Serv. Lloyd's Ins. Co. v. J.C. Wink, Inc., 182 S.W.3d 19 (Tex. App.—San Antonio 2005, pet. filed).

61. *Id.* at 28-29.

62. Liberty Mut. Ins. Co. v. Graham, 407 F. Supp. 2d 808, 813 (N.D. Tex. 2005).

63. *Id.* (citing Blue Ridge Ins. Co. v. Hanover Ins. Co., 748 F. Supp. 470, 473 (N.D. Tex. 1990)).

64. *Id.* at 811.

65. *Id.* at 813-14. *See also* Lincoln Gen. Ins. Co. v. Reyna, 401 F.3d 347 (5th Cir. 2005) (concluding that a business-auto insurer had no duty to defend allegations against a bus owner for negligent actions in hiring, supervision, and entrustment because the owner's negligence would not exist "but for" the bus crash, which was not covered because it occurred outside the policy's coverage territory).

2. The Insurer's Right to Control the Defense

In *Ross v. Marshall*, the insurer sought to intervene in a suit against its insured to appeal a $10 million judgment against its insured.[66] The district court denied the motion to intervene, and the insurer appealed.[67] The Fifth Circuit explained that, under the federal rule governing intervention, the potential intervenor must assert an interest related to the property or transaction at issue in the case. To meet this requirement, the intervenor must point to an interest that is direct, substantial, and legally protectable.[68]

The insurer argued that its interest was a substantial judgment against its insured. Agreeing with the insurer, the Fifth Circuit emphasized that, "without question, an insurer has a financial stake in securing a favorable outcome for its insured in a lawsuit alleging potentially covered claims. This financial interest is particularly strong when, as here, the insurer has been given an opportunity to defend the suit and, therefore, is in privity with the insured as to ensuing judgment."[69] For this reason, policies often give the insurer the right to take control of the insured's defense or contractually require insurers to defend.[70]

While the court easily concluded that the insurer has a financial stake, the court had more difficulty determining whether the insurer's interest was sufficiently direct to permit intervention as of right. The court concluded that an insurer that reserves its rights does not surrender its interest in minimizing the liability of its insured. In this case, because a judgment already existed against the insured, the insurer's intervention would not interfere with the insured's defense, and the insurer could not attempt to steer the jury towards a verdict holding the insured liable on non-covered grounds. To the contrary, "[the insurer's] interest in minimizing the potential exposure was aligned with [the insured's] interest in avoiding a $10 million judgment."[71] Further, because the insured had assigned its rights against the insurer to the claimants, the insurer had a second interest in the litigation—minimizing its potential exposure in a bad-faith claim. Based on these facts, the court concluded that the insurer had a sufficient interest in the suit to merit intervention as of right to appeal the judgment and, therefore, that the district court erred in denying the motion for intervention.[72]

66. 426 F.3d 745 (5th Cir. 2005).
67. *Id.* at 748.
68. *Id.* at 757 (citing New Orleans Pub. Serv., Inc. v. United Gas Pipe Line Co., 732 F.2d 452, 463 (5th Cir. 1984)).
69. *Id.*
70. *Id.*
71. *Id.* at 759.
72. *Id.* at 758-61.

B. Whether an Insurer Must Be Prejudiced in Order to Deny Coverage Based on Late Notice

Several federal and state courts issued opinions during this Survey period analyzing whether an insurer is required to show prejudice in order to deny coverage based on the insured's breach of the policy's notice provisions. These opinions instruct that the application of a prejudice requirement depends on the type of policy at issue.

In *Ridglea Estate Condominium Ass'n v. Lexington Insurance Co.*, the Fifth Circuit considered whether the insurer was required to show that it was prejudiced by the insured's breach of the provision of the property insurance policy requiring "prompt notice of the loss or damage."[73] The court explained that it is "quite clear that Texas law requires a showing of prejudice in order to raise breach of a notice requirement as a defense against claims on certain types of policies."[74] For example, certain orders of the Texas Department of Insurance require statements in general-liability and automobile insurance policies that any provision requiring notice of occurrence or loss will not bar liability unless the insurer is prejudiced by the insured's failure to comply with the notice provision.[75]

The insurer argued that the prejudice requirement applies only to those types of policies designated in the orders—general liability and automobile. In rejecting this argument, the Fifth Circuit relied on the general principles of contract interpretation previously enunciated by the Texas Supreme Court.[76] According to contract law, when one party commits a material breach, the other party is discharged from any obligation to perform. To determine whether a breach is material, the court must consider "the extent to which the non-breaching party will be deprived of the benefit that it could have reasonable anticipated from full performance."[77] Following this reasoning, the Fifth Circuit concluded that the prejudice requirement applied to the property insurance policy at issue and remanded the case to the trial court for a determination of whether the insurer had been prejudiced by the insured's late notice.[78]

Importantly, the *Ridglea* court emphasized that its holding was "a narrow one," and that it did not read *Hernandez* as necessarily creating a

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73. No. 04-10447, 2005 U.S. App. LEXIS 16724, at *3, *14 (5th Cir. Aug. 10, 2005) (op. on reh'g).

74. *Id.* at *14.

75. *Id.* (citing Texas State Board of Insurance Order No. 23080).

76. *Id.* at *14-15 (citing Hernandez v. Gulf Group Lloyds, 875 S.W.2d 691 (Tex. 1994) (concluding that an insurer that is not prejudiced by an insured's settlement may not deny coverage based on a settlement-without-consent provision)).

77. *Id.* at *16 (citing *Hernandez*, 875 S.W.3d at 693).

78. *Id. See also* Clarendon Nat'l Ins. Co. v. FFE Transp. Servs., Inc., No. 3:03-CV-1752-BF, 2004 U.S. Dist. LEXIS 23958, at *19-20 (N.D. Tex. 2004) (finding that insurer had established prejudice because the insured did not give notice until after the case went to trial and judgment had been entered against the insured for $1.1 million, and that the insured's lack of notice foreclosed guarantees to the insurer under the policy, including the opportunity to investigate the accident, to contribute to the development of a defense strategy, to participate in the lawsuit, and to evaluate and accept or reject settlement demands).

prejudice requirement for all insurance policies issued in Texas. For instance, the court affirmed its prior holding that an insurer may deny coverage under a "claims made" liability policy without a showing of prejudice.[79] Consistent with this statement, the Fifth Circuit recently held in a second opinion that "[a]n insurer is not required to show prejudice from late notice where a claims-made policy is involved."[80] The court explained that under an occurrence policy, an occurrence during the policy period is sufficient to trigger coverage. In contrast, under a claims-made policy, providing notice triggers the insured's coverage. The court was unwilling to apply a prejudice requirement to claims-made policies because to do so would interfere with the right to contract. As the court explained, "A party rightly should be held to know the conditions of the policy and the conscious choice that it made in selecting a claims-made policy instead of an occurrence policy."[81] The court therefore concluded that "the failure to provide proper notice under a claims-made policy negates coverage, regardless of whether the insurer has been prejudiced."[82]

The *Singleentry.com* opinion is also significant because the court recognized that an insured's delay in providing notice can constitute a breach of a claims-made policy's notice requirement even if the notice is given during the policy period. In that case, the insured learned of the litigation against it on December 7, 2000, but did not notify the insurer until September 18, 2001. Despite this nine-month delay, the insured argued that coverage existed because notice was given before the policy's expiration on November 9, 2001. The Fifth Circuit rejected this argument as "unavailing" in light of the policy language that "specifically mandated that notice be provided 'as soon as possible.'"[83] Noting that "there is ample Texas authority that taking eleven months to notify an insurer is not 'as soon as practicable,'" the court concluded that the insured breached the policy's notice requirement.[84]

In *Paj, Inc. v. Hanover Ins. Co.*, the Dallas Court of Appeals similarly recognized that the application of a prejudice requirement depends on the type of coverage at issue.[85] However, in contrast to the Fifth Circuit, the court concluded that *Hernandez* was not controlling because that case

79. *Id.* at *16 n.4 (citing Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co., 174 F.3d 653, 659 (5th Cir. 1999)).

80. Singleentry.com, Inc. v. St. Paul Fire & Marine Ins. Co., 117 F. App'x 933, 936 (5th Cir. 2004).

81. *Id.*

82. *Id.* (further stating that a showing of prejudice is required only in narrowly defined cases involving bodily injury and property damage).

83. *Id.* at 935, 937.

84. *Id.* at 937. *See also* First Prof'l Ins. Co., Inc. v. Heart & Vascular Inst. of Tex., 182 S.W.3d 6 (Tex. App.—San Antonio 2005, no pet.) (concluding that, under a claims-made policy, notice to the insurer of claims made against two physicians practicing in the same medical group did not constitute timely notice of a claim against the group itself if the policy required notice of "claims," not a liability "event," and if the letters from the claimants that were forwarded to the insurer did not assert a claim against the group).

85. 170 S.W.3d 258 (Tex. App.—Dallas 2005, pet. granted).

did not deal with a notice provision or any other condition precedent, but rather a settlement-without-consent exclusion.[86] The court stated, "We see a significant difference between a policy condition (performance of which is necessary to trigger any obligation for coverage) and a policy exclusion (which operates only after the obligation for coverage is in place)."[87]

The court emphasized that before the endorsement requiring prejudice was added to general-liability policies under the 1973 board order, failure to perform a notice condition was an absolute defense to liability on the policy.[88] The policy at issue contained the mandated endorsement imposing a prejudice requirement with respect to bodily-injury and property-damage liability under "Coverage A." The court concluded that this endorsement was limited to claims for bodily injury and property damage and, therefore, did not apply to the copyright-infringement claim at issue, which implicated only personal- and advertising-injury liability under "Coverage B." "For thirty years, the entities charged with overseeing these matters have declined to broaden the endorsement's language to include advertising injury, and we will not imply such a change in the policy before us."[89] Accordingly, the court declined to impose a prejudice requirement and affirmed the grant of summary judgment in favor of the insurer.[90]

C. CGL Policies

1. *Issue of Whether Construction-Defect Claims Allege an "Occurrence" and "Property Damage" Was Certified to the Texas Supreme Court*

As in the last Survey, insurers, insureds, and courts continued to struggle in determining whether allegations meet the "occurrence" requirement of general-liability policies, particularly in the context of construction-defect claims. Until the Texas Supreme Court addresses this issue, it will continue to present difficulties. Fortunately, it will have the opportunity to do so, as the Fifth Circuit recently determined that these issues should be certified to the supreme court.[91]

The Fifth Circuit explained that state intermediate courts of appeal and federal district courts in Texas are split on whether construction-defect claims allege an "occurrence" and "property damage," as those terms are used in CGL policies. Courts that have found that construction errors do not constitute an "occurrence" generally conclude that a claim for bad workmanship is really a claim for breach of contract, which is not cov-

86. *Id.* at 263 (citing *Hernandez*, 875 S.W.2d at 692).
87. *Id.*
88. *Id.* at 262-63 (citing Members Mut. Ins. Co. v. Cutaia, 476 S.W.2d 278, 279 (Tex. 1972)).
89. *Id.* at 263.
90. *Id.*
91. Lamar Homes, Inc. v. Mid-Continent Cas. Co., 428 F.3d 193, 196-201 (5th Cir. 2005).

ered, reasoning that shoddy work is foreseeable by the contractor and, therefore, is not an accidental or unexpected loss. In finding no "property damage," these courts reason that claims for the cost of repairing faulty workmanship are nothing more than claims for economic loss, which are damages that typically flow from a breach of contract and that a CGL policy does not insure against business risks, as to do so would result in little difference between a CGL policy and a performance bond.[92]

In contrast, courts that have found an "occurrence" in this context generally determine that, if the shoddy workmanship is the result of the builder's negligence, rather than intentional conduct, the loss is unexpected and, therefore, accidental. In finding "property damage," these courts reason that when construction errors cause physical damage to the object of the contract, such damage constitutes physical property damage and is covered under the policy regardless of whether the only tangible property damaged was the residence itself.[93]

Noting the frequency with which this issue is litigated and the copious amount of conflicting caselaw on both sides regarding whether construction errors causing damage to the subject of the contract constitute an "occurrence" causing "property damage" under a CGL policy, the Fifth Circuit decided that the issue should be resolved by the Texas Supreme Court and, accordingly, certified the following questions:

> 1. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege an "accident" or "occurrence" sufficient to trigger the duty to defend or indemnify under a CGL policy?
>
> 2. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege "property damage" sufficient to trigger the duty to defend or indemnify under a CGL policy?[94]

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92. *Id.* at 196-98.

93. *Id. See also* Home Owners Mgmt. Enters., Inc. v. Mid-Continent Cas. Co., 174 S.W.3d 334, 341-42 (N.D. Tex. 2005) (determining that because the claimant never alleged that the insured intended to cause foundation damage to the home, but rather that the damage was negligently caused by the insured, the allegation of negligence constituted an accidental "occurrence" under the policy and was sufficient to trigger the insurer's duty to defend); Archon Invs., Inc. v. Great Am. Lloyds Ins. Co., No. 01-03-01299-CV, 2005 Tex. App. LEXIS 6933, at *18-21 (Tex. App.—Houston [1st Dist.] Aug. 25, 2005, pet. filed) (finding duty to defend because pleading alleged that the insured was negligent; beached the warranties of good workmanship, construction, and suitability; made negligent misrepresentations and violated the DTPA; and the insured's subcontractors were negligent); Lennar Corp. v. Great Am. Ins. Co., No. 14-02-00860-CV, 2005 Tex. App. LEXIS 4214, at *29 (Tex. App.—Houston [14th Dist.] June 2, 2005, no pet.) (reasoning that the relevant inquiry is not whether the insured damaged its own work, i.e., whether the claim sounds in contract only, and concluding that defective construction resulting in damage to the insured's own work can constitute an "occurrence" as long as the resulting damage was unintentional and unexpected); Mid-Continent Cas. Co. v. JHP Dev., Inc., No. SA-04-CA-192-XR, 2005 U.S. Dist. LEXIS 16212, at *13 (W.D. Tex. Apr. 21, 2005) (concluding that, in the absence of allegations that the insured intentionally caused the damage, the construction-defect claims alleged an "occurrence" under the CGL policy).

94. *Lamar Homes*, 428 F.3d at 199-201.

2. *Whether Misrepresentation Claims Allege an "Occurrence"*

In *Federal Insurance Co. v. Ace Property & Casualty Co.*,[95] the insured, Electronic Data Systems Corporation ("EDS"), was sued for damages arising from its involvement in a purported project for the North Atlantic Treaty Organization ("NATO"). As the general contractor on the project, EDS invited two companies to bid on the project, representing to the companies that the bidding process required them to ship sample products to NATO representatives who would have the right to destroy the products as part of their testing procedures. Relying on EDS's representations, the companies signed authorization agreements and shipped property worth millions. After three years of shipments, EDS and the companies learned that the operation was a fraud and that the equipment was sold for commercial purposes. The companies sued EDS for negligent misrepresentations regarding the fraudulent scheme. EDS sought coverage under two CGL policies, but the insurer refused to provide a defense on the ground that the alleged negligent misrepresentations were not "occurrences."[96]

The Fifth Circuit explained that, while EDS may not have known that the NATO project was a hoax, it did expect that the companies' products would never be returned. Because EDS intended the companies to ship sample products, expecting that the products would never be returned, the loss of those products was the natural and probable consequence of EDS's representations. Regardless of the companies' characterization of EDS's conduct as negligent, the cause of the alleged property damage was EDS's intent and plan that the companies would permanently part with their property. Under these facts, the court concluded that none of EDS's conduct nor any of its alleged omissions was an "accident" within the meaning of the CGL policies and, therefore, that the insurer had no duty to defend or indemnify EDS.[97]

3. *Determining the Number of Occurrences*

In *Lennar Corp. v. Great American Insurance Co.*, the Fourteenth District Court of Appeals also addressed whether the insured homebuilder's application of defective synthetic stucco, called Exterior Insulation and Finish System ("EIFS"), to numerous homes constituted one occurrence or separate occurrences under the CGL policies.[98] The court explained that Texas courts apply a "cause" analysis to determine whether a set of facts involves one or more occurrences. Under this analysis, the proper focus is on the number of events that cause the injuries and result in the insured's liability, rather than the number of injurious effects.[99] The in-

95. 429 F.3d 120 (5th Cir. 2005).
96. *Id.* at 121-22.
97. *Id.* at 125.
98. No. 14-02-00860-CV, 2005 Tex. App. LEXIS 4214, at *1-5, *58-63 (Tex. App.—Houston [14th Dist.] June 2, 2005, no pet.).
99. *Id.* at *58-59.

sured contended that there was only one occurrence because there was only one cause of damage to the homes—the EIFS's repeated and continuous entrapment of water. Disagreeing with this contention, the court reasoned that the insured was not the designer or the manufacturer of EIFS. Rather, the insured's liability to a particular homeowner stemmed from its application of EIFS and the resulting damage to the particular home. Additionally, the EIFS's entrapment of water on a particular home caused the damage to that home only; thus, the insured was exposed to a new and separate liability for each home on which EIFS was installed. The court therefore concluded that the EIFS claim against the insured for each house constituted a separate occurrence.[100]

4. The Business-Risk Exclusions

In *Mid-Continent Casualty Co. v. Camaley Energy Co.*, the Northern District of Texas analyzed whether the "business risk" exclusions in the CGL policy applied to preclude coverage.[101] The underlying lawsuit alleged that the insureds were negligent in drilling, completing, producing, and operating a well. Specifically, the plaintiffs alleged that the insureds failed to properly and adequately evaluate the location of the well bore and trespassed onto a neighboring leasehold.[102] Exclusion j(5) excluded coverage for property damage to that particular part of real property on which the insureds, or any contractors or subcontractors working on their behalf, are performing operations, if the property damage arises out of those operations. Because the plaintiffs alleged that the insureds' negligence caused property damage to the property on which the insureds were hired to work, the court found that the damages fell squarely within this exclusion.[103]

The policy also contained a "your work" exclusion, which excluded coverage for property damage to the insured's work arising out of it or any part of it and included in the "products-completed operations hazard," but did not apply if the damaged work or the work out of which the damage arises was performed by a subcontractor. Reading the pleading liberally in favor of the insured, the court concluded that this exclusion did not apply if the pleading was vague as to whether subcontractors caused the damage.[104]

Exclusion m excluded coverage for property damage to "impaired property" or property that has not been physically injured arising out of: (1) a defect, deficiency, inadequacy, or dangerous condition in the insured's product or work, or (2) a delay or failure by the insureds or any-

100. *Id.* at *61-62.
101. 364 F. Supp. 2d 600, 606-08 (N.D. Tex. 2005).
102. *Id.* at 602.
103. *Id.* at 606-07.
104. *Id. See also* Mid-Continent Cas. Co. v. JHP Dev., Inc., No. SA-04-CA-192-XR, 2005 U.S. Dist. LEXIS 16212, at *16-17 (W.D. Tex. Apr. 21, 2005) (determining that the policy's "your work" exclusion did not apply because the insured's work on the condominiums had not yet been completed).

one acting on their behalf to perform a contract or agreement in accordance with its terms. The insurer argued that this exclusion applied because the insureds' negligence caused the plaintiffs to lose their leasehold, amounting to a breach of contract. Conversely, the insureds argued that the damages the plaintiffs sought did not fall within the definition of "impaired property." The court disagreed, noting that this exclusion applies to "impaired property" or "property that has not been physically injured," such as the leasehold at issue. The court found that the alleged negligent conduct constituted a defect, deficiency, inadequacy, or dangerous condition in the insureds' work or, alternatively, a failure to perform the work in accordance with their contract. The court concluded that the exclusion barred coverage and, therefore, that the insured had no duty to defend or indemnify.[105]

5. *The Professional-Services Exclusion*

In *Allstate Insurance Co. v. Disability Services of the Southwest, Inc.*, the underlying suit against the insured arose out of the death of a quadriplegic under its care and alleged that the insured was negligent in its provision of medical care to the deceased and in its failure to provide the deceased with communication devices for emergencies.[106] The CGL policy contained a professional-service exclusion that excluded coverage for any bodily injury or property damage arising out of the rendering or failure to render medical service, treatment, advice, instruction, or any health or therapeutic service, treatment, advice, or instruction. The court reasoned that, because communication with patients is vital to providing health or nursing services, the claim that the death was caused by the failure to provide communication devices was inseparable from the claim that the insured failed to provide adequate medical care. The court concluded that the exclusion applied and, therefore, that the insurer had no duty to defend.[107]

D. Homeowners Policies

1. *Seller's Misrepresentation to the Buyer Does Not Constitute an "Occurrence" under a Homeowners Policy*

In *Huffhines v. State Farm Lloyds*, the insured homeowners sold their townhouse to two buyers. After the sale, the owner of the adjoining townhouse sued the buyers, alleging that defects in the buyers' property caused water to encroach on and damage her townhouse, and the buyers in turn sued the insureds.[108] The event or conduct at issue was the insureds' assuring the buyers that they were not aware of defects of the townhouse when the insureds did have knowledge of such defects, including water encroaching. The court found that because water damage is of

105. *Mid-Continent*, 364 F. Supp. 2d at 606, 608.
106. 400 F.3d 260, 261-62 (5th Cir. 2005).
107. *Id.* at 262, 264-65.
108. 167 S.W.3d 493, 495-96 (Tex. App.—Houston [14th Dist.] 2005, no pet.).

a type that ordinarily follows from existing and undisclosed water encroachment, the property damage to the adjoining townhouse could be reasonably anticipated by the insureds. The court concluded that the pleading did not allege an "accident," that absent an "accident" there could be no "occurrence" under policy, and that the insurer was not required to defend.[109]

2. *Whether Mold Damage Is Excluded from Coverage*

The Fourteenth District Court of Appeals addressed whether a Texas Homeowner's Form B-T policy ("HOB-T") provided coverage for mold damage.[110] The "Perils Insured Against" section of the policy stated that the insurer would insure against physical loss to the property caused by a listed peril, unless the loss was specifically excluded. One of the perils listed was accidental discharge, leakage, or overflow of water or steam from within a plumbing, heating, or air conditioning system or household appliance. The insured argued that the mold damage to her personal property was covered because it was caused by a leak from an air conditioning system. Conversely, the insurer contended that because mold was not a named peril in the policy, mold was excluded from coverage. The court reasoned that the insurer's narrow view ignored the undeniable fact that mold can be damage, and depending on the circumstances, a cause of loss. The court concluded that if a named peril—the accidental discharge, leakage, or overflow of water from the air conditioning system—caused the mold, then the damage could be a physical loss covered under the policy because this type of damage was not specifically excluded from coverage. The court therefore reversed the trial court's grant of summary judgment in favor of the insurer and remanded the case for further proceedings.[111]

The Eastern District of Texas reached a different result in construing a standard Texas Dwelling Policy—Form 3.[112] Although the policy had a specific exclusion for loss caused by mold, the insured argued that based on the "ensuing loss" language of the exclusion, coverage is not excluded if the mold is an ensuing loss from a covered event, such as water damage. The court found this policy distinguishable from the standard Texas Homeowner's Policy—Form B, which contains a Coverage B stating that certain exclusions do not apply to loss caused by accidental discharge of water. In contrast, the Form 3 policy specifically excludes mold damage. Based on this distinction, the court determined that the "ensuing loss caused by water damage" referred to water damage, which is the result,

109. *Id.* at 499. *See also* Allstate Tex. Lloyd's v. Meyers, No. 3:03-CV-2635-N 2005 U.S. Dist. LEXIS 1974, at *4-5 (N.D. Tex. Feb. 9, 2005) ("Under Texas law, sellers' misrepresentations to purchasers are not covered 'occurrences' under the standard form homeowner's insurance policy.").

110. De Laurentis v. United Servs. Auto. Ass'n, 162 S.W.3d 714 (Tex. App.—Houston [14th Dist.] 2005, pet. filed) (op. on reh'g).

111. *Id.* at 721-25.

112. Malley v. Allstate Tex. Lloyds, 347 F. Supp. 2d 346 (E.D. Tex. 2004).

not the cause, of mold damage. Because the alleged mold damage resulted from earlier water damage, the court concluded that the mold damage was not covered by the policy.[113]

3. *The Business-Pursuits Exclusion*

In *Allstate Insurance Co. v. Hallman*, the Texas Supreme Court addressed whether a business-pursuits exclusion in a homeowners policy barred coverage for a suit brought against the insured by neighboring property owners for damages related to limestone mining on the insured's property.[114] The policy specifically excluded coverage for bodily injury or property damage arising out of or in connection with a business that an insured engaged in, but not for activities that are ordinarily incidental to non-business pursuits. The supreme court adopted the two-prong standard previously enunciated by the San Antonio Court of Appeals requiring: (1) continuity or regularity of the activity, and (2) a profit motive, usually as a means of livelihood, gainful employment, earning a living, procuring subsistence, or financial gain.[115]

Applying this standard, the court found that even though the insured had executed only one lease ten years earlier, the mining activity remained ongoing and, thus, met the continuity requirement. As to the second requirement, while the underlying pleading did not refer to the insured's pecuniary interest, the court reasoned that a profit motive could be inferred from the nature of the activity, as a person does not allow limestone mining with dynamite blasting to occur on his property without some expectation of remuneration or monetary gain. Recognizing that the purpose of the business-pursuits exclusion is to lower homeowners-insurance premiums by removing coverage for activities that are not typically associated with the operation and maintenance of a home, the court concluded that the mining lease constituted a business pursuit and, therefore, that the underlying lawsuit was excluded from coverage.[116]

E. Auto Policies

Two cases during this Survey period addressed uninsured/underinsured motorist ("UM/UIM") coverage in Texas auto policies. In *McDonald v. Southern County Mutual Insurance Co.*, two men sought UIM coverage for injuries that they sustained when they were struck by another vehicle while walking along the I-10 service road after they had left the vehicle to get assistance for a tire blow-out on the tractor in which they had been traveling.[117] The UM/UIM part of the policy defined an "insured" to include any person occupying a covered auto and defined "occupying" to

113. *Id.* at 348-50.
114. 159 S.W.3d 640, 641 (Tex. 2005).
115. *Id.* at 643-44 (citing United Servs. Auto. Ass'n v. Pennington, 810 S.W.2d 777, 778-80 (Tex. App.—San Antonio 1991, writ denied)).
116. *Id.* at 644-45.
117. 176 S.W.3d 464, 466 (Tex. App.—Houston [1st Dist.] 2004, no pet.).

mean "in, upon, getting in, on, out or off."[118] The court explained that "occupying" requires a causative nexus with the vehicle. Because the men had crossed the road and were proceeding away from the vehicle, the court concluded that the men were not "occupying" the vehicle and, thus, did not constitute "insureds" under the UM/UIM coverage.[119]

In *Burling v. Employers Mutual Casualty Co.*, David Burling made a claim on his employer's commercial auto insurance policy, which the insurer denied on the ground that Burling was not listed as a designated person on the UM/UIM coverage part of the policy.[120] This part defined an "insured" to include designated persons, but the employer did not name a designated person on the policy. Burling argued that the policy was ambiguous as to whom it covered because the employer, a corporation, was the only named insured, and a corporation cannot be injured in an automobile accident. The court reasoned that the corporation could have named Burling as a designated person in the policy, which would have created coverage for Burling, but it did not do so. While the failure to designate Burling rendered the policy language regarding a designated person inapplicable, it did not create an ambiguity. The court therefore concluded that Burling did not qualify as an "insured" under the UM/UIM coverage.[121]

F. D&O Liability Policies

1. *To Allege a Loss under a D&O Policy, the Company Must Specifically Plead That It Indemnified Its Directors and Officers*

In *Westcott Holdings, Inc. v. Monitor Liability Managers, Inc.*, the insured corporation sued its insurer for failure to pay costs that it incurred in two underlying lawsuits under a directors' and officers' liability policy, which provided coverage for "wrongful acts" committed by the corporation's directors and officers to the extent that the corporation indemnified the directors and officers.[122] The insurer moved to dismiss for failure to state a claim,[123] arguing that the corporation's petition failed to plead indemnification of the directors and officers and, thus, failed to allege any actual loss under the policy. In response, the corporation contended that the formal grant of indemnification was unnecessary because it was merely a condition precedent to the lawsuit and that the petition generally pleaded that all conditions precedent had been performed.[124]

Rejecting the insured's contention, the court found that the corporation's obligation to indemnify its directors and officers was not a condi-

118. *Id.* at 466-67.
119. *Id.* at 469-72.
120. No. 05-04-00155-CV, 2005 Tex. App. LEXIS 373, at *1 (Tex. App.—Dallas Jan. 19, 2005, no pet.).
121. *Id.* at *3-7.
122. No. H-05-1945, 2005 U.S. Dist. LEXIS 20149, at *1-3 (S.D. Tex. Sept. 12, 2005).
123. *See* FED. R. CIV. P. 12(b)(6).
124. *See* FED. R. CIV. P. 9(c).

tion precedent, but rather a requirement for coverage under the policy. The court emphasized that the language of Coverage Section B, which explicitly stated that the insurer would pay losses to the corporation for claims made against its directors and officers "to the extent that the Company has indemnified the Directors or Officers" clearly anticipated the corporation's indemnification of its directors and officers as a requirement for establishing any right to payment of loss under the policy.[125] The court also rejected the corporation's reliance on its bylaws because the indemnification provided by the bylaws was conditional (i.e., indemnification occurred only to the extent permitted by law and only if requested by the directors and officers). The court concluded that the existence of a conditional requirement for indemnification did not satisfy the corporation's obligation to allege indemnification in order to establish a loss covered by the policy: "Indemnification must be specifically pleaded by the plaintiff."[126]

2. *The Contractual-Liability Exclusion*

The First District Court of Appeals analyzed the applicability of a contractual-liability exclusion in a directors' and officer's ("D&O") liability insurance policy.[127] The insured officer sought coverage under the D&O policy for an underlying lawsuit brought against him in his individual capacity by his former wife seeking alimony and other contractual rights that she alleged she was owed under their divorce decree. The former wife alleged that the officer covenanted in the divorce decree to receive funds for her benefit and, as such, to act in a fiduciary capacity with regard to her interests and that the officer breached his fiduciary duty to her.[128] The policy excluded coverage for claims alleging, arising out of, based upon, or attributable to any actual or alleged contractual liability of the company or any insured under any express contract or agreement. The court noted that each of the former wife's allegations arose out of, was based upon, and could be attributed to specific sections of the divorce decree and that the only breach of duty alleged was one that the divorce decree expressly created. The court therefore concluded that the contractual-liability exclusion barred coverage for all of the claims.[129]

G. Professional Liability Policies

In *Lexington Insurance Co. v. Educare Community Living Corp.-Gulf Coast*, the Fifth Circuit addressed whether the medical professional liability ("MPL") coverage part of a policy provides coverage for a lawsuit arising out the sexual assault of a resident of a group home by one of the

125. *Westcott Holdings*, 2005 U.S. Dist. LEXIS 20149, at *9.
126. *Id.* at *10.
127. King, Chapman & Broussard Consulting Group, Inc. v. Nat'l Union Fire Ins. Co., 171 S.W.3d 222 (Tex. App.—Houston [1st Dist.] 2005, no pet.).
128. *Id.* at 224.
129. *Id.* at 228-29.

insured entity's employees.[130] The MPL coverage part covered amounts that the entity became legally obligated to pay as damages resulting from a medical incident arising out of professional services. The third subpart of the definition of "professional services" listed supervising, teaching, and proctoring others.[131] The entity argued that the allegations against it for negligent training and supervision of the employee fell within this subpart. The court, however, noted that such an argument wholly removed the phrase from the list in which it was enumerated and from the context that the list provided, namely professional healthcare. The court determined that, when read in context, the supervision and teaching must be for healthcare services, which are professional in nature and demand either specialized knowledge or recognized training. Because the entity's training and supervision of the employees did not involve professional services, the court concluded the MPL coverage part did not provide coverage.[132]

H. Additional Insureds

Several courts issued opinions during this Survey period that analyzed issues relating to additional insureds. The Fort Worth Court of Appeals explained that in Texas, the term "additional insured" has a clear technical meaning—"a party protected under a policy without being named in the policy."[133] A party typically becomes an additional insured under an agreement obligating the named insured to add the additional insured to the named insureds' pre-existing insurance policy. Texas courts have consistently allowed an additional insured to seek coverage under such insurance policies.[134] In this case, an employee of Vratsinas Construction Company was injured when a construction trailer that he was occupying blew over. Transport International Pool, Inc. d/b/a GE Capital Modular Space ("GE") owned the trailer and leased it to Vratsinas. The employee sued GE, which in turn sought indemnity from Vratsinas and its insurer. The lease agreement between Vratsinas and GE provided that Vratsinas would procure and keep in effect a CGL insurance policy naming GE as an additional insured. Vratsinas' CGL policy insured any organization from whom Vratsinas leased equipment as long as Vratsinas and the organization had agreed that the organization would be added as an additional insured. Because GE leased the trailer to Vratsinas, the court concluded that GE was an additional insured under the policy.[135]

130. 149 F. App'x 326, 327 (5th Cir. 2005).
131. *Id.* at 329.
132. *Id.* at 329-31.
133. Transp. Int'l Pool, Inc. v. Cont'l Ins. Co., 166 S.W.3d 781, 786 (Tex. App.—Fort Worth, no pet.).
134. *Id.* at 786-87.
135. *Id.* at 783, 787. *See also* U.S. Fire Ins. Co. v. Gnade, No. 10-03-00289-CV, 2005 Tex. App. LEXIS 1825, at *4-7 (Tex. App.—Waco Mar. 9, 2005, pet. denied) (concluding that if a separate endorsement beyond the blanket additional insured endorsement expressly identifies the party, the party is an additional insured even though the named insured is not contractually required to insure the party).

In *ALCOA v. Hydrochem Industrial Services*, the Corpus Christi Court of Appeals addressed the interplay between contractual indemnity provisions and additional-insured provisions.[136] The court explained that liability insurance provisions are often included as part of indemnity agreements to guard against an indemnitor's insolvency. If an additional-insured provision is solely supplemental to the indemnity provision, it has no effect beyond the applicability of the indemnity agreement. Conversely, an additional-insured provision that constitutes a separate obligation is not limited to the scope of any indemnity clause and could require an obligor to provide insurance coverage to an obligee that would effectively relieve the obligee of responsibility for its own actions without a valid indemnity agreement.[137] Two factors are considered in determining whether an additional-insured provision is a separate and distinct obligation from an indemnity agreement: (1) whether the indemnity clause contains an internal provision stating that insurance is required to cover the extent of indemnity, and (2) whether the general additional-insured provision specifies that it applies whether or not required by the other contract provisions.[138]

The contract at issue contained a section entitled "INSURANCE," providing that the seller could not commence work until it furnished the buyer with certificates of insurance for specified policies and that the buyer would be named as an additional insured in such policies. However, this section did not specify that it applied whether or not required by other clauses in the contract, and the indemnity agreement in the contract did not contain a separate, internal additional-insured provision. The court concluded that the absence of these elements showed that the additional-insured provision was not intended to stand alone as a distinct obligation, but rather was intended only to assure the performance of the indemnification agreement. Consequently, if the indemnification agreement was found on remand to be unenforceable or inapplicable, the buyer would not qualify as an additional insured.[139]

I. "Other Insurance" Provisions

The Fifth Circuit examined the interplay between the "other insurance" clauses of two professional-liability policies issued to the insured nursing home.[140] Texas law recognizes three types of "other insurance" provisions: (1) pro rata clauses, which restrict the liability of concurring insurers to an apportionment basis; (2) excess clauses, which restrict the liability of an insurer to excess coverage, which pays out only after the

136. No. 13-02-00531-CV, 2005 Tex. App. LEXIS 2010, at *30-32 (Tex. App.—Corpus Christi Mar. 17, 2005, pet. denied).

137. *Id.* at *30-31.

138. *Id.* at *31 (citing Getty Oil Co. v. Ins. Co. of N. Am., 845 S.W.2d 794, 804-05 (Tex. 1992)).

139. *Id.* at *31-32.

140. Royal Ins. Co. of Am. v. Hartford Underwriters Ins. Co., 391 F.3d 639, 640 (5th Cir. 2004).

primary coverage is exhausted; and (3) escape clauses, which avoid all liability in the event of additional coverage. When, from the point of view of the insured, there is coverage from either one of two policies but for the existence of the other policy, and each contains a provision that is reasonably subject to a construction that it conflicts with a provision in the other policy, there is a conflict in the provisions. In the event of a conflict, Texas courts ignore the conflicting provisions and apportion liability pro rata between the insurers and require both insurers to defend.[141]

Applying these principles, the court found a conflict between the escape clause in the policy issued by Hartford Underwriters Insurance Company and the pro rata clause in the policy issued by Royal Insurance Company of America:

> [T]his case appears to be just another permutation of the conflict explained in Hardware Dealers. Viewed from the perspective of [the nursing home], the insured, one finds that Hartford provides coverage for the underlying suit if Royal's policy did not exist. Similarly, one sees that Royal provides full coverage for the underlying suit if Hartford's policy did not exist. A "reasonable construction" of the two policies from this perspective yields a conflict.[142]

The court concluded that both Hartford and Royal were liable proportionally and that both had a duty to defend the nursing home.[143]

J. Appraisal Provisions

In *In re State Farm Lloyds, Inc.*, a dispute arose concerning the amount owed by the insurer on the insured's claim for living expenses from the loss of use of the house due to fire damage.[144] The policy provided that if the insured and insurer failed to agree on the actual cash value, amount of loss, or cost of repair or replacement, either could make a written demand for appraisal, and it specified the procedures for the appraisal process. The insurer sent a letter to the insured invoking the appraisal provision, but the insured refused to participate in the appraisal process and filed suit against the insurer for breach of contract. The insurer moved to enforce the appraisal provision, which the trial court denied. Rejecting the insured's argument that the insurer waived the appraisal provision by failing to comply with other policy provisions, the court of appeals concluded that the trial court's refusal to enforce the appraisal provision constituted a clear abuse of discretion and granted the insurer mandamus relief.[145]

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141. *Id.* at 643 (citing Hardware Dealers Mut. Fire Ins. Co. v. Farmers Ins. Exch., 444 S.W.2d 583 (Tex. 1969)).

142. *Id.* at 644.

143. *Id.*

144. 170 S.W.3d 629, 630 (Tex. App.—El Paso 2005, orig. proceeding).

145. *Id.* at 630-31, 633-35. *See also In re* Clarendon Ins. Co., No. 2-04-305-CV, 2004 Tex. App. LEXIS 11537, at *8-9 (Tex. App.—Fort Worth Dec. 23, 2004, orig. proceeding)

K. Non-Assignment Provisions

In *Dr. Michael Hoffman and Associates v. St. Paul Guardian Insurance Co.*,[146] the insured filed a claim under its commercial-property insurance policy for damages to its building from plumbing leaks. While the claim was pending, the insured sold the buildings to a buyer under a contract for sale, which provided that if a claim had been made against any insurance carried on the property, the insured would assign any rights that it had under the policy to the buyer. When the insurer denied the claim, the buyer, as the insured's assignee, sued the insurer. The policy contained a "non-assignment" provision prohibiting the insured from assigning or turning over its interest in the policy without the insurer's written consent. Emphasizing that non-assignment clauses have been consistently enforced by Texas courts, the court concluded that because the evidence conclusively established that the insured never received written consent from the insurer, the buyer could not pursue the insured's claims against the insurer.[147]

L. The Fortuity, Known-Loss, and Loss-in-Progress Doctrines

The Fourteenth District Court of Appeals reiterated that under Texas law, fortuity is an inherent requirement of all risk insurance policies.[148] The "known loss" and "loss in progress" doctrines are components of the fortuity doctrine. A "known loss" is a loss that the insured knew had occurred when it purchased the policy. A "loss in progress" occurs when the insured is, or should be, aware of an ongoing progressive loss when it purchased the policy. Insurance coverage is precluded for a "known loss" or "loss in progress."[149] The evidence showed that the insured homebuilder knew of damage to a few homes when the policy was purchased and in fact, had repaired similar problems on several homes beginning four years earlier. Based on this evidence, the court found that the insured clearly knew of these losses when it purchased the policy, even though the insured at that time may not have known the underlying cause of the problems or the extent of the problems. The court, therefore, concluded that these doctrines precluded coverage as a matter of law for homes that the insured knew of damage or had made repairs when it purchased the policy.[150]

(stating that in the absence of waiver, a trial court abuses its discretion and misapplies the law by refusing to enforce the appraisal provision).

146. No. 05-04-00902-CV, 2005 Tex. App. LEXIS 6500 (Tex. App.—Dallas Aug. 16, 2005, no pet.).

147. *Id.* at *1-6.

148. Lennar Corp. v. Great Am. Ins. Co., No. 14-02-00860-CV, 2005 Tex. App. LEXIS 4214, at *76 (Tex. App.—Houston [14th Dist.] June 2, 2005, no pet.).

149. *Id.*

150. *Id.* at *77-79. *Cf.* U.S. Fire Ins. Co. v. Gnade, No. 10-03-00289-CV, 2005 Tex. App. LEXIS 1825, at *8-9 (Tex. App.—Waco Mar. 9, 2005, pet. denied) (declining to apply the known-loss doctrine because there was no evidence that the additional insured knew about the accidents, made any incorrect representations, or concealed any information from the insurer before the insurer's issuance of the additional insured endorsement).

M. The Made-Whole Doctrine

The Waco Court of Appeals explained that under the "made-whole doctrine," an insurer is not entitled to subrogation if the insured's loss is in excess of the amounts recovered from the insurer and the third party causing the loss.[151] Thus, if the uncontroverted evidence showed that the insured's past and future medical expenses exceeded the combined amount of the settlement that the third parties paid and the health-insurance benefits that the insurer paid, the court concluded that the insured had not been "made whole," and, therefore, the insurer was not entitled to recover on its subrogation and reimbursement claims.[152]

IV. PROCEDURAL ISSUES

A. Determining the Duty to Indemnify by Declaratory Judgment before a Judgment in the Underlying Suit

The Eastern District of Texas explained that, until recently, the law in Texas was that courts lacked jurisdiction to entertain a declaratory-judgment action regarding an insurer's duty to indemnify its insured for damages that could be assessed in a pending lawsuit, as any such determination was deemed to be dependent on a contingency and purely advisory in nature.[153] However, the Texas Supreme Court has retreated from this position, holding that "the duty to indemnify is justiciable before the insured's liability is determined in the liability lawsuit when the insurer has no duty to defend and the same reasons that negate the duty to defend likewise negate any possibility the insurer will ever have a duty to indemnify."[154] Thus, if the same reasons that negated the duty to defend negated any possibility that the insurer would have a duty to indemnify, the court ruled in the declaratory-judgment action that the insurer had no duty to indemnify the insured for any adverse judgment that might be rendered in the underlying suit.[155]

B. The Limitations Period in a Coverage Dispute Begins on the Date of the Insurer's Denial

In *Pace v. Travelers Lloyds of Texas Insurance Co.*,[156] the insured and the insurer agreed that the two-year limitations period on the insured's claims against the insurer began to run upon the denial of the claim, but disagreed on when that denial occurred. The insurer had sent a letter to the insured stating:

151. Fortis Benefits v. Cantu, 170 S.W.3d 755, 758 (Tex. App.—Waco 2005, pet. filed).
152. *Id.* at 758-60.
153. Nat'l Am. Ins. Co. v. Breaux, 368 F. Supp. 2d 604, 615 (E.D. Tex. 2005).
154. *Id.* at 615-16 (quoting Farmers Tex. County Mut. Ins. Co. v. Griffin, 955 S.W.2d 81, 83 (Tex. 1997)).
155. *Id.* at 619.
156. 162 S.W.3d 632 (Tex. App.—Houston [14th Dist.] 2005, no pet.).

> After careful consideration of all information available to us, we have determined that the damage to your property is not afforded coverage under the insurance policy. . . . If you have any additional information that you feel may have an impact on this coverage decision or should you have any question concerning this claim please forward same to me. . . .[157]

The insured argued that the last sentence concerning additional information rendered the letter ambiguous as to whether the coverage decision was final and whether the letter was a denial of coverage. Rejecting this argument, the court found that the letter plainly stated that the insurer had determined that coverage was not afforded under the policy, provided a reason for the decision, reiterated that the insurer would be unable to make a payment, and thus, unequivocally communicated a decision to deny coverage. Although the final paragraph invited the insured to provide any additional information that he felt might have an impact on the decision, the letter did not request any further information, suggest that any further information would be needed to reach a decision, or otherwise imply that the coverage decision had not been made. Under these facts, the court concluded that the limitations period began on the date of this letter.[158]

157. *Id.* at 633.
158. *Id.* at 634-35.