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A Duty to Indemnify with No Duty to Defend: *D.R. Horton-Texas, Ltd. v. Markel Int'l Ins. Co., Ltd.* --- S.W.3d ----, No. 06-1018 (Tex. Dec. 11, 2009)

The Texas Supreme Court held that an insurer may have a duty to indemnify, even if there is no corresponding duty to defend. *D.R. Horton-Texas* involved a general contractor seeking defense and indemnity as an additional insured under a subcontractor's commercial general liability policy for injuries allegedly arising from the presence of mold in the claimants' home. While the claimants' petition identified only D.R. Horton as responsible party, D.R. Horton contended that the work of one of its subcontractors, Rosendo Ramirez, contributed to the alleged defect. Ramirez had obtained a CGL policy from Markel International Insurance Company, Ltd. ("Markel") that named D.R. Horton as an additional insured for its liability arising out of Ramirez's defective work. However, Markel refused to defend D.R. Horton, because the petition did not allege that Ramirez's work was defective. D.R. Horton hired its own defense counsel and settled the underlying case prior to trial. D.R. Horton then sued Markel for reimbursement of its defense costs and settlement payment. The trial court granted Markel's motion for summary judgment, holding that Markel had no duty to defend or indemnify D.R. Horton. The Fourteenth Court of Appeals affirmed the trial court's judgment, and D.R. Horton appealed to the Texas Supreme Court.[1]

With respect to Markel's duty to indemnify, the Court noted that the duty to defend and the duty to indemnify are separate and distinct duties. The facts established in the underlying action, in comparison to the terms and conditions of the policy, determine whether an insurer has a duty to indemnify. The Court noted that "[e]vidence is usually necessary in the coverage litigation to establish or refute an insurer's duty to indemnify," which is especially true when the underlying litigation is resolved before a trial on the merits. Thus, the Court wrote:

> We hold that, even if Markel has no duty to defend D.R. Horton, it may still have a duty to indemnify D.R. Horton as an additional insured under Ramirez's CGL insurance policy. That determination hinges on the facts established and the terms and conditions of the CGL policy.

Markel had relied upon *Farmers Tex. County Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 84 (Tex. 1997) for the proposition that, if the insurer has no duty to defend based upon the factual allegations in the petition, then proof of such allegations could not create a duty to indemnify. The Court limited *Griffin* to its facts and explained that the holding in *Griffin* was based upon the impossibility that the policyholder could introduce any conceivable facts proving that injuries arising out of an alleged drive-by shooting would fall within the coverage of the automobile policy at issue. *Griffin* did not hold that, if there is no duty to defend under the pleadings, then an insurer never has a duty to indemnify. Rather, in *Griffin*, the Court recognized that the parties may not be able to resolve indemnity disputes until after the underlying litigation is complete, as coverage may depend on the facts proven in that case.

In this case, the Court observed that D.R. Horton had presented evidence in response to Markel's motion for summary judgment that showed (1) Ramirez was a subcontractor who worked on the claimants' home; (2) he performed masonry work that contributed to the defect; and (3) the Markel policy named D.R. Horton as an additional insured. Accordingly, the Court held that this evidence raised sufficient fact issues to defeat Markel's motion for summary judgment on the duty to indemnify. The Court reversed that part of the judgment and remanded the case back to the trial court for further proceedings.

Diego Garcia

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[1] On the duty to defend, D.R. Horton argued that the lower courts had erred in not reviewing extrinsic evidence to determine Markel's duty to defend. However, the Texas Supreme Court held that D.R. Horton waived this issue, because it failed to raise this argument until its second motion for rehearing before the Court of Appeals. The Court thus affirmed the trial court's judgment that Markel had no duty to defend D.R. Horton.

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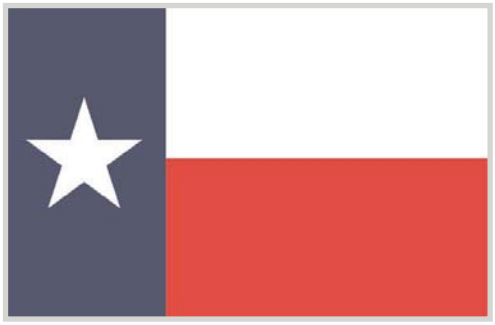
Back in 2006, the Texas Supreme Court piqued our interest when it entertained the idea that there may be some situations in which it is appropriate to look beyond the eight corners of a petition and a policy to determine whether an insurer has a duty to defend. *See GuideOne Elite Ins. Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305 (Tex. 2006). Although the Court did not allow extrinsic evidence to be considered in that case, its discussion on the possible use of extrinsic evidence in some circumstances was somewhat of a departure from the Court's prior rulings on this issue. The *GuideOne* ruling begged the question, "Is Texas really still a strict eight-corners rule state?"

In February, the Court issued its opinion in *Pine Oak Builders, Inc. v. Great American Lloyds Insurance Company*, once again adhering to its traditional eight-corners analysis. Thus, it appears that, for now, we remain a strict eight-corners rule state. The *Pine Oak* case also revisited issues the Court recently addressed in two other cases – *Lamar Homes, Inc. v. Mid-Continent Casualty Co.* and *Don's Building Supply, Inc. v. One Beacon Insurance Co.*



The facts in *Pine Oak* are fairly standard for a construction defect case. Pine Oak Builders, Inc. ("Pine Oak") was sued by five different homeowners alleging various construction defects, including water damage because of defective construction. Four of the suits alleged improper installation of a synthetic stucco product known as an Exterior Insulation and Finish System ("EIFS"). The other suit, the "*Glass* Lawsuit", alleged water damage due to improper design and construction of columns and a balcony.

Great American and Mid-Continent Casualty Co. issued occurrence-based commercial general liability (CGL) policies to Pine Oak, covering April 1993 to April 2003. The homeowner suits were filed between February 2002 and March 2003. Pine Oak tendered the claims to its insurers, and the insurers denied any duty to defend. The insurers sought a declaratory judgment that they owed no defense, and Pine Oak sued for breach of the insurers' defense obligations. Both sides sought summary judgment. The trial court granted summary judgment for the insurers on all issues. An intermediate court of appeals held that Great American had a duty to defend four of the five underlying lawsuits but held that Great American did not have a duty to defend Pine Oak in the *Glass* Lawsuit by virtue of the "Damage to Your Work" Exclusion. Pine Oak appealed, among other things, that part of the appeals court ruling pertaining to the *Glass* Lawsuit.

COURT REFUSES EXTRINSIC EVIDENCE — *PINE OAK BUILDERS, INC., V. GREAT AMERICAN LLOYDS INSURANCE COMPANY,* 279 S.W.3D 650 (TEX. 2009), CONT'D

The first two issues addressed by the Court in its opinion relate to its decision in *Lamar Homes, Inc. v. Mid-Continent Casualty Company*, 242 S.W.3d 1 (Tex. 2007). Great American argued that Pine Oak's faulty-workmanship claims did not allege "property damage" caused by an "occurrence". The Court concluded, "This argument is foreclosed by *Lamar Homes*…, where we held that a claim of faulty workmanship against a homebuilder was a claim for damage caused by an occurrence under a CGL Policy." Citing *Lamar Homes* again, the Court reversed the court of appeal's holding that the Prompt Payment of Claims Statute does not apply to an insurer's breach of the duty to defend.

The Court next addressed an issue raised in *Don's Building Supply, Inc. v. OneBeacon Insurance Co.*, 267 S.W.3d 20 (Tex. 2008) – trigger of coverage. Great American urged the Court to adopt a manifestation rule for deciding whether property damage occurred during a Great American policy period. The court of appeals had followed an exposure rule to determine what policies were triggered. The Texas Supreme Court noted that it rejected both of these trigger theories in *Don's Building* and adopted the actual-injury rule instead. Under the Court's version of the actual-injury rule, property damage occurs during the policy period if "actual physical damage to the property occurred" during the policy period. The Court held that, on remand, the trial court should apply the actual-injury rule.

The final issue addressed by the Court was Pine Oak's request to introduce evidence outside of the eight corners of the policy and the underlying petition to establish Great American's duty to defend in the *Glass* Lawsuit. In the four underlying lawsuits where the appeals court had held that Great American had a duty to defend Pine Oak, there were allegations that the defective work was performed by one or more of Pine Oak's subcontractors. The *Glass* petition, however, contained no allegations of defective work performed by a subcontractor. Instead, the *Glass* petition asserted causes of actions for breach of contract and warranty, violation of the Residential Construction Liability Act, and negligence, based on Pine Oak's alleged failure to perform its work in a good and workmanlike manner and a failure to make requested repairs.

At issue was the "subcontractor exception" to the "Damage to Your Work" Exclusion, which states that the exclusion does not apply "if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor." Coverage, therefore, depends in part on whether the alleged defective work was performed by Pine Oak or a subcontractor.

In the coverage lawsuit, Pine Oak submitted evidence that the defective work alleged in the *Glass* case was performed by subcontractors. Pine Oak argued that this extrinsic evidence should be considered in a duty to defend analysis, even though it directly contradicted the facts alleged in the *Glass* Lawsuit. The *Glass* Lawsuit alleged that Pine Oak alone was responsible for the defective construction.

Hewing to its strict interpretation of the eight-corners rule, the Court rejected Pine Oak's invitation to relax its interpretation of the eight-corners rule and allow insureds the opportunity to offer extrinsic evidence to trigger the duty to defend. Rather, the Court held that the claims of faulty workmanship against Pine Oak were excluded from coverage under the "your work" exclusion and that the "subcontractor exception" did not apply because the *Glass* petition had not alleged any faulty workmanship performed by subcontractors. Thus, Texas remains a strict eight-corners rule state, in which the insurer's duty to defend is limited to those claims actually asserted in the underlying lawsuit.

Jamie Carsey and Diana Brown

WHEN MOLD ATTACKS — ACCIDENTAL DISCHARGE UNDER AN HO-B FORM: *PAGE V. STATE FARM LLOYDS*

Having already heard oral arguments in *Page v. State Farm Lloyds*, the Texas Supreme Court is considering whether the Texas Homeowners Form B ("HO-B") covers mold damage to personal property *and* the dwelling that results from accidental discharge, such as plumbing leakage.

The HO-B policy is a standardized insurance form that was the most commonly purchased insurance policy in Texas as recently as the early 2000s. At that time, its use began to decline as its susceptibility to water damage losses became apparent to insurance carriers. The Coverage A insuring agreement of the HO-B policy provides that all physical loss to the dwelling is covered unless the loss is excluded. Coverage B provides that all physical loss to personal property caused by a *listed* peril is covered unless excluded. One of the listed perils includes "accidental discharge, leakage or overflow of water or steam" from within a plumbing system. Immediately following this peril is the "exclusion repeal provision," which provides that a mold exclusion (among others) listed later in the policy does not apply to a loss caused by this peril.

The Waco Court of Appeals held in *Page* that the HO-B policy provides dwelling and personal property coverage for this type of loss. *Page v. State Farm Lloyds*, 259 S.W.3d 257, 264 (Tex.App.—Waco 2008, pet. granted). In *Page*, State Farm received a claim for mold damage growing out of leaks in the insured's home sewer lines. State Farm was initially complicit in remediating the claimed damage. However, when the insured requested additional funds to replace carpet, State Farm declined to remit funds without a showing that amounts already paid were insufficient to cover the loss. The insured subsequently filed suit, alleging a myriad of claims, including breach of contract.

State Farm contended that the Supreme Court's decision in *Fiess v. State Farm Lloyds* was controlling. In *Fiess*, the Court addressed whether mold contamination caused by water leakage in the roof and around windows was excluded by the mold exclusion. The Supreme Court held that this exclusion was applicable and that the claimed mold damage was excluded. In reaching its conclusion, the Court held that (1) the mold exclusion was unambiguous, and (2) mold damage is not "water damage." State Farm's position, as clarified in its petition to the Supreme Court, is that this holding stood for the proposition that the HO-B policy does not provide dwelling coverage for mold damage. Therefore, the heart of the dispute between State Farm and the insured is State Farm's belief that the "exclusion repeal provision" contained in the HO-B policy applies only to a loss of *personal property* caused by accidental leakage.

The court of appeals declined to apply *Fiess* based on factual distinctions and, instead, followed the Texas Supreme Court's opinion in *Balandran v. Safeco Insurance Company of America*. In that case, the Supreme Court addressed the issue of whether the HO-B policy covers damage from foundation movement caused by an underground plumbing leak. It held that the exclusion repeal provision was ambiguous, because it subjected the policy to two competing interpretations: (1) it applies only to a loss to personal property caused by a plumbing leak, or (2) it applies to any covered loss caused by a plumbing leak. Because Texas courts construe ambiguous insurance provisions in favor of the insured, the Court adopted the insured's construction that the exclusion repeal provision applies to any covered loss caused by a plumbing leak.

Following *Balandran*, the Waco Court of Appeals in *Page* also held that the exclusion repeal provision is ambiguous. The court, therefore, concluded that, as a matter of law, the HO-B policy covers any loss (including mold) to personal property *and* the dwelling resulting from accidental discharge. Whether this analysis stands is currently in the hands of the Texas Supreme Court.

Steve Poston

TEXAS SUPREME COURT ADDRESSES STATUTORY EMPLOYER IMMUNITY FOR GENERAL CONTRACTORS

The Texas Supreme Court rendered its opinion in *HC Beck, Ltd. v. Rice* this spring, addressing the extent to which a general contractor must "provide" workers' compensation insurance under the Workers' Compensation Act to qualify for statutory employer status and the resulting immunity from the work-related claims of subcontractor's employees. 284 S.W.3d 349 (Tex. 2009). In that case, FMR Texas, Ltd. contracted with HCBeck to construct an office campus on FMR's property. One of the features of the contract was a workers' compensation insurance plan provided by FMR covering the worksite. The contract also provided that the insurance plan, part of an owner-controlled insurance program (OCIP), must be incorporated into all HCBeck's subcontracts pertaining to the FMR project. Accordingly, HCBeck contractually required its subcontractors to enroll in the OCIP. And, as each subcontractor enrolled in the OCIP, FMR's insurance representative designated the subcontractor an "insured" for workers' compensation.

While working on the FMR project, Charles Rice, an employee of HCBeck's subcontractor, Haley Greer, was injured and submitted a claim for worker's compensation benefits under the policy issued to Haley Greer pursuant to FMR's OCIP. Rice then filed a negligence suit against HCBeck.

HCBeck moved for summary judgment asserting that, because it "provided" worker's compensation insurance to Haley Greer, HCBeck qualified as a statutory employer pursuant to Texas Labor Code §406.123(e), and Rice's exclusive remedy should be worker's compensation benefits, which he received. Rice contended that HCBeck did not "provide" insurance, because HCBeck did not pay the premiums for the FMR OCIP, and the HCBeck/Haley Greer subcontract obligated Haley Greer to provide its own coverage in the event that FMR terminated the OCIP. The supreme court rejected Rice's reasoning, holding that HCBeck "provided" workers' compensation insurance under the Act and was, therefore, entitled to the exclusive remedy defense.

In its opinion, the court pointed out that §406.123(a) of the Labor Code expressly allows a general contractor to enter into a written agreement to provide worker's compensation insurance to subcontractors and their employees, and that provision does not require a general contractor to actually buy workers' compensation insurance. In this case, HCBeck "provided" workers' compensation insurance by contractually requiring the subcontractor, Haley Greer, to enroll in the FMR OCIP. Additionally, in the event the OCIP was terminated, HCBeck contractually agreed either to buy the insurance itself or to compensate Haley Greer for any insurance premiums. In any event, the court noted that the mere possibility Haley Greer might have to secure alternate insurance on its own if the OCIP was terminated should not prevent HCBeck from asserting statutory employer status under the Act. Accordingly, because HCBeck "provided" coverage to Haley Greer and its employees by virtue of the OCIP, HCBeck qualified as a statutory employer and was afforded the Act's employer benefits, including the exclusive remedy defense.

Linda M. Szuhy

FIFTH CIRCUIT CLARIFIES THE CGL POLICY'S EXCLUSIONS (J)(5) AND (J)(6) AND FINDS AN INSURER IS BOUND BY A DEFAULT JUDGMENT AFTER A WRONGFUL DENIAL

Earlier this year, the United States Court of Appeals for the Fifth Circuit issued an opinion in *Mid-Continent Cas. Co. v. JHP Development, Inc.*, clarifying the application of exclusions (j)(5) and (j)(6) in a commercial general liability policy under Texas law. 557 F.3d 207 (5th Cir. 2009). The Fifth Circuit also found that an insurer that wrongfully denies is liable for a default judgment entered against the insured.

Mid-Continent Casualty Company ("Mid-Continent") filed suit against JHP Development, Inc. ("JHP"), seeking a declaration that it had no duty to defend or indemnify JHP in a lawsuit alleging that JHP defectively constructed a condominium project. JHP and the underlying plaintiff, TRC Condominiums, Ltd. ("TRC"), entered into an agreement for the construction of a four-story structure to be divided into five units, with one unit designated as a model unit. The other four units were to remain partially unfinished until they were sold to allow the new owners to select the finishes. At the time JHP completed the model unit, the other four units still required painting, flooring, plumbing and electrical fixtures, and the activation of the HVAC system. Due to JHP's failure to properly water-seal the exterior finishes and retaining walls, large amounts of water entered the interior of the units, damaging drywall, framing, flooring and electrical wiring. As a result of the damage and JHP's refusal to repair the damage and complete the work, TRC terminated the construction agreement. TRC completed the repairs and construction at its own cost of over $2.2 million. Mid-Continent denied JHP's request for coverage and a defense, and a default judgment ultimately was entered against JHP, which did not attend trial, in an amount exceeding $1.5 million.

The District Court found that Mid-Continent owed coverage to JHP and was bound by the default judgment. Mid-Continent appealed, asserting that exclusions (j)(5) and (j)(6) precluded coverage for TRC's damage. Exclusion (j)(5) excludes "property damage" to "[t]hat particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the 'property damage' arises out of those operations." Exclusion (j)(6) excludes "property damage" to "[t]hat particular part of any property that must be restored, repaired or replaced because 'your work' was incorrectly performed on it." The policy further states that exclusion (j)(6) "does not apply to 'property damage' included in the 'products-completed operations hazard.'"

The parties[1] agreed that the use of the present tense "are performing operations" in exclusion (j)(5) means that the exclusion only applies to "property damage" occurring during JHP's construction operations, but they disagreed as to whether JHP actually was "performing operations" when the water intrusion occurred. Mid-Continent argued that JHP

1 JHP failed to answer in the declaratory judgment action. TRC also was sued by Mid-Continent, and argued in favor of coverage as a judgment creditor.

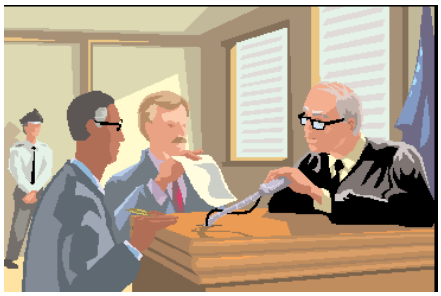
FIFTH CIRCUIT CLARIFIES THE CGL POLICY'S EXCLUSIONS (J)(5) AND (J)(6) AND FINDS AN INSURER IS BOUND BY A DEFAULT JUDGMENT AFTER A WRONGFUL DENIAL, CONT'D

was performing operations, because four units remained unfinished; whereas TRC asserted that JHP was not performing operations, because construction had been suspended at the time the water intrusion occurred. The Court agreed with TRC: the prolonged, open-ended and complete suspension of construction activities pending the purchase of condominium units does not fall within the ordinary meaning of "performing operations." The Court noted that this was not merely a brief or temporary halt, but rather a total cessation of active construction for the foreseeable future. Therefore, the Court held that exclusion (j)(5) did not apply to bar coverage.

TRC argued that the "[t]hat particular part" language in exclusion (j)(6) applied the exclusion only to the exterior portions of the condominiums that were not properly waterproofed, because this portion of JHP's work was the particular part improperly performed that caused damage. Mid-Continent argued that the exclusion applied to all property damage resulting from JHP's work on the project. The Court held that exclusion (j)(6) bars coverage only for "property damage" to the actual part of the property that was the subject of the defective work and does not apply to the part of the property that was the subject of non-defective work and damaged as a result of defective work on another part of the property.

Mid-Continent also argued, unsuccessfully, that it was not bound by the default judgment because the underlying lawsuit was not a fully adversarial proceeding. In support of its argument, Mid-Continent relied upon *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996), in which the court invalidated an insured's assignment of his claims against his insurer. Prior to *Gandy*, the Texas Supreme Court held in *Employers Cas. Co. v. Block* that an insurer who refuses to defend an insured when it has a duty to do so is bound by the amount of the judgment against the insured. *See* 744 S.W.2d 940 (Tex. 1988). In *Gandy*, the Supreme Court modified the holding in *Block* in instances where an insured assigned its rights to a claimant without a fully adversarial trial.

The Texas Supreme Court recently clarified *Gandy's* holding to apply "only to cases that present its five unique elements." *See Evanston Ins. Co. v. ATOFINA Petrochems., Inc.*, 256 S.W.3d 660 (Tex. 2008). Citing *ATOFINA*, the Fifth Circuit held that *Gandy* did not apply, because JHP did not assign any claims against Mid-Continent to TRC. In accordance with *Block* and *ATOFINA*, Mid-Continent was bound by the default judgment against JHP.



This holding has the potential to seriously affect the manner in which an insurer handles its claims, particularly in those cases involving insureds with smaller businesses. In other words, if an insurer denies coverage, the insured who cannot or will not defend itself at trial potentially sets up the insurer for a large indemnity payment. Accordingly, unless the insurer is completely secure in its coverage position, the insurer would be wise to resolve the coverage issue if at all possible through a declaratory judgment action.

Mariah Quiroz

PRODIGY COMMUNICATIONS CORP. V. AESIC: THE TEXAS SUPREME COURT DISTINGUISHES NOTICE PROVISIONS IN CLAIMS-MADE POLICIES AND REQUIRES A SHOWING OF PREJUDICE

On March 27, 2009, the Texas Supreme Court considered whether the notice-prejudice rule announced in *PAJ, Inc. v. The Hanover Insurance Company* applies to a claims-made policy in which the notice provision requires that the insured, "as a condition precedent" to its rights under the policy, give the insurer notice of a claim "as soon as practicable…, but in no event later than ninety (90) days after the expiration of the Policy Period or Discovery Period." The parties disputed whether notice of the claim was given "as soon as practicable," but they agreed that the insured gave notice within the ninety-day cut-off period. The insurer also admitted that it suffered no prejudice by the delayed notice. The supreme court concluded that "notice as soon as practicable" was not an essential part of the bargain under the claims-made policy at issue, and prejudice to the insurer was thus required to defeat coverage. *Prodigy Communications Corp. v. Agric. Excess & Surplus Ins. Co.*, 288 S.W.3d 374 (Tex. 2009).

Prodigy Communications merged with FlashNet Communications in May of 2000. FlashNet was insured at the time under a directors-and-officers claims-made liability policy issued by Agricultural Excess & Surplus Insurance Company ("AESIC"). The policy covered losses resulting from claims first made against FlashNet and its directors and officers between March 16, 2000, and May 31, 2000. Anticipating its merger with Prodigy, FlashNet paid additional premium for a three-year Discovery Period, which extended coverage for claims first made between May 31, 2000, and May 31, 2003. The policy included an amended "Notice of Claim" provision that read:

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

Id. at 376.

A class action securities lawsuit was filed against FlashNet in late 2001; and Prodigy was served with the complaint on June 20, 2002. Prodigy first notified AESIC of the FlashNet lawsuit by letter dated June 6, 2003. AESIC denied coverage, asserting that Prodigy's June 6, 2003, letter did not comply with the policy's condition precedent of notifying AESIC of the claim "as soon as practicable."

The question to the supreme court was whether an insurer can deny coverage under a claims-made policy "based on its insured's alleged failure to comply with a policy provision requiring that notice of a claim be given 'as soon as practicable,' when (1) notice of the claim was provided before the reporting deadline specified in the policy; and (2) the insurer was not prejudiced by the delay." In analyzing this legal issue, the court first reiterated its holding in *PAJ* (dealing with an occurrence-based policy) that "an insured's failure to timely notify its insurer of a claim or suit does not defeat coverage if the insurer was not prejudiced by the delay." The conclusion in *PAJ* was based on a prior supreme court holding that an immaterial breach does not deprive the insurer of the benefit of the bargain or relieve the insurer of a coverage obligation. *Id.* at 377.

AESIC advanced two main arguments that *PAJ* was distinguishable and did not control the outcome of its dispute with Prodigy. First, AESIC argued that, unlike the *PAJ* policy, AESIC's policy stated that the insured's duty to give written notice as soon as practicable is a "condition precedent" to coverage. But the court summarily disposed of this argument by pointing out that the holding in *PAJ* did not rest on the distinction between conditions and covenants. Rather, *PAJ* focused on whether the breach of the insurance contract was material, such that the non-breaching party (*i.e.*, the insurer) would be deprived of the benefit that it could have reasonably anticipated from full performance. *Id.* at 378.

PRODIGY COMMUNICATIONS CORP. V. AESIC: THE TEXAS SUPREME COURT DISTINGUISHES NOTICE PROVISIONS IN CLAIMS-MADE POLICIES AND REQUIRES A SHOWING OF PREJUDICE, CONT'D

The bulk of the court's opinion addressed AESIC's second argument that *PAJ* involved an occurrence-based policy and AESIC's was a claims-made policy. The court acknowledged that it recognized in *PAJ* the critical distinction between the role of notice in claims-made policies and that of occurrence policies, concluding that timely notice "was not an essential part of the bargained-for exchange in *PAJ's* occurrence-based policy." *Id.* (citing *PAJ*, 243 S.W.3d at 636). To determine whether "notice as soon as practicable" was an essential part of the bargained-for exchange in AESIC's claims-made policy, the court reviewed the basic distinctions between occurrence and claims-made policies and analyzed the different notice requirements typically associated with each, relying almost exclusively on insurance law treatises and non-Texas cases.

A claims-made policy covers only those claims first asserted against the insured during the policy period, which is a limitation appearing in the insuring clause, while an occurrence-type policy covers only claims arising out of occurrences happening in the policy period, irrespective of when the claim is made. *Id.* (citing 3 ROWLAND H. LONG, THE LAW OF LIABILITY INSURANCE § 12A.05[3] (2006). The primary advantage of a claims-made policy is to limit liability to claims asserted during the policy period, which allows insurers "to calculate risks and premiums with greater precision." *Id.* at 379 (citing 20 HOLMES' APPLEMAN ON INSURANCE 2D § 130.1(A)(l)). By eliminating its exposure for claims filed after the policy period, the insurer is able to issue claims-made policies at reduced premiums.

Both occurrence policies and claims-made policies typically require that the insurer be notified of a claim promptly or "as soon as practicable." But, unlike occurrence policies, claims-made-*and-reported* policies also require that the claim be reported to the insurer within the policy period or a specified number of days thereafter.[1] These two reporting requirements in a claims-made policy serve very different purposes. In a claims-made policy, the requirement that notice be given to the insurer "as soon as practicable" serves to "maximiz[e] the insurer's opportunity to investigate, set reserves, and control or participate in negotiations with the third party asserting the claim against the insured." […] By contrast, the requirement that the claim be made during the policy period "is directed to the temporal boundaries of the policy's basic coverage terms.... [This type of notice] is not simply part of the insured's duty to cooperate, but defines the limits of the insurer's obligation, and if there is no timely notice, there is no coverage." […]

Similarly, a notice provision requiring that a claim be reported to the insurer during the policy period or within a specific number of days thereafter "define[s] the scope of coverage by providing a certain date after which an insurer knows it is no longer liable under the policy."

Id. at 380 (citations omitted). The court also cited a Massachusetts Supreme Court case for the proposition that "'Fairness in rate setting is the purpose of a requirement that notice of a claim be given within the policy period or shortly thereafter' and therefore this type of notice requirement 'is of the essence in determining whether coverage exists' in a claims-made policy." *Id.* (citing *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28, 29-30 (Mass. 1990)).

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[1] The AESIC policy's requirement that notice of a claim be given "as soon as practicable during the policy period,… but in no event later than ninety (90) days after the expiration of the Policy Period, or Discovery Period" was characteristic of a claims-made-and-reported policy. *Id.* at n.7.

PRODIGY COMMUNICATIONS CORP. V. AESIC: THE TEXAS SUPREME COURT DISTINGUISHES NOTICE PROVISIONS IN CLAIMS-MADE POLICIES AND REQUIRES A SHOWING OF PREJUDICE, CONT'D

Because the requirement that a claim be reported to the insurer during the policy period or within a specific number of days thereafter is considered essential to coverage under a claims-made-and-reported policy, the supreme court noted that most courts have found that an insurer does not need to demonstrate prejudice to deny coverage based on an insured's failure to comply with this reporting requirement. The court then discussed two foreign state supreme court decisions holding that the statutory notice-prejudice requirements in those jurisdictions applied only to the "as soon as practicable" type of notice and not to the requirement that a claim be reported within the policy period or the extended reporting period. *Id.* at 381-82 (citing *Chas. T. Main*, 551 N.E. 2d at 30; *T.H.E. Insurance Company v. P.T.P., Inc.*, 628 A.2d 223, 227-28 (Md. 1993)).

The Texas Supreme Court agreed with these other supreme courts' analyses, holding that in a claims-made policy, "when an insured gives notice of a claim within the policy period or other specified reporting period, the insurer must show that the insured's non-compliance with policy's "as soon as practicable" notice provision prejudiced the insurer before it may deny coverage." In reaching this holding, the court concluded that Prodigy's obligation to provide AESIC with notice of a claim "as soon as practicable" was not material to the bargained-for exchange under the claims-made policy at issue. Because AESIC admitted that it was not prejudiced, its coverage denial based on Prodigy's alleged failure to provide notice "as soon as practicable" was improper. *Id.* at 382.

Justice Johnson dissented in an opinion joined by Justices Hecht and Willett, remarking that the court had rewritten an unambiguous insurance contract and changed the agreement of the parties. The dissenting justices noted that the insuring agreements and notice provisions of the AESIC policy were completely separate, which they believe should militate against classifying one notice provision as more important than the other. They asserted that the policy language shows that AESIC and Prodigy intended for the two notice provisions to have the same effect – that of a condition precedent – and the court should respect the agreement. "[I]f changes to insurance policy language are to be mandated that affect timing and amount of insurers' actual or incurred loss provisions, other parts of the insurance companies' business, and policy clauses related to rate or premium calculations," the better choice, according to the dissent, is for courts to leave such changes to the legislature and regulatory agencies.

On the same day that the *Prodigy v. AESIC* opinion was delivered, the Texas Supreme Court also ruled on a virtually identical certified question from the U.S. Fifth Circuit Court of Appeals in *Financial Indus. Corp. v. XL Specialty Ins. Co.*, 285 S.W.3d 877 (Tex. 2009). That case involved a claims-made policy rather than a claims-made-and-reported policy like the one at issue in *Prodigy*. *Id.* at 878. Financial Industries and its insurer, XL, stipulated that Financial Industries' notice breached the policy's prompt notice provision but did not prejudice XL, since the notice was still given during the policy period. The court relied on its reasoning in *Prodigy*, holding that Financial Industries' failure to give notice "as soon as practicable" did not interfere with XL's material benefit under the policy to "close its books" at the policy's expiration. *See id.* at 878-79.

After *Prodigy Communications*, it is now well established in Texas that an insurer must show prejudice because of an insured's failure to give notice "as soon as practicable" to deny coverage under either an occurrence or claims-made policy. Although the Texas Supreme Court has not yet confirmed that an insurer must also show prejudice to deny coverage for an insured's failure to comply with other liability policy conditions, such as the voluntary payments clause, its materiality-to-the-bargain analysis and reluctance to give legal effect to "condition precedent" policy language would seem to make the existence of a prejudice requirement in those situations more likely.

Eric K. Bowers

TEXAS MUTUAL INSURANCE COMPANY V. RUTTIGER
WILL TEXAS MAINTAIN BAD FAITH IN WORKERS' COMPENSATION CLAIMS?

Will the cause of action for breach of the duty of good faith and fair dealing remain a viable claim in Texas in the context of a bad faith suit arising from the handling of a workers' compensation claim?

In *Texas Mut. Ins. Co. v. Ruttiger*, 265 S.W.3d 651 (Tex. App.—Houston [1st Dist.] 2008, pet. granted) the First District Houston Court of Appeals addressed a number of issues regarding the trial court's finding that Texas Mutual acted in bad faith through its handling of Timothy Ruttiger's workers' compensation claim. Ruttiger originally filed a claim for workers' compensation benefits alleging that he sustained bilateral inguinal hernias after lifting metal conduit while working for A & H Electric Company. Texas Mutual, the workers' compensation insurer for A & H, denied Ruttiger's claim on the grounds that he sustained his injury while playing softball, and, therefore his injury was not compensable because it did not occur in the course and scope of his employment. However, Texas Mutual later entered into a Benefit Dispute Agreement ("BDA") with Ruttiger providing that Ruttiger had sustained a compensable injury in the form of bilateral inguinal hernias on the date in question.

After his claim was accepted as compensable, Ruttiger filed a suit against Texas Mutual alleging that it violated the Texas Insurance Code ("TIC") and Texas Deceptive Trade Practices – Consumer Protection Act ("DTPA") and breached the common law duty of good faith and fair dealing in denying the compensability of his claim. The jury found that Texas Mutual failed to comply with its duty of good faith and fair dealing, engaged in unfair and deceptive acts or practices, and engaged in those acts and practices knowingly. The jury awarded Ruttiger $37,500 for past physical pain and suffering, $5,000 for future physical pain and suffering, $11,500 for past damage to credit reputation, $5,000 for future damage to credit reputation, $4,500 for past physical impairment, $100,000 for past mental anguish, and $20,000 in additional damages based on the finding that Texas Mutual's conduct was committed knowingly.

On appeal, Texas Mutual asserted, in part, that the trial court lacked jurisdiction to award damages to Ruttiger based on his bad faith claim, because Ruttiger had never obtained a finding from the Texas Workers' Compensation Commission that he was entitled to workers' compensation benefits. Texas Mutual also asserted on appeal that no cause of action exists in Texas for breach of the duty of good faith and fair dealing in the context of a workers' compensation claim.

The First District Court of Appeals, in first addressing Texas Mutual's jurisdictional argument, noted that *American Motorists Ins. Co. v. Fodge*, 63 S.W.3d 801 (Tex. 2001) was distinguishable from the facts of this case. In *Fodge*, a workers' compensation claimant was initially denied workers' compensation benefits, but the claimant and insurer later agreed that the claimant had sustained a compensable injury. The Commission hearing officer ordered the insurer to pay income benefits to the claimant, which it did. But, the claimant never complained about the insurer's denial of medical benefits. She then filed a bad-faith suit alleging that the insurer had denied payment for medical benefits, had delayed payment of awarded income benefits, and had failed to pay her additional income benefits that had never been awarded by the Commission. The Texas Supreme Court found that, because only the Commission can determine a claimant's entitlement to benefits, a court cannot award damages for a denial in payment of compensation benefits until the Commission finds that such benefits are due. Consequently, the court had juris-

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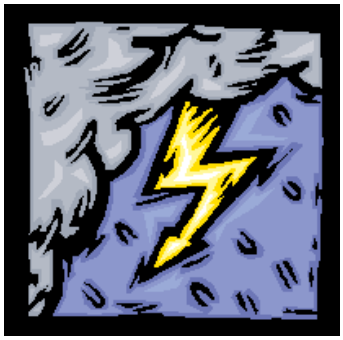
APPRAISE FIRST, ARGUE LATER — TEXAS SUPREME COURT SENDS MESSAGE THAT TEXAS COURTS WILL NOT ALLOW PARTIES TO CIRCUMVENT APPRAISAL CLAUSES BUT WILL LET THEM ARGUE COVERAGE LATER

In *State Farm Lloyds v. Johnson*, 290 S.W.3d 886 (Tex. 2009), the Texas Supreme Court held that "appraisals should generally go forward without preemptive intervention by the courts." Arguably, this means that, if a contract contains an appraisal clause and no agreement can be made as to the amount of loss, only in extraordinary circumstances will a court allow a party to refuse to submit to the appraisal.

In *Johnson*, the court noted that appraisal clauses exist in virtually all Texas property insurance policies; and, despite the vagueness regarding the scope of appraisal, there has rarely been any litigation regarding what the scope of appraisal includes. *Johnson* involved a dispute over hail damage to a homeowner's roof, and both parties agreed that the scope of appraisal included damage questions and excluded liability questions. They disagreed, however, as to whether the particular facts involved concerned a damage or liability question.

After a hailstorm hit Plano, Texas, in April of 2003, the homeowner filed a claim under her homeowner's policy. State Farm's inspector determined that only the damage to the ridgeline of her roof was due to hail and estimated repair costs below the deductible. The homeowner's roofing contractor determined that the entire roof needed to be replaced. The difference between the two estimates was almost $13,000.



The homeowner demanded appraisal of the "amount of loss" under the Appraisal Clause in her standard-form homeowner's policy. The Appraisal Clause requires the parties to submit to an appraisal if no agreement on the amount of loss can be reached. Each party selects an appraiser, and then the two appraisers select an impartial umpire. If the two appraisers are unable to come to an agreement as to the amount of loss within a reasonable time, they submit their differences to the umpire. Any written agreement signed by two of the three appraisers shall set the amount of loss.

State Farm refused to participate in an appraisal, because it claimed the parties disagreed over the cause of loss rather than the amount of loss; and causation is for the courts to decide. The court discussed the problem with this rationale, "[e]ven if the parties' dispute involves causation, that does not prove whether it is a question of liability or damages." The court explained that the difficulty arises from the fact that causation is the link between liability and damages, which sometimes falls solely in the arena of the courts and other times the appraiser. The court discussed hypothetical situations to illustrate this point.

The court explained that "when different causes are alleged for a single injury to property, causation is a liability question for the courts." Otherwise, in these situations, an appraiser who determined the cost of repairs and the causation would leave no liability question for the courts. On the other hand, "when different types of damage occur to different items of property, appraisers may have to decide the damage caused by each before the courts can decide liability."

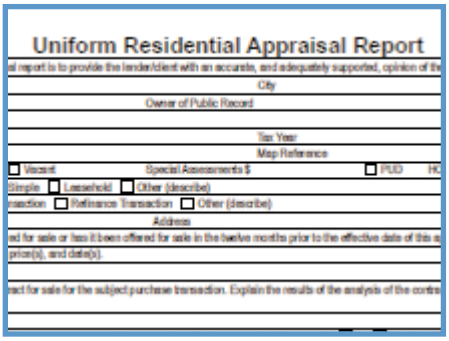
For example, in a case involving damages due to water (a covered peril) and damages due to mold (coverage was disputed), the appraiser assessed a dollar amount for the water damage but made no finding regarding the mold damage. The court of appeals rejected the "argument that appraisal is barred 'whenever causation factors into the award'" and affirmed the water damage award, finding the mold damage moot by finding no coverage. The court concluded that, "[i]n this context, courts can decide whether water or mold damage is covered, but if they can also decide the amount of damage caused by each, there would be no damage questions left for the appraisers."

It appears the court is concerned with ensuring that the appraisal clause maintains its significance, while also maintaining a role for the courts. Therefore, appraisers must be allowed to "allocate damages between covered and excluded perils." Otherwise, whenever the causation issue involved determining loss due to a covered event versus a pre-existing condition,

APPRAISE FIRST, ARGUE LATER — TEXAS SUPREME COURT SENDS MESSAGE THAT TEXAS COURTS WILL NOT ALLOW PARTIES TO CIRCUMVENT APPRAISAL CLAUSES BUT WILL LET THEM ARGUE COVERAGE LATER, CONT'D

the appraiser would be unable to make a determination. This would result in rendering appraisal clauses inoperative in a large number of cases. The Texas Supreme Court has held that "we must read all parts of a policy together, giving meaning to every sentence, clause, and word to avoid rendering any portion inoperative."

The court concluded its discussion of whether causation disputes are a question of liability or damages by acknowledging that "[a]ny appraisal necessarily includes some causation element, because setting the 'amount of loss' requires appraisers to decide between damages for which coverage is claimed from damages caused by everything else." Ultimately, the court decided that State Farm could not avoid appraisal "merely because there might be a causation question that exceeds the scope of appraisal."


Uniform Residential Appraisal Report

The court noted factors helpful in determining whether an appraiser has gone beyond the damage questions: the nature of the damage, the possible causes, the parties' dispute, and the structure of the appraisal award. The court's language indicates that these factors would only be applied after the appraisal has taken place; and, thus, parties will almost always have to submit to an appraisal before being able to dispute whether the appraisal exceeded its intended scope. The court said,

> There may be a few times when appraisal is so expensive and coverage is so unlikely that it is worth considering beforehand whether an appraisal is truly necessary. But unless 'amount of loss' will never be needed (a difficult prediction when litigation has yet to begin), appraisals should generally go forward without preemptive intervention by the courts.

In other words, appraise first and argue about whether the scope was exceeded later.

Matthew Rittmayer

INSURERS BEWARE: PENALTIES ACCRUE WHEN DEFENSE FEES ARE INCURRED

The Northern District of Texas issued an unexpected opinion favorable to insureds that extends the punitive effect of the penalties provided by Texas' Prompt Payment of Claims Act when applied to an insured's right to a defense benefit. *See Trammell Crow Residential Co. v. Virginia Surety Company, Inc.*, 643 F. Supp.2d 844 (N.D. Tex. 2008, rehrg. denied). Even after recognizing that proof of the insured's defense costs are necessary to calculate the damages for which an insurer is liable, Chief Judge Sidney Fitzwater held that an insurer can be liable under the Prompt Payment of Claims Act for wrongfully failing to defend even when the insured has not submitted statements of its defense costs to the insurer. 643 F. Supp.2d at 859. Insurers must be mindful that, even if its decision to deny a defense is made in good faith and constitutes a reasonable dispute of a coverage question, the penalties prescribed by the Texas Prompt Payment of Claims Act can be assessed when a defense is wrongfully denied and interest penalties accrue as soon as the insured begins incurring defense costs.

The Prompt Payment of Claims Act ("the Act") prohibits insurers from unnecessarily delaying the payment of first-party claims. TEX. INS. CODE §§542.051 – .061(Vernon 2007). Section 542.058 provides:

> "Except as otherwise provided, if an insurer, after receiving all items, statements, and forms reasonably requested and required under Section 542.055,

INSURERS BEWARE: PENALTIES ACCRUE WHEN DEFENSE FEES ARE INCURRED, CONT'D

> delays payment of the claim…, the insurer shall pay damages and other items as provided by Section 542.060."

Until 2007, the question of whether the Act applies to an insurer's denial of a duty to defend was a hotly-contested issue. In that year, however, the Texas Supreme Court issued a surprising and controversial opinion that answered the question and held that an "insured's right to a defense benefit is a first-party claim" and that the Act "may be applied when an insurer wrongfully refuses to promptly pay a defense benefit owed to the insured." *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 20 (Tex. 2007). The Supreme Court reasoned that, "when the insurer wrongfully rejects its defense obligation, the insured has suffered an actual loss that is quantified after the insured retains counsel and begins receiving statements for legal services." *Lamar Homes*, 242 S.W.3d at 19. The Supreme Court explained that "[t]hese statements or invoices are the last piece of information needed to put a value on the insured's loss." *Id.* By contorting a demand for defense into a "first-party claim," the Supreme Court permitted insureds, who successfully contest an insurer's decision to deny a defense, to recover the amount of the "claim" and "interest in an amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees." TEX. INS. CODE §542.060 (Vernon 2007). Despite the unfavorable ruling, there was little question among the insurance industry that the *Lamar Homes* opinion, while a tortured effort to transform a third-party claim into a first-party claim, also required the insured to forward defense billing statements and invoices to the insurer as a condition precedent to the insured's invocation of an alleged violation of the Act. In other words, there could be no violation of the Act unless the insurer received the insured's documentation of incurred defense fees and costs and failed to pay them within the deadlines prescribed by the Act.

Not so, said Chief Judge Fitzwater.

In response to Trammell Crow's motion for summary judgment raising the issue of the Prompt Payment penalties, Virginia Surety contended that, even if it had wrongfully denied a defense to Trammell Crow, the central issue as to application of the Act is when Virginia Surety had all information necessary to secure a final proof of loss as provided by the Act. Virginia Surety urged the Act requires that an insurer have received evidence of the incurred defense costs to have standing to assert a violation of the Act. Trammell Crow responded by noting that Virginia Surety denied coverage outright and offered no evidence of a request to Trammell Crow for production of defense invoices or any information bearing on Virginia Surety's defense obligation.

After granting summary judgment in favor of Trammell Crow on the question of whether a defense was owed, the Court found that Trammell Crow was also entitled to summary judgment on its claims for penalties assessed by the Act, irrespective of Trammell Crow's failure to submit documentation to Virginia Surety evidencing any fees incurred by Trammell Crow in defense of the underlying liability action. In contravention of the Act's requirement that the insurer receive all items, statements, and forms reasonably required as a condition precedent to invoking the penalties of the Act, Judge Fitzwater held that "an insurer becomes liable under the [Act] when it wrongfully rejects its defense obligation." *Trammell Crow*, 643 F. Supp.2d at 859. Directly rejecting Virginia Surety's argument, Judge Fitzwater held that the penalties of the Act can begin accruing when the insured actually incurs the defense costs, irrespective of whether the insured forwards the defense billing statements or invoices to the insurer. *See also Basic Energy Serv., Inc. v. Liberty Mutual Ins. Co.*, 2009 WL 2998134 (W.D. Tex. September 18, 2009) (applying the penalties provided by the Act and determining that the "policy holder suffers an actual loss that is quantified after it retains counsel for the underlying suit and begins receiving statements or invoices for legal services").

The Fifth Circuit Court of Appeals will not have the opportunity to weigh in on the issue, at least for now. After filing a notice of immediate appeal, Virginia Surety withdrew its immediate appeal pursuant to a confidential settlement with Trammell Crow.

Rhonda Thompson

TEXAS MUTUAL INSURANCE COMPANY V. RUTTIGER
WILL TEXAS MAINTAIN BAD FAITH IN WORKERS' COMPENSATION CLAIMS?, CONT'D

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diction to entertain the claimant's bad faith claim arising from the delay in paying benefits awarded by the Commission but did not have jurisdiction to hear the claimant's bad-faith claims arising from the denial of medical benefits and/or additional income benefits that the Commission had never ordered should be paid.

Texas Mutual argued that under *Fodge* the trial court did not have jurisdiction over Ruttiger's bad-faith claims, because the Benefit Dispute Agreement entered into by it and Ruttiger was not a determination of benefits by the Commission but rather only a compromise. The Court disagreed, noting that the Texas Workers' Compensation Act does not require a claimant who has entered into a binding agreement to settle a benefits dispute to continue through all four tiers of the dispute administration process. *Id*. at 657. The Court further noted that the Benefit Dispute Agreement reflected that Ruttiger sustained a compensable injury in the form of a hernia on the date in question, and it also set forth a time frame for compliance after being received by Texas Mutual. *Id*. at 657-58. The Court likened the compensability dispute to the claimant's bad faith claim for delay in paying benefits that had been awarded and paid in *Fodge*, which the Texas Supreme Court had ruled were ripe for adjudication. *Id*. at 658. In other words, since Texas Mutual had already agreed to pay benefits to Ruttiger, the trial court had jurisdiction to hear his bad faith claim based on a delay in paying those benefits.

> . . . due to the administrative framework set in place through the Texas Workers' Compensation Act, insurers should not be subject to a bad-faith claim relative to the handling of a workers' compensation claim.

The First District Court of Appeals failed to address Texas Mutual's contention that no cause of action for breach of the duty of good faith and fair dealing exists with regard to the handling of a workers' compensation claim. But, in addressing Texas Mutual's contention that there was no evidence that it failed to attempt in good faith to effectuate a prompt, fair and equitable settlement of a claim with respect to which liability had become reasonably clear and that it refused to pay a claim without conducting a reasonable investigation, the Court cited *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48 (Tex. 1997) and *Travelers Personal Sec. Ins. Co. v. McClelland*, 189 S.W.3d 846 (Tex. App.—Houston [1st Dist.] 2006, no pet.), stating that an insurer breaches its duty of good faith and fair dealing by denying or delaying payment of a claim if the insurer knows or should know that it is reasonably clear that the claim is covered. *Id*. at 660-61.

Texas Mutual filed a petition for review with the Texas Supreme Court in November of 2008. On February 13, 2009, the Supreme Court requested that the record from the First District Court of Appeals be filed with the clerk of the Supreme Court; and the Court asked for briefing from the parties on the merits of the case. Briefs have been filed by the parties, and a number of amicus briefs have also been filed. While Texas Mutual has raised a number of issues in its briefing, perhaps the most important is the proposition that the common law duty of good faith and fair dealing should no longer apply to claims handling of workers' compensation claims. The basis for this argument is that, due to the administrative framework set in place through the Texas Workers' Compensation Act, insurers should not be subject to a bad-faith claim relative to the handling of a workers' compensation claim. Assuming the Supreme Court agrees to hear the case, it will be interesting to see whether the Court concludes that the common law duty of good faith and fair dealing does not apply to the handling of a workers' compensation claim.

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