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THE INSURANCE LAW SECTION OF THE STATE BAR OF TEXAS

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Journal of Texas Insurance Law

The Journal of Texas Insurance Law is published by the Insurance Law Section of the State Bar of Texas. The purpose of the ***Journal*** is to provide Section members with current legal articles and analysis regarding recent developments in all aspects of Texas insurance law, as well as convey news of Section activities and other events pertaining to this area of law.

Anyone interested in submitting a manuscript for publication should contact Christopher W. Martin, Editor of ***The Journal of Texas Insurance Law***, at 713-632-1701 or by email at martin@mdjwlaw.com. Manuscripts for publication must be typed double-spaced with endnotes (PC-compatible disks are appreciated). Replies to articles published in the ***Journal*** are welcome.

On the Cover:
White limestone used in the Hill County courthouse in North Central Texas came from neighboring Bosque County. The architect, Wesley Clarke Dodson of Waco, was a battle-scarred veteran of the Confederate Army with a painful limp as proof. When the courthouse was occupied in 1891, a promotional publication noted that "all the office rooms are built in the most modern style."

Courtesy of *Texas Highways* magazine

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Comments FROM THE CHAIR

BY KAREN L. KELTZ
Riddle and Williams, P.C.

This will be the last Journal issue in which I have the opportunity to address the Section as its Chair. I am pleased to say that as a Section we had a very productive year. We accomplished all of the goals set for the Section for the 2007-2008 year. I want to thank everyone on the Council and in the Section for his and her assistance this year. Thanks also go to Donna Passons, our Executive Director, for making the year run so smoothly. What follows is a summary of new services, as well as an update on existing services provided to the Section.

Listserv: The Section added a new service to the members benefit list. To facilitate communication between Section members, the Section launched a listserv that will allow members to communicate directly. The listserv will function much like an online community bulletin board for lawyers. I will send a separate letter to Section with information about the new listserv. Thank you to Brian Blakeley for his effort on this project.

CLE: The Section and TTLA are co-sponsoring an Insurance Law Symposium and Beach Party in South Padre Island August 14-15, 2008. Watch for details on this innovative program. If well attended, this program could add revenue to our Section. The Section sponsored five telephone CLE programs this year. These programs also resulted in revenue to the Section. The Section continues to co-sponsor the University of Texas and the State Bar of Texas Insurance Law Seminars. This year the attendance at the University of Texas seminar warranted revenue paid to the Section. Together with the Consumer Law Section, the Section presented an excellent pro bono consumer law program in December in Edinburg, Texas. The seminar was free to lawyers who signed up to handle a pro bono case in the local legal aid office. Lawyers attending this seminar will handle approximately 20 pro bono cases in South Texas this year.

Ben Love Scholarship: The Section's Ben Love Scholarship Fund continues to grow. The scholarship is given yearly to a worthy insurance law student. If you wish to contribute to the scholarship fund, please contact Council Member Brian Martin of Thompson Coe in Houston.

ILS Legends Award: Each year the Section recognizes a legend in the field of insurance law. On this, the tenth anniversary of the Section, we honored two insurance law legends at the State Bar of Texas Insurance Law Seminar in Dallas. Congratulations go to Ernest Martin of Dallas and Jim Cornell of Houston, recipients of this year's award recognizing their many achievements and contributions to insurance law as well as to the Council and the Section.

Journal: The longest running benefit provided to the Section is the Insurance Law Journal. Thank you to Chris Martin, our Editor-in-Chief, for his continued persistence in turning out a high quality publication and to the editors and writers for their effort in keeping the Section up to date. We encourage participation of new authors. Please contact Chris Martin if you would like to contribute an article to the Journal.

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BY ZACH WOLFE[1]

FLECKMAN & MCGLYNN, PLLC

Late Notice and Prejudice to Insurance Companies: The Texas Supreme Court's *PAJ* Decision

OVERVIEW

PAJ holds that the insurer is required to prove prejudice to deny coverage based on late notice but leaves some questions unanswered.

A new client has been sued and comes to you for advice. He says he has some good news and some bad news. The good news is that he has insurance that covers the claims asserted in the suit. The bad news is that he did not give his insurance company timely notice of the lawsuit, and the insurance company has cited the late notice as a basis for denying coverage. Will the insurance company have to show that it was prejudiced by the late notice? The Texas Supreme Court recently addressed this issue in *PAJ, Inc. v. Hanover Insurance Co.*, holding that the insurance company was required to prove it was prejudiced by the lack of timely notice.[2]

Prior to *PAJ*, the best answer you could give this client was "it depends." As the Fifth Circuit stated in *Motiva Enterprises, LLC v. St. Paul Fire & Marine Insurance Co.*, "it is not entirely clear under Texas law whether an insurer must demonstrate prejudice before it can avoid its obligations under a policy where the insured breaches a prompt-notice provision or a consent-to-settle provision."[3] More recently, in *XL Specialty Insurance Co. v. Financial Industries Corp.*, the Fifth Circuit noted that "Texas Courts of Appeals currently appear to take different positions on the prejudice requirement."[4]

Courts have previously addressed several factors relevant to the prejudice issue, including: (i) whether the policy was subject to a special endorsement required by the Texas Department of Insurance for "bodily injury" and "property damage" coverage; (ii) whether the client had a "claims made" or "occurrence"-based policy; and (iii) whether the language of the notice provision would be construed as a "covenant" or a "condition precedent." Of course, the venue of the coverage suit and whether it was in state or federal court were also important considerations.

After *PAJ*, it is much more likely that the insurance company will have to prove prejudice in order to avoid coverage. In a 5-4 decision, *PAJ* held that the insured's failure to give its insurer timely notice of a claim does *not* defeat coverage if the insurer was not prejudiced by the delay. The *PAJ* majority reached this conclusion despite the insured's undisputed breach of the prompt notice provision and policy language stating that "[n]o person or organization has a right under this Coverage Part . . . to sue on this Coverage Part unless all of its terms have been fully complied with."[5] The dissent argued that the policy created a condition precedent to coverage, and that the court was ignoring the unambiguous language of the policy.[6] However, the majority seemed more concerned that an insured should not forfeit coverage based on an immaterial violation of the policy.

PAJ's holding now provides powerful ammunition to the policyholder who argues that prejudice is required, but it leaves a number of questions unresolved. First, does it make any difference if the notice requirement is construed as a "covenant" or a "condition precedent," or has the court obliterated this distinction? The *PAJ* majority discusses this issue but never squarely resolves it. Second, does it make a difference if the insured has a "claims made" versus an "occurrence" policy? Again, the majority opinion discusses this factor but does not say whether it is dispositive. In addition, it remains to be seen how courts will apply *PAJ* to breaches of other types of policy requirements.

SOME RELEVANT HISTORY: *CUTAIA*, BOARD ORDER 23080, AND *HERNANDEZ*.

PAJ did not write on a blank slate. The Texas Supreme Court previously addressed whether the insurer is required to

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prove it was prejudiced by late notice in *Members Mutual Insurance Co. v. Cutaia*,[7] and *Hernandez v. Gulf Group Lloyds*.[8] The argument in *PAJ* essentially boiled down to which of these cases was controlling.

Cutaia held that an insured's failure to timely forward suit papers in compliance with the policy barred coverage *regardless* of whether the insurer was prejudiced.[9] The policy in Cutaia provided that "no action shall lie against the company unless, as a condition precedent thereto, the insured shall have fully complied with all the terms of this policy."[10] The *Cutaia* court reasoned that the policy language created a condition precedent to coverage that the court was bound to enforce.[11] The court recognized the "apparent injustice" of the result but concluded that any changes to the policy form should be mandated by the Legislature or the State Board of Insurance, not by the courts.[12]

A year after the *Cutaia* decision, the State Board of Insurance responded by issuing Board Order 23080, which required the following endorsement to all Texas CGL policies:

> As respects bodily injury liability coverage and property damage liability coverage, unless the company is prejudiced by the insured's failure to comply with the requirement, any provision of this policy requiring the insured to give notice of action, occurrence or loss, or requiring the insured to forward demands, notices, summons or other legal process, shall not bar liability under this policy.[13]

In effect, Board Order 23080 neutralized the holding of *Cutaia*, at least as to liability coverage for "bodily injury" and "property damage." Policyholders could rely on the Board Order to avoid the strict condition precedent analysis of *Cutaia*. For example, in *Coastal Refining & Marketing, Inc. v. U.S. Fidelity & Guaranty Co.*, the court rejected the insurance company's argument that timely notice was a condition precedent to coverage for bodily injury and property damage, citing the unambiguous policy language required by the Board Order.[14]

As the *PAJ* majority would later note, at the time of the Board Order there was no standard coverage for "advertising injury."[15] Questions later arose regarding whether the Board Order was limited to bodily injury and property damage coverage. In *Chiles v. Chubb Lloyds Insurance Co.*, the court held that prejudice was not required because the Board Order did not apply to a homeowners' policy.[16] In *Gemmy Industries Corp. v. Alliance General Insurance Co.*, the federal district court cited *Chiles* and held that the prejudice requirement mandated by the Board Order did not apply to advertising injury coverage.[17] In *PAJ*, the Dallas Court of Appeals reached the same conclusion.[18] Thus, Board Order 23080 did not entirely resolve the prejudice issue in Texas .

Two decades after the Board Order, the Texas Supreme Court gave policyholders additional ammunition in *Hernandez v. Gulf Group Lloyds*.[19] The issue in *Hernandez* was not late notice, but whether an insured's violation of a settlement-without-consent exclusion negated coverage where the insurer failed to show actual prejudice.[20] Notwithstanding its prior decision in *Cutaia*, the court held that the insurer was required to prove it was prejudiced by the insured's failure to obtain the insurer's consent to the settlement.[21]

The exclusion in *Hernandez* stated that coverage did not apply to bodily injury or property damage with respect to which the insured made any settlement without the insurance company's written consent.[22] Despite this exclusion, the *Hernandez* court reasoned that insurance policies are contracts subject to the same rules that apply to contracts generally, including the principle that only a *material* breach by one party will excuse the other party from performing.[23] Therefore, the court held, when the insurer is not prejudiced by the insured's breach, the breach is not material, and coverage is not affected.[24] As the *PAJ* majority would later note,[25] the *Hernandez* court did not rely on any distinction between covenants and conditions or classify the exclusion at issue as one or the other.[26]

APPLYING *HERNANDEZ* AND *CUTAIA*

In late notice cases arising after *Hernandez*, state and federal courts faced the question of whether to apply *Hernandez's* prejudice requirement or *Cutaia's* strict "condition precedent" approach. The results were mixed.

The Fifth Circuit addressed the issue in *Hanson Production Co. v. Americas Insurance Co*.[27] The insurer in *Hanson* argued that the prejudice requirement is limited to those policies that are subject to the mandatory endorsement required by Board Order 23080. The Fifth Circuit disagreed, stating that it believed the Texas Supreme Court "would opt for a uniform rule of construction" requiring the insurer to show prejudice.[28] Applying *Hernandez*, the court held that the insurer must show prejudice to avoid coverage based on insured's failure to provide prompt notice of a claim. The court reasoned that "[t]he fundamental principle of contract law recognized in *Hernandez*—that a material breach by one contracting party excuses performance by the other party, and an immaterial breach does not—is equally applicable to notice cases."[29]

The Fifth Circuit followed the same reasoning in *Ridglea Estate Condominium Association v. Lexington Insurance Co.*,

holding that the prejudice requirement applied to a property insurance policy.[30] The court based its decision on "the method of the Texas Supreme Court's reasoning" in Hernandez, and the "general principle underlying that reasoning."[31]

In contrast, the Dallas Court of Appeals adopted a narrower interpretation of *Hernandez*. In its opinion in *PAJ*, the Dallas Court of Appeals focused on the distinction between covenants and conditions precedent.[32] The court acknowledged *Hernandez's* principle that only a material breach excuses performance by the other party,[33] but it distinguished *Hernandez* as dealing with a mere contractual *covenant*, as opposed to a contractual *condition*.[34] The court cited *Cutaia* for the proposition that if an insured fails to meet a condition requiring notice, then coverage is barred regardless of whether the insurer is prejudiced.[35] The court also noted that the clause at issue in *Hernandez* was contained within a policy *exclusion*, stating: "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)."[36] The Dallas Court of Appeals declined to follow federal cases requiring the insurer to show prejudice.[37] The case then went to the Texas Supreme Court.

IN *PAJ*, THE TEXAS SUPREME COURT CONSTRUED *HERNANDEZ* BROADLY AND LIMITED THE REACH OF *CUTAIA*.

PAJ presented the Texas Supreme Court with an opportunity to reconcile the tension between the "materiality" analysis of *Hernandez* and the "condition precedent" analysis of *Cutaia*. In the 5-4 decision, the majority adopted a broad construction of *Hernandez* consistent with the approach applied by the Fifth Circuit.

The policy at issue required the insured, PAJ, to notify the insurer, Hanover, of an occurrence or an offense that may result in a claim "as soon as practicable."[38] The Commercial General Liability Conditions section of the policy also provided that "[n]o person or organization has a right under this Coverage Part . . . to sue us on this Coverage Part unless all of its terms have been fully complied with."[39] Because the coverage part at issue in *PAJ* was "advertising injury," the endorsement required by Board Order 23080 did not apply.

The parties stipulated that the insured failed to comply with the notice requirement, but that the late notice caused no prejudice to the insurer.[40] The case therefore turned on a pure question of law: whether the insurer had to prove prejudice in order to deny coverage. Hanover argued that the policy language created a condition precedent, "the failure of which defeats coverage under the policy irrespective of prejudice to the insurer."[41]

In response, PAJ made two arguments. First, in an attempt to distinguish *Cutaia*, PAJ argued that the prompt notice requirement in the policy was a covenant, not a condition precedent. Therefore, PAJ argued, only a *material* breach of the covenant would excuse the insurance company from providing coverage, as the *Hernandez* court held.[42] Second, PAJ argued that Texas law requires the insurance company to prove prejudice even if the prompt notice requirement is a condition precedent.[43]

The court sided with PAJ, but it did not clearly state which argument it agreed with. Writing for the majority, Justice O'Neill simply concluded that "[w]e agree with PAJ that only a material breach of the timely notice provision will excuse Hanover's performance under the policy." [44]

After discussing *Cutaia*, Board Order 23080, and *Hernandez*, Justice O'Neill noted that courts and several major treatises had interpreted *Hernandez* broadly as adopting a "notice-prejudice rule." She cited the Fifth Circuit's broad interpretation of *Hernandez* as part of a "modern trend in favor of requiring proof of prejudice." [45] She rejected the dissent's attempt to distinguish *Hernandez* as involving a covenant rather than a condition, stating that the policy language in *Hernandez* was indistinguishable from the language at issue in Hanover's policy.[46]

The court then made this interesting statement about *Hernandez*: "Nevertheless, we made no distinction between the two in deciding that the insurer had to show prejudice before it could avoid its coverage obligations."[47] This observation implies the court would require the insurer to prove prejudice *regardless* of whether the policy language at issue was classified as a covenant or a condition precedent. This was some indication that the court agreed with PAJ's second argument, and that the prejudice requirement would apply regardless of whether timely notice was a covenant or a condition.

However, the court seemed reluctant to go that far. It went on to "question" the dissent's "fundamental premise" that the timely notice provision created a condition precedent rather a covenant.[48] The court distinguished the language of PAJ's policy, which did not expressly use the words "condition precedent," with the policy provision at issue in *Cutaia*, which specifically included the words "as a condition precedent." The court also cited the general principle that conditions are not favored in the law, and that courts will construe contract provisions as covenants if there is any reasonable basis for doing so.[49]

This second line of reasoning implies that the covenant/condition distinction may still matter, and that the *PAJ* majority construed the policy language as a covenant rather than a condition. However, the court never explicitly stated whether it construed the policy provision as a covenant, and it never stated clearly whether its decision turned on that distinction.

In contrast, the dissent in *PAJ* framed the issue as depending entirely on the covenant/condition distinction. If the notice requirement was a condition, Justice Willett reasoned, *Cutaia* would apply and there would be no prejudice requirement. If it was a covenant, *Hernandez* would apply and the insurer would have to prove it was materially prejudiced by the late notice.[50] The dissent viewed this distinction as the only principled way to reconcile *Cutaia* with *Hernandez*. The dissent rejected the attempt to distinguish *Cutaia* based on the "as a condition precedent" language contained in the *Cutaia* policy, pointing out that no "magic words" are necessary to create a condition precedent.[51] The majority opinion did not fully engage the dissent on this issue.

Similarly, the majority did not explicitly state whether its decision depended on the distinction between an "occurrence"-based policy and a "claims made" policy. Noting that PAJ had an occurrence-based policy, the court cited Fifth Circuit precedent reasoning that actual prejudice is required under an occurrence policy because the notice requirement in an occurrence policy is subsidiary to the event that triggers coverage.[52] The court referred to this as a "critical" and "important" distinction,[53] implying that the prejudice requirement might not apply to the notice clause of a claims-made policy. One would think that a "critical" distinction would be one that makes a difference in the outcome. However, the court did not expressly state whether the result would be different for a claims-made policy.

The court was also concerned that the dissent's strict condition precedent analysis "would impose draconian consequences for even *de minimis* deviations from the duties the policy places on insureds," leading to the absurd result that failing to promptly forward a deposition notice could forfeit coverage, etc.[54] The dissent responded that this problem is better addressed by the "substantial compliance" doctrine, which would excuse a "trivial misstep" in complying with a notice requirement.[55]

In its conclusion, the *PAJ* majority described its holding broadly: "We hold 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."[56] In future coverage disputes, policyholders are likely to cite this language for the sweeping proposition that Texas law requires the insurance company to show it was prejudiced by late notice, regardless of the specific policy language. Insurance companies, on the other hand, will try to distinguish their policies from the policy at issue in *PAJ*, arguing that *PAJ* did not abandon distinctions such as conditions versus covenants and occurrence versus claims-made policies.

WHAT THE *PAJ* MAJORITY DID NOT SAY

The majority opinion in *PAJ* is notable for what it does not say. The arguments presented the court with two distinct options. First, the court could have decided the case based solely on PAJ's first argument that the language at issue created a covenant rather than a condition. The reasoning would be something like this:

> (1) If the policy provision can reasonably be interpreted as a covenant rather than a condition, courts will construe the provision as a covenant to avoid forfeiture.
>
> (2) The policy provision at issue does not expressly state that it is a "condition precedent" (as the policy at issue in *Cutaia* did) and can be reasonably interpreted as a covenant.
>
> (3) The policy provision is therefore a covenant.
>
> (4) The materiality analysis of *Hernandez*, not the conditions precedent analysis of *Cutaia*, therefore applies.
>
> (5) The insurer can only deny coverage if the insured's breach of the notice requirement is material, meaning that the insurer must show the breach caused actual prejudice.

Although portions of the majority opinion reflect this approach, this is not exactly what the court said. The court never actually decided whether the policy created a covenant or a condition, and it never explicitly stated whether its decision turned on that distinction. The majority did "question" what it called the dissent's "fundamental premise" that compliance with the notice requirement was a condition precedent to obtaining coverage.[57] Along this line, the court noted that the notice-of-claim requirement appeared in a subsection entitled "duties" in the event of an occurrence, claim, or suit, a term more consistent with a covenant than a condition.[58] However, the majority did not explicitly reject the dissent's argument that the policy language created a condition precedent. Perhaps this was simply a compromise that was necessary to put five votes together. And it may have reflected a concern that the dissent had a strong technical argument that the policy created a condition precedent.

The second approach the court could have taken was to decide the case based on the insured's argument that the insurer must show prejudice even if the late notice provision is construed as a condition precedent. Under this approach, the opinion would have construed *Hernandez* broadly as holding that only a material breach of the policy will forfeit coverage, even if the provision breached is a condition precedent. Rather than attempting to reconcile *Cutaia* and *Hernandez*, this approach would interpret *Hernandez* as tacitly overruling *Cutaia*. This rationale would focus on a modern trend towards requiring prejudice rather than technical principles of contract construction.

The dissent interpreted the majority opinion in this way, arguing that the court treated *Cutaia* as a "dead letter" that was overruled by *Hernandez*,[59] and some commentators have interpreted *PAJ* as adopting this approach and sweeping aside the traditional covenant/condition distinction. The court emphasized that the language at issue in *Hernandez* was indistinguishable from the language in PAJ's policy, and that the *Hernandez* court made no distinction between covenants and conditions in reaching its decision that the insurer was required to prove prejudice.[60] These statements imply a broad reading of *Hernandez* that disregards the covenant/condition distinction for purposes of evaluating whether the insurer has to show prejudice.

However, the court never explicitly overruled *Cutaia*, and some parts of its analysis are inconsistent with this interpretation. As noted above, the court questioned the dissent's argument that the policy language at issue created a condition rather than a covenant, implying that the distinction may still matter. The court may have been reluctant to expressly abandon a distinction that has broader implications for contract law in general. Furthermore, the court emphasized the distinction between occurrence and claims-made policies, implying that the condition precedent approach of *Cutaia* may apply to claims-made policies.

The majority opinion is also notable for the absence of a word one expects to see in almost every insurance law opinion: "ambiguous." It is well settled (at least in theory) that an ambiguous policy provision must be construed in favor of coverage, meaning that the insured's construction of the policy must be adopted as long as it is reasonable, even if the insurer's construction is more reasonable.[61] Thus, the insured almost always argues that the policy provision at issue is ambiguous, and the insured in *PAJ* was no exception. In its brief, *PAJ* made a third argument that the policy was ambiguous as to whether failure to give timely notice would forfeit coverage.[62] However, the *PAJ* court ignored the argument that the policy was ambiguous, instead focusing on PAJ's first two arguments.

Rather than clearly identifying one of these two arguments as the ground for its decision, the *PAJ* court took a broader approach. It cited all of the arguments supporting its conclusion without specifying which arguments were dispositive. As a result, while the case is a clear win for policyholders, it does not provide a precise rationale for Texas courts to follow in future cases.

THE TEXAS SUPREME COURT MAY CLARIFY THE SCOPE OF *PAJ'S* PREJUDICE REQUIREMENT IN *PRODIGY COMMUNICATIONS* AND *XL SPECIALTY INSURANCE*

The Texas Supreme Court may soon clarify the scope of *PAJ* in its review of *Prodigy Communications Corp. v. Agricultural Excess & Surplus Insurance Co*.[63] In *Prodigy Communications*, a claims-made policy required the insured to give notice of a claim "as soon as practicable" but in no event less than 90 days after the expiration of the policy period.[64] After finding that the insured had breached this notice requirement, the Dallas Court of Appeals applied its own decision in *PAJ* and concluded that the insurer was not required to prove it was prejudiced by the insured's delay in giving notice.[65]

Of course, the Texas Supreme Court later reversed the Dallas Court of Appeals' decision in *PAJ*. And on the same day that the Texas Supreme Court released its *PAJ* opinion, it granted the insured's petition for review in *Prodigy Communications*. That same day, the court also accepted the following certified question from the Fifth Circuit in *XL Specialty Insurance*: "Must an insurer show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured's breach of the policy's prompt-notice provision, but the notice is nevertheless given within the policy's coverage period?"[66]

The Texas Supreme Court's decisions in *Prodigy Communications* and *XL Specialty Insurance* may tell us how far the prejudice requirement of *PAJ* reaches. Perhaps the court will hold that the prejudice requirement applies to all policies, regardless of the type of coverage or specific policy language. On the other hand, given the close 5-4 decision in *PAJ*, it seems likely the court will focus on the distinction between occurrence policies and claims-made policies and hold that the prejudice requirement does not apply to a claims-made policy.

EVALUATING THE PREJUDICE ISSUE AFTER *PAJ*

Returning to the hypothetical client who failed to give prompt notice, what advice can the insurance coverage lawyer give the client after *PAJ*? Will the insurance company be required to prove that it was prejudiced by the insured's failure

to provide timely notice in accordance with the policy? While the answer is now much more likely to be "yes," it may still depend on the specific policy language at issue. The attorney should examine the following questions.

Does the Texas Department of Insurance's mandatory endorsement apply? This is the easiest question. If the coverage at issue is for "bodily injury" or "property damage" and the mandatory endorsement required by the State Board of Insurance applies, then the insurance company may only deny coverage if it was prejudiced by the late notice.[67]

Is the policy language the same as the language at issue in *PAJ*? Although there are variations in policy forms, many policies will contain language identical or very similar to that of the typical CGL policy that was at issue in *PAJ*. If the language is the same, the insured's counsel can simply cite *PAJ*. If the language is different, analysis of the distinctions and their potential effect will be necessary.

Does the policy language create a covenant or a condition precedent? Until the Texas Supreme Court clarifies whether the condition versus covenant distinction still matters in the context of late notice, lawyers representing the policyholder will need to be prepared to argue that the policy language at issue creates a covenant, while insurance company lawyers will continue to argue that the policy creates a condition precedent to coverage. A good starting point for understanding the distinction is *Hohenberg Brothers Co. v. George E. Gibbons & Co.*, which states these general principles:

- Conditions precedent are events that must occur before there is a right to immediate performance and before there is a breach of a contractual duty.
- While no particular words are necessary for the existence of a condition, terms such as "if," "provided that," "on condition that," or some other phrase that conditions performance, usually establish a condition rather than a covenant.
- Because forfeiture is generally disfavored, a provision will be construed as a covenant where the intent of the parties is doubtful, where a condition would impose an absurd result, or where the provision may reasonably be interpreted as a covenant.[68]

Another case worth reviewing is *Varel v. Banc One Capital Partners, Inc.*, which states that under Texas law the non performance of a condition precedent is excused if the condition's requirement: (a) will involve extreme forfeiture or penalty, and (b) its existence or occurrence forms no essential part of the exchange for the promisor's performance. 55 F.3d 1016, 1018 (5th Cir. 1995). The *PAJ* majority alluded to this principle by stating that the timely notice provision "was not an essential part of the bargained-for exchange" under the occurrence-based policy.[69] Although the distinction between covenants and conditions may be less important after *PAJ*, this principle gives the insured an additional argument to consider.

Is the policy an occurrence-based or claims-made policy? Generally, an "occurrence" policy provides coverage for claims arising out of an occurrence that takes place during the policy period, while a "claims-made" policy provides coverage for claims that are made during the policy period. In late notice situations, some courts have drawn a distinction between occurrence-based policies and claims-made policies, holding that the prejudice requirement does not apply to the latter.[70] The rationale is that coverage does not even arise under a claims-made policy until the claim is made and reported, while coverage under an occurrence policy arises from the occurrence of the underlying event. As stated in *Hirsch v. Texas Lawyers' Insurance Exchange*, "[t]o require a showing of prejudice for late notice would defeat the purpose of 'claims-made' policies, and in effect, change such a policy into an 'occurrence' policy." [71]

The *PAJ* majority cited these cases favorably and referred to the difference between occurrence and claims-made policies as a "critical" and "important" distinction. When the policy is "claims-made," insurers will seize on this distinction and argue that *PAJ's* prejudice requirement does not apply. Insureds, on the other hand, will focus on the broad language in *PAJ* and argue that the *PAJ* decision did not turn on this distinction. As noted above, the Texas Supreme Court may address this issue in its upcoming decision in *Prodigy Communications*.

There is a further distinction between a "claims-made" policy, which requires that the claim be made during the policy period, and a "claims-made and reported" policy, which requires the claim to be made *and reported to the insurer* during the policy period.[72] The insured might argue that the prejudice requirement should apply where the policy is merely "claims-made" but not where the policy is "claims-made and reported." However, this argument was rejected by at least one federal district court in *Chicago Insurance Co. v. Western World Insurance Co.*[73]

After *PAJ*, the focus may shift to what constitutes prejudice

The *PAJ* opinion focused exclusively on whether the insurance company was required to prove that it was preju-

diced by the insured's failure to give prompt notice. It said nothing about what facts would be necessary to prove that prejudice occurred. The simple reason was that the insurance company in *PAJ* stipulated that it was not prejudiced. Now that *PAJ* has expanded the scope of the prejudice requirement, the focus of litigation in this area is likely to shift to the question of whether the insurance company was prejudiced.[74]

After *PAJ*, insurance companies will be less likely to obtain summary judgment based on the insured's failure to give timely notice. In some cases, the facts may establish prejudice to the insurer as a matter of law, such as when the insurance company does not receive notice until after entry of a default judgment against the insured.[75] In other cases, the court may find that the alleged prejudice is insufficient as a matter of law.[76] However, it seems likely that most cases will raise fact issues concerning prejudice to the insurance company. As stated by the court in *Struna v. Concord Ins. Services, Inc.*, "[w]hether an insurer is prejudiced by its lack of notice is generally a question of fact."[77]

This means that *PAJ* may lead to increased litigation in late notice situations. Thus, while *PAJ* is a win for policyholders, lawyers may be the group that benefits the most from the decision.

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2. *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630, 636–37 (Tex. 2008).

3. 445 F.3d 381, 386 (5th Cir. 2006).

4. 2007 WL 4461190, at *2 (5th Cir. Dec. 19, 2007).

5. *PAJ*, 381 S.W.3d at 638 (Willett, J., dissenting).

6. *Id.* at 637, 639 (Willett, J., dissenting).

7. 476 S.W.2d 278 (Tex. 1972).

8. 875 S.W.2d 691 (Tex. 1994).

9. *Cutaia*, 476 S.W.2d at 281.

10. *Id.* at 278.

11. *Id.* at 279–80.

12. *Id.* at 281.

13. *PAJ*, 243 S.W.3d at 632.

14. 218 S.W.3d 279, 284-85 (Tex. App.— Houston [14th Dist.] 2007, pet. denied).

15. *PAJ*, 243 S.W.3d at 633.

16. 858 S.W.2d 633, 635–36 (Tex. App.—Houston [1st Dist.] 1993, writ denied).

17. *Gemmy Indus. Corp. v. Alliance Gen. Ins. Co.*, 190 F. Supp. 2d 915, 921–22 (N.D. Tex. 1998), *aff'd*, 200 F.3d 816 (5th Cir. 1999) (unpublished table decision, available at 1999 WL 33644433).

18. *PAJ, Inc. v. Hanover Ins. Co.*, 170 S.W.3d 258, 261 (Tex. App.—Dallas 2005), *rev'd*, 243 S.W.3d 630 (Tex. 2008).

19. 875 S.W.2d 691 (Tex. 1994).

20. *Id.* at 693.

21. *Id.*

22. *Id.* at 692 n.1.

23. *Id.* at 692–93.

24. *Id.* at 693.

25. *PAJ*, 243 S.W.3d at 633.

26. *See Hernandez*, 875 S.W.2d at 692–93.

27. 108 F.3d 627 (5th Cir. 1997).

28. *Id.* at 630.

29. *Id.* at 631.

30. 415 F.3d 474, 480 (5th Cir. 2005).

31. *Id.* at 480.

32. 170 S.W.3d at 261.

33. *Id.* at 260.

34. *Id.* at 263.

35. *Id.* at 262.

36. *Id.* at 263.

37. *Id.*

38. *PAJ*, 243 S.W.3d at 632.

39. *Id.* at 638 (Willett, J., dissenting).

40. *Id.* at 642 (Willett, J., dissenting).

41. *Id.* at 632.

42. *Id.*

43. *Id*.

44. *Id*.

45. *Id*. at 634 (citing *Hanson*, 108 F.3d at 631).

46. *Id*. at 635–36.

47. *Id*. at 635.

48. *Id*. at 636.

49. *Id*.

50. *Id*. at 638–39 (Willett, J., dissenting).

51. *Id*. at 638 (Willett, J., dissenting).

52. *Id*. at 636 (citing *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co*., 174 F.3d 653, 658 (5th Cir. 1999)).

53. *Id*.

54. *Id*.

55. *Id*. at 644 (Willett, J., dissenting).

56. *Id*. at 636–37.

57. *Id*. at 636.

58. *Id*.

59. *Id*. at 642 (Willett, J., dissenting).

60. *Id*. at 635.

61. *See Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Hudson Energy Co*., 811 S.W.2d 552, 555 (Tex. 1991); *Ramsay v. Maryland Am. Gen. Ins. Co*., 533 S.W.2d 344, 349 (Tex. 1976).

62. Petr.'s Br. , 2006 WL 683979, at *21–22 (Feb. 24, 2006).

63. 195 S.W.3d 764 (Tex. App.—Dallas 2006, pet. granted).

64. *Id*. at 766.

65. *Id*. at 768.

66. 2007 WL 4461190, at *2.

67. *See, e.g., Coastal Ref*., 218 S.W.3d at 284.

68. 537 S.W.2d 1, 3 (Tex. 1976).

69. *PAJ*, 243 S.W.3d at 636.

70. *See Ridglea*, 415 F.3d at 480 n.4 (holding that claims-made policies, unlike occurrence policies, are not subject to a prejudice requirement); *Fed. Ins. Co. v. CompUSA, Inc*., 319 F.3d 746. 754-55 (5th Cir. 2003) (same); *Matador Petroleum*, 174 F.3d at 658 (same). *Compare St. Paul Guardian Ins. Co. v. Centrum G.S. Ltd*., 383 F. Supp. 2d 891, 899-00 (N.D. Tex. 2003) (holding that prejudice requirement applies to all occurrence-based policies).

71. 808 S.W.2d 561, 565 (Tex. App.—El Paso 1991, writ denied).

72. *See, e.g., Jones v. Lexington Manor Nursing Ctr.*, 480 F. Supp. 2d 865, 868–69 (S.D. Miss. 2006) (explaining the distinction).

73. 1998 WL 51363, at *3 (N.D. Tex. 1998) (not designated for publication).

74. For a helpful survey of Texas case law on this issue, see Robert J. Cunningham, NOTICE, PREJUDICE, CONDITIONS PRECEDENT AND CONSENT-TO-SETTLE ISSUES (2008).

75. *Liberty Mut. Ins. Co. v. Cruz,* 883 S.W.2d 164, 166 (Tex. 1993).

76. *See Centrum*, 383 F. Supp. 2d at 903–04 (holding that the insurer's alleged inability to negotiate a more favorable settlement because of untimely notice did not constitute prejudice sufficient to relieve insurer of its coverage obligations).

77. 11 S.W.3d 355, 359–60 (Tex. App.— Houston [1st Dist.] 2000, no pet.).

Comments from the Chair

continued from page 1

Web site: The Section website address is www.txins.org. We plan to add three new features to our Section website this coming year. First, the Section will post the Journal on the Section website for member access. Second, we are embarking on creation of an 'expert witness' database. Last, we will endeavor to add a jury charge section to the website to enable members to share seasoned jury charges. We may also add a link to the website that would link members to the Workers' Compensation Section. These ideas are in the developmental stage; we welcome your input and ideas.

Last, I wish to extend congratulations to long-standing Insurance Law Section Council and Section member, The Honorable Catharina Haynes. The Senate recently confirmed Judge Hayne's appointment by President Bush to the Fifth Circuit Court of Appeals.

Please contact Donna Passons at admin@txins.org for information on joining or becoming active in the Section, member benefits or any other questions regarding the Section.

Karen Louise Keltz; Chair, Insurance Law Section

STATE BAR OF TEXAS
ANNUAL MEETING
JUNE 26, 2008
HOUSTON, TEXAS

INSURANCE LAW SECTION
ANNUAL MEETING AND CLE EXTRAVAGANZA
ANATOMY OF AN INSURANCE CASE
3.0 HOURS CLE/1.0 HOURS ETHICS

COURSE DIRECTOR, Karen Keltz **EXECUTIVE DIRECTOR, Donna Passons**

1:30 pm **Section Business Meeting**

CLE PROGRAM

2:00 pm **Introductory Remarks**
Brian Martin, Houston

2:05 pm **Anatomy of an Insurance Policy**
Linda Dedman, Dallas

2:35 pm **Getting it Started: Selection of**
(.5 Ethics) **Independent Counsel**
Trevor Hall, Amarillo

3:05 pm **BREAK**

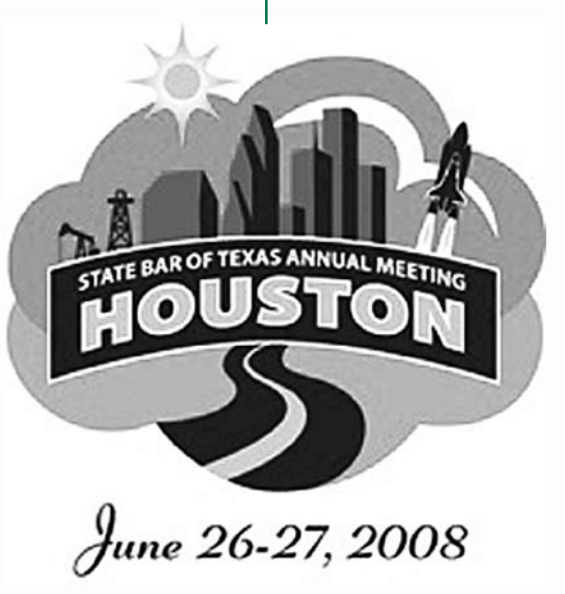
3:25 pm **Where Do We Go From Here:**
The Duty to Defend/Extrinsic Evidence
Michael Huddleston, Dallas
Karen Keltz, Dallas

3:45 pm **Preparing the Insurance Witness**
(.5 Ethics) Meloney Perry, Dallas

4:10 pm **Mechanics of Auto, Liability & Property Insurance**
Bill Chriss, Austin
Janet Colaneri, Arlington

4:40 pm **Who Pays: The Right to Reimbursement**
Robert Perry, Dallas

5:05 pm **What the Supreme Court Had to Say this Year**
Brian Blakeley, San Antonio
Lee Shidlofsky, Austin



BY MATT W. HOLLEY

HAYNES AND BOONE, LLP

The So-called "Fortuity Doctrine" Unmasked: Trading "Known Loss" for "Known Risk"

Fortuity (i.e., some "contingency" or "uncertainty" with respect to the risk insured) is a requirement of all insurance contracts. In recent years, insurers in Texas have increasingly sought to avoid coverage under third party liability policies by invoking the historically first party property insurance concepts of known loss and loss-in-progress under the name "fortuity doctrine."[1] The so-called fortuity doctrine, as advanced by insurers (and unfortunately adopted by some Texas courts) however, is a misnomer because it is not based on any true lack of fortuity or insurable risk. It is instead a cleverly disguised attempt to go beyond the language of the policy to avoid coverage by *misapplying* both the principal of fortuity and the known loss rule in the context of liability insurance policies to create a new "known risk" defense—a defense not supported by either the law or by fundamental principles of insurance.

This new "known risk" defense is based on two fundamentally flawed premises: (1) that knowledge of a *risk of liability* in the third party liability context is no different than knowledge of an *actual loss* in the first party property context; and (2) a person's knowledge of a *risk of liability* precludes the ability to purchase insurance for that risk. Unfortunately, these arguments have been accepted and adopted by some Texas courts (and federal courts purporting to apply Texas law). Most troubling is the holding of some courts that the so-called "fortuity doctrine" may be invoked in the context of the eight corners rule to defeat the duty to defend found in liability policies. These holdings are directly at odds with well-established jurisprudence regarding both the known loss rule and the duty to defend.

THE FORTUITY PRINCIPLE

It is often stated that fortuity is a requirement of all insurance contracts. This simply means, however, that insurance is intended to cover risks, not certainties. 2 GEORGE J. COUCH, COUCH ON INSURANCE 2D § 2:7 (rev. ed. 1984) (stating that "Risk . . . is of the very essence of insurance. In general, the risk may be any uncertain event which may in any way be of disadvantage to the party insured."); *see also Bartholomew v. Appalachian Ins. Co.*, 655 F.2d 27, 29 (1st Cir. 1981) ("The concept of insurance is that the parties, in effect, wager against the occurrence or non-occurrence of the specified event; the carrier insures against a risk, not a certainty.").

The fortuity principle is, in fact, reflected and embodied in the policy terms of different forms of liability insurance. For example, Commercial General Liability ("CGL") policies typically cover the insured's liability for bodily injury and property damages caused by an "occurrence" which takes place during the policy period. An "occurrence" is typically defined as an "accident," and coverage is excluded for bodily injury or property damage that is "expected or intended." Such policies also cover the insured's liability for "personal injury" or "advertising injury" caused by certain "offenses" committed within the policy period. Thus, CGL policies incorporate the concept of fortuity in several ways: (1) it is the insured's actual liability that is insured against, and litigation is inherently uncertain; (2) the liability must be predicated on an "occurrence" or "offense," which happens within the policy period, thereby excluding coverage for pre-policy "occurrences" or "offenses"; and (3) the bodily injury/property damages covered by the policy must be accidental and neither intended nor expected. *See* BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 8.03(a) (7th ed. 1994) ("Thus, the standard occurrence definition excludes coverage for injury expected or intended by the insured and incorporates the fundamental concept that fortuitous loss in a prerequisite for coverage."); *see also United States Liab. Ins. Co. v. Selman*, 70 F.3d 684, 690 (1st Cir. 1995) (same). In other words, the fortuity requirement is accounted for and satisfied by the terms of general liability policies.

The same is true of claims-made liability policies. Again, the "loss" covered is the insured's actual *liability*, which is determined through the inherently uncertain litigation process. Moreover, that liability must result from a claim that is first made within the policy period; thus, coverage is excluded for any "claims" made prior to the policy's inception. "Claim" is typically defined broadly to include any written "demand" received by the insured. Finally, such policies typically exclude coverage for claims alleging knowingly wrongful conduct.

Matt Holley is a Partner in the Dallas office of Haynes and Boone, LLP. His practice focuses on business litigation and representing corporate policyholders in insurance coverage disputes. Mr. Holley is also a connoisseur of Texas music.

Because the fortuity requirement is embodied in and satisfied by the terms of liability insurance policies (policies written by the insurer), it follows, then, that coverage which otherwise exists under the terms of the insurance policy itself should not be excluded by an insurer's invocation of an extra-contractual "fortuity defense."

THE KNOWN LOSS RULE

Developed in the context of first party property insurance, the known loss rule holds that a person cannot purchase insurance to cover a property loss that he knows has already occurred. *See Burch v. Commonwealth County Mut. Ins. Co.*, 450 S.W.2d 838, 840 (Tex. 1970). The insured's failure to disclose the damage constitutes fraud that would enable the insurer to set aside the contract. *Id.* at 840.[2] At issue in *Burch* was whether an insured could recover under an automobile policy antedated to include the time at which damage to the insured's automobile occurred, where the insured did not know of the loss at the time the policy was issued. The court held that the insured could recover under these circumstances, reasoning that if it is not established that the insured had prior knowledge of the property loss, there is no basis for charging him with fraud. *Id.* at 841. Significantly, the court flatly rejected the insurer's argument that an insurer can never assume the risk of a loss that has already occurred. The court stated:

> Aside from any question of protecting insurance companies against possible fraud on the part of their customers or agents, we can think of no reason for holding that the parties may not effectively contract for the insurer to assume the risk of a loss that may or may not have occurred when the contract is made. If that is their intention, they are not mistaken in any material respect even though the insured property has, in fact, been damaged or destroyed When neither of them knows of the loss, there is no basis for charging the insured with fraud . . . .

Id. at 841. Thus, the known loss rule articulated in *Burch* is a fraud-based defense requiring the insurer to *prove* that the insured had *actual, subjective knowledge* of the loss before the policy's inception. *Id.* The related loss-in-progress rule holds that a person may not buy insurance coverage for an ongoing property loss which the insured knows has already began. *See Summers v. Harris,* 573 F.2d 869, 871-72 (5th Cir. 1978).

THE KNOWN LOSS RULE HAS LIMITED APPLICATION TO LIABILITY POLICIES

The application of the known loss and loss-in-progress rules to first party property insurance is relatively straightforward. The distinctions inherent in first party property insurance and third party liability insurance, however, require a different analysis when attempting to apply these doctrines to the latter. Any proper application of the historically first party known loss rule to liability policies must necessarily take into account the difference between the event insured against in first party property insurance and the event insured against in third party liability policies. First party policies insure against the risk of loss/damage to the insured's property. Liability policies, on the other hand, insure against the insured's risk of liability. In other words, the insured event under a liability policy is not the act or event that might give rise to liability—*it is the insured's actual liability.*

In discussing the application of the known loss doctrine to liability policies, the court in *UTI Corp. v. Fireman's Fund Ins. Co.,* 896 F. Supp. 362 (D.N.J. 1995), made clear the distinction between first party insurance policy liability and third party liability, stating:

> This is a critical point because it is all to easy too confuse the principles barring coverage under a *first party* insurance policy for a loss already in progress at the time the insurance is purchased, *see, e.g., Summers v. Harris,* 573 F.2d 869 (5th Cir. 1978) (flooding of property covered by homeowners insurance policy), with the principles that would operate as a bar to coverage in the *third party* liability insurance context. In the context of first party insurance policies, once the unfortunate event occurs (like the flood in *Summers*), there remains no statistical uncertainty of risk to be appropriately insured against. By contrast, however, the occurrence of the event (here, the leak of TCEs) does not destroy the requisite element of the statistical uncertainty in the third party liability context, as the relevant events remain to be determined, including: is there any harm to off-site locations; will claims be filed at all; what number of claims will be filed; what sums of money will the claims demand. In other words, plaintiff did not purchase liability insurance to compensate it for all property damage, but rather to compensate it for all sums for which it is held *liable* as a result of claims in which damage to property of third parties is alleged. The relevant "loss" to plaintiff is not the property damage itself, but rather the company's legal liability arising therefrom.

Id. at 376-77.

The distinction between first party property insurance and third party liability insurance is vividly depicted in the case of *In re MGM Grand Hotel Fire Litig.*, 570 F. Supp. 913 (D. Nev. 1983). The *MGM* case was an outgrowth of the disastrous fire at the MGM Grand Hotel in Las Vegas, Nevada in November of 1980. After the fire, MGM anticipated its existing insurance policies would be inadequate to handle the claims which were mounting against it. *Id*. at 928. Thus, it negotiated for and obtained an additional $170 million in coverage as retroactive insurance. *Id*. This was accomplished well after the fire had occurred, the physical damage had been assessed, and numerous suits had been filed against MGM. Because the extent of MGM's legal liability had not yet been determined at the time coverage began, however, the "loss" was unknown, and insurance was obtainable. As the court in *Monsanto Co. v. Aetna Cas. & Sur. Co.*, No. 88C-JA-118, 1993 WL 563251 (Del. Super. Ct., Dec. 9, 1993), explained:

> The MGM case illustrates how the insurance industry has recognized the distinction between what constitutes an insurable loss in the first and third-party contexts, despite the current defendants' protestations to the contrary. It accurately depicts how an *occurrence* which may give rise to coverage may already exist while the *insurable loss* is still undetermined and thus, unknown. Therefore, as long as all the material facts are not concealed and the extent of legal liability is yet to be determined, the issuance of insurance to cover the liability resulting from a known occurrence is not violative of public policy.

Id. at *17.

Numerous other courts, recognizing the distinctions between first party property coverage and third party liability coverage, have properly held that the "loss" to be considered in connection with the known loss doctrine as applied to a liability policy *is the insured's actual liability*—not the liability-generating act or injury. *See, e.g., Stonehenge Eng'g Corp. v. Employers Ins. of Wausau*, 201 F.3d 296, 302 (4th Cir. 2000); *Montrose Chem. Corp. of California v. Admiral Ins. Co.*, 913 P.2d 878, 905-06 (Cal. 1995); *Pittston Co. Ultramar Am., Ltd. v. Allianz Ins. Co.*, 124 F.3d 508, 518 (3d Cir. 1997); *Peck v. Public Service Mutual Ins. Co.*, 363 F. Supp. 2d 137, 146 (D. Conn. 2005); *CPC Int'l, Inc. v. Hartford Accident & Indem. Co.*, 720 A.2d 408, 422 (N.J. Super. Ct. App. Div. 1998); *Gould, Inc. v. Arkwright Mut. Ins. Co.*, 907 F. Supp. 103, 109 (M.D. Pa. 1995); *UTI Corp. v. Fireman's Fund Ins. Co.*, 896 F. Supp. 362, 376-77 (D.N.J. 1995). This is the majority rule among courts that have considered this issue. *See State v. Hydrite Chem. Co.*, 695 N.W.2d 816, 828 (Wis. Ct. App. 2005).

In the third party context, even if the acts or events that might result in the imposition of liability occurred (and are known to the insured) before the policy incepts, there are a number of "fortuities" or "uncertainties" remaining to support coverage, such as (1) whether any claim will be made; (2) whether a lawsuit will be filed; (3) what causes of action will be asserted in the suit; (4) whether any or all of the claims will be successful; (5) will elements such as "duty" and "proximate cause" be established; and (6) whether the insured's *actual liability* will be established and, if so, in what amount. Because of these uncertainties, it simply cannot be known in advance whether a loss will ever be suffered. Nor can it be said that merely engaging in certain conduct constitutes a loss-in-progress. In the context of third party liability policies, then, for the insured risk to be a true "known loss" and thus uninsurable, the *actual liability* of the insured must be known at the time the policy is purchased. For this reason, numerous courts that have considered this issue have properly held that the known loss and loss-in-progress doctrines will not defeat coverage under a third party general liability policy unless it has been established, at the time the insurer entered into the insurance contract, that the insured had a legal obligation to pay damages to a third party in connection with a loss. *See e.g., Pittston,* 124 F.3d at 518; *Peck*, 363 F. Supp. 2d at 146-47; *CPC*, 720 A.2d at 422; *Gould*, 907 F. Supp. at 109-10; *Montrose*, 913 P.2d at 905-06; *Monsanto*, 1993 WL 563251, at *16-18; *Ins. Co. of N. Am. v. Kayser-Roth Corp.*, 770 A.2d 403, 415-17 (R.I. 2001). Said another way, so long as there is any uncertainty about the imposition of liability, there is an insurable risk to support coverage.

…the known loss rule holds that a person cannot purchase insurance to cover a property loss that he knows has already occurred.

This rule does not undermine the basic concept of fortuity because, in the third party liability context, the insurable risk is the uncertainty of liability. *Pittston*, 124 F.3d at 518; *see also Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1215 (2nd Cir. 1995) (rejecting insurer's known loss defense even though insured was aware prior to the inception of the policies of potential liability, because "it was highly uncertain . . . as to the prospective number of injuries, the

number of claims, the likelihood of successful claims, and the amount of ultimate losses it would be called upon to pay); *Peck*, 363 F. Supp. 2d at 146 (stating that "[G]iven the risks and uncertainties of litigation . . . establishment of liability and damages cannot be deemed inevitable."); *UTI Corp*., 896 F. Supp. at 376 ("[T]he occurrence of an event . . . does not destroy the requisite element of statistical uncertainty in the third party liability context . . . ."). Indeed, this is the only standard for application of the known loss rule to liability policies which can be viewed as based on any true lack of fortuity or insurable risk.

Nor does this rule leave insurers unprotected when insuring such risks. Coverage will still be barred in appropriate cases by the language of the policy itself (language drafted by the insurer), and insurers will still be able to avoid coverage by proving that the insured misrepresented/concealed material information when purchasing the insurance. *See Nat'l Union Ins. Co. of Pittsburgh, Pa. v. The Stroh Companies, Inc*., 265 F.3d 97, 108 (2nd Cir. 2001). As the court stated in CPC:

> As long as there remains uncertainty about damage or injury that may occur during the policy period and the imposition of liability upon the insured, and no legal obligation to pay third party claims has been established, we hold that there is a potential insurable risk for which coverage may be sought . . . . We are satisfied that this rule, coupled with the more "narrow" doctrine regarding concealment and misrepresentation, and damages that are "expected" or "intended" by the insured, sufficiently protect the insurer's interest in combating fraud without diminishing the reasonable expectations of the insured.

720 A.2d at 422; *see also City of Johnstown v. Bakers Standard Ins. Co.*, 877 F.2d 1146, 1153 (2nd Cir. 1989); *UTI Corp*., 896 F. Supp. at 376.

In applying the known loss rule to third party liability policies, most courts from other jurisdictions agree on two points: (1) the loss to be considered is the insured's liability; and (2) the insured's knowledge of the loss is to be judged by a subjective, rather than objective, standard. *See e.g., United States Liab. Ins. Co. v. Selman,* 70 F.3d 684, 691 (1st Cir. 1995) (application of the known loss doctrine depends on the insured's actual knowledge of the loss; the test, therefore, is subjective, not objective); *United Technologies Corp. v. Am. Home Assur. Co*., 989 F. Supp. 128, 151 (D. Conn. 1997) (the purpose of the loss-in-progress doctrine, preventing fraud, is served by a subjective knowledge analysis); *Gen. Housewares Corp. v. Nat'l Sur. Corp.,* 741 N.E.2d 408, 413 (Ind. Ct. App. 2000); *Domtar, Inc. v. Niagara Fire Ins. Co.,* 563 N.W.2d 724, 737 (Minn. 1997). The major area of disagreement among courts attempting to apply the known loss concept to liability policies is the degree of certainty of liability that must be established before it can be said that a "loss" exists. As discussed above, numerous courts have held that liability must be certain (i.e., legally established) prior to the policy's inception. Other courts have held that the insured's liability must be either certain or "substantially certain." *See, e.g., Gen. Housewares,* 741 N.E.2d at 414;[3] *Selman*, 70 F.3d at 691; *Stonehenge*, 201 F.3d at 302. Other courts have adopted a "substantial probability of liability" standard. *See, e.g., Outboard Marine Corp. v. Liberty Mut. Ins. Co*., 607 N.E.2d 1204, 1212 (Ill. 1992) (the insured must know that there is a "substantial probability" that it will suffer or has already suffered a loss); *Hydrite*, 695 N.W.2d at 828-29.[4]

Any standard requiring less than *actual knowledge of an actual loss* is, however, directly at odds with the Texas Supreme Court's articulation of the known loss rule in *Burch*. Any such standard also fails to recognize that if the insured's liability is to any degree "contingent" or "uncertain," there is an insurable risk to support coverage. Either a loss has occurred or it has not.

THE KNOWN LOSS RULE CANNOT LOGICALLY BE APPLIED TO THE DUTY TO DEFEND IN THE CONTEXT OF THE EIGHT CORNERS RULE

Whatever limited application the known loss and loss-in-progress rules may have to liability policies in general, those rules should not be applied to defeat the duty to defend found in liability policies. Under the "complaint allegation rule," also known as the "eight corners rule," the duty to defend is determined solely from the face of the plaintiff's complaint in the underlying action and the language in the insurance policy. The allegations in the complaint are considered without reference to their truth or falsity. The allegations must be given a liberal interpretation in favor of coverage, and the duty to defend applies so long as there are any allegations in the complaint potentially stating a covered claim. Any doubts in this regard must be resolved in favor of the duty to defend. *King v. Dallas Fire Ins. Co. of Pittsburgh, Pa*., 85 S.W.3d 185, 191 (Tex. 2002); *Nat'l Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc*., 939 S.W.2d 139, 141 (Tex. 1997); *Heyden Newport Chem. Corp. v. S. Gen. Ins. Co.,* 387 S.W.2d 22, 24-26 (Tex. 1965). The known loss rule cannot logically be applied in the context of the eight corners rule for several reasons.

- **The Mere Filing of a Lawsuit Does Not Establish a Loss**

Properly viewing the "loss" as the insured's actual liability,

the known loss rule cannot defeat the duty to defend because that "loss" is not established by either: (a) the filing of the lawsuit against the insured; or (b) unproven allegations of misconduct by the insured/injury to a third party in the plaintiff's petition. Instead, the loss is established by a judgment ultimately rendered against the insured. Allegations simply do not equal wrongdoing or legal liability.

- **A Known Loss Cannot Be Established by Unproven Allegations in the Underlying Complaint**

The basis for the known loss doctrine is that the insured's failure to disclose a loss he knows has occurred constitutes fraud. To invoke the known loss rule, the insurer has the burden of *proving* (1) that the insured had actual, subjective knowledge of the loss at the time the policy is purchased; and (2) the insured knowingly failed to disclose the existence of the loss to the insurer. *Burch*, 450 S.W.2d at 841. *See also City of Johnstown v. Bakers Standard Ins. Co.*, 877 F.2d 1146, 1153 (2nd Cir. 1989) (known loss defense requires proof that insured fraudulently misrepresented or concealed a material fact at the inception of the contract of insurance); *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 737 (Minn. 1997) (the known loss doctrine is a fraud-based defense of insurer requiring proof that insured withheld material information concerning existence of property damage); *CPC Int'l, Inc. v. Hartford Accident & Indem. Co.*, 720 A.2d 408, 422 (N.J. Super. Ct. App. Div. 1998) (known loss doctrine has its roots in the prevention of fraud). At the duty to defend stage, however, nothing has been *proven*. *See Argonaut Sw. Ins. Co. v. Maupin,* 500 S.W.2d 633, 636 (Tex. 1973) ("The duty to defend does not depend on what the facts are, or what might be determined finally by the trier of the facts."). Instead, under the eight corners rule, the duty to defend is triggered by *unproven allegations* of a third party in the underlying complaint. An insurer's burden of proof under the known loss rule simply cannot be discharged by unproven allegations in the underlying complaint which trigger the insurer's duty to defend. This is true whether the insurer's liability must be "certain," "substantially certain," or "substantially probable." It is also true even if the "loss" is erroneously viewed as the liability-generating act/injury to the third party, instead of the insured's actual liability. Simply put, under any standard used, the known loss rule and the eight corners rule are incompatible concepts.

The basis for the known loss doctrine is that the insured's failure to disclose a loss he knows has occurred constitutes fraud.

Applying the known loss doctrine based on unproven allegations in the underlying complaint would also contravene and undermine established Texas law governing an insurer's burden of proving fraud in order to avoid its obligations under a contract of insurance. *See Mayes v. Mass. Mut. Life Ins. Co.*, 608 S.W.2d 612, 616 (Tex. 1980) (defining insurer's burden of proof). *See also City of Johnstown,* 877 F.2d at 1153 (rejecting a broad application of the known loss doctrine because it "might well swallow up the more narrow doctrines regarding … concealment and misrepresentation . . . .").

- **The Determination of a Known Loss Involves Questions of Fact that Cannot Be Resolved in the Context of the Eight Corners Rule**

Despite any disagreement among courts from other jurisdictions as to whether the insured's liability must be "certain," "substantially certain," or substantial probable," or whether the insured's knowledge is determined by a subjective or objective standard, all courts appear to agree on one key point -- any standard used inherently involves questions of fact such as (1) whether the facts demonstrate that the loss is either "certain," "virtually certain" or "substantially probable"; and (2) the insured's knowledge of the "loss" (e.g., what did the insurer know and when did he know it). *See Outboard Marine,* 607 N.E.2d at 1211 (issues of fact precluded summary judgment in favor of insurer on known loss defense); *Inland Waters Pollution Control, Inc. v. Nat'l Union Fire Ins. Co.*, 997 F.2d 172, 178 (6th Cir. 1993) (whether insured knew or should have known of "loss" is a question of fact preventing summary judgment for insured on "known risk" defense); *Gen. Housewares,* 741 N.E.2d at 413-14 (insured's actual knowledge of loss is a question of fact); *Montrose*, 913 P.2d at 905-06 ("[T]he factual uncertainties needed to be resolved in order to establish the defense generally cannot be resolved on a motion for summary judgment . . . ."); *Nestle Foods Corp. v. Aetna Cas. & Sur. Co.*, 842 F. Supp. 125, 130-31 (D.N.J. 1993) (whether the insured knew of any "loss" and whether any "loss" was in progress are issues of fact which cannot be resolved in a motion for summary judgment); *see also Lennar Corp. v. Great Am. Ins. Co.*, 200 S.W.3d 651, 689 (Houston [14th Dist.] 2006, pet. denied) (issues of fact regarding insured's knowledge precluded summary judgment in favor of insured on known loss defense). The eight corners rule, necessarily and by definition, involves questions of law. *See Southstar Corp. v. St. Paul Surplus Lines*

Ins. Co., 42 S.W.3d 187, 190 (Tex. App.—Corpus Christi 2001, no pet.); *State Farm Gen. Ins. Co. v. White,* 955 S.W.2d 474, 475 (Tex. App.—Austin 1997, no pet.). Thus, the known loss rule simply cannot be applied in the context of the eight corners rule.

- **The Known Loss Rule Can Never Defeat a Duty to Defend that Otherwise Exists.**

Under the eight corners rule, if the underlying complaint contains *any* allegations which are even potentially covered, the insurer has a duty to defend the entire lawsuit. *See St. Paul Ins. Co. v. Texas Dept. of Transportation*, 999 S.W.2d 881, 884 (Tex. App.—Austin 1999, pet. denied). Under the eight corners rule, the allegations in the underlying complaint simply cannot both invoke coverage (under the policy) and, at the same time, *negate* coverage (under the so-called "fortuity doctrine"). If the allegations invoke the duty to defend under the policy language, there is a duty to defend. Period. Thus, under a proper application of the eight-corners rule, the known loss rule can never defeat a duty to defend that otherwise exists under the policy. *See E & L Chipping Co., Inc. v. Hanover Ins. Co.*, 962 S.W.2d 272, 276 (Tex. App.—Beaumont 1998, no pet.) (eight corners rule precluded application of known loss and loss-in-progress doctrines to defeat the duty to defend where that duty was established by the insurance policy and the underlying pleadings); *Peck*, 363 F. Supp. 2d at 147 (holding that the known loss doctrine may not be applied to defeat coverage where the policy expressly provided for coverage).

TEXAS COURTS' MISAPPLICATION OF THE KNOWN LOSS RULE TO LIABILITY POLICIES

The current state of Texas law regarding the application of the known loss and loss-in-progress rules to liability policies is, frankly, a mess. The decisions of various courts have been inconsistent, confusing and often poorly reasoned. A review of some of the key Texas cases applying the so-called "fortuity doctrine" to liability policies demonstrates how a trail of confusing language and errors has culminated in the creation of a new "known risk" defense which is not based on any true lack of fortuity and is, in fact, contrary to both the fortuity principle and well-established Texas law regarding both the known loss rule and the duty to defend.

Two Pesos

The application by Texas courts of the known loss doctrine to liability policies began with *Two Pesos, Inc. v. Gulf Ins. Co.*, 901 S.W.2d 495 (Tex. App.—Houston [14th Dist.] 1995, no writ). In *Two Pesos*, a $2 million judgment had already been rendered against the insured (Two Pesos) for trademark infringement (improperly copying Taco Cabana's building decor) *before* the insured purchase the insurance policy. The "claim" in the coverage dispute was Taco Cabana's motion for "supplemental damages" suffered after the entry of the original judgment because Two Pesos had not changed the appearance of its restaurants, in violation of a permanent injunction in the prior judgment.

The occurrence based general liability policy in *Two Pesos* provided coverage for personal injury or advertising injury caused by "offenses" committed during the policy period. The court first found no coverage under the policy because the "offense" occurred before the policy period began, and then added that coverage would also be precluded by the fortuity doctrine. *Two Pesos,* 901 S.W.2d at 501-02. In this unnecessary dicta, the court cited a federal Sixth Circuit decision for the proposition that the "fortuity doctrine" precludes coverage "when the insured is, *or should be,* aware of an on-going progressive loss or known loss at the time the policy is purchased." *Id.* (citing *Inland Waters Pollution Control, Inc. v. Nat'l Union Fire Ins. Co.*, 997 F.2d 172, 175-77 (6th Cir. 1993)).[5] This "should be aware of" standard from *Two Pesos* is directly contrary to the Texas Supreme Court's holding in *Burch*, which requires that the insured have actual, subjective knowledge of the loss. Nevertheless, under the facts of the case, the end result in *Two Pesos* is at least consistent with the notion that a known loss in the third party liability context is established only where the insured's legal liability has been *established* prior to the inception of the policy.[6]

Franklin v. Fugro-McClelland

Citing *Two Pesos*, the federal district court in *Franklin v. Fugro-McClelland (Southwest), Inc.*, 16 F. Supp. 2d 732 (S.D. Tex. 1997), another case involving an occurrence based general liability policy, compounded the problem by applying the "should be aware of" standard articulated in *Two Pesos* and adding two errors of its own: (1) stating that the "loss" to be considered in applying the known loss and loss-in-progress doctrines to liability policies is not the insured's own liability, but is instead the injury to the third party as a result of the insured's conduct; and (2) stating that, in applying the loss-in-progress rule to a general liability policy, "the relevant inquiry is whether they knew at the time they entered into the insurance policy that they were engaging in activity for which they could possibly be held liability." *Franklin*, 16 F. Supp. 2d at 736-37. Under these standards, the known loss rule is converted from a rule requiring that the insured have knowledge of an actual loss, to a rule defeating coverage if the insured merely has knowledge of acts/events which the insured should know might possibly result in liability.

A rule holding that the insured's knowledge of the risk of liability, or knowledge of acts/events that might result in liability, however, is antithetical to the very concept of insurance. Individuals and companies purchase liability insurance precisely because there is a chance or probability that the event insured against may occur. *See Epmeier v. United States,* 199 F.2d 508, 509-10 (7th Cir. 1952) ("Insurance . . . involves a contract, whereby, for an adequate consideration, one party undertakes to indemnify another against loss arising from certain specified contingencies or perils. Fundamentally and shortly, it is contractual security against possible anticipated loss."). A basic tenet of insurance is that the public interest is served by enabling policyholders and insurers to shift the risk of a potential loss in return for the insured's payment of premiums. The fact that the risk of potential loss is "known" by virtue of the insured's awareness of acts/events that might give rise to a future claim simply does not preclude the ability to purchase insurance. *See Buckeye Ranch, Inc. v. Northfield Ins. Co.,* 839 N.E.2d 94, 105 (Ohio Ct. Com. Pl. 2005) (awareness by the insured of an act that might someday result in liability is not equivalent to knowledge of liability); *Hydrite*, 695 N.W.2d at 828 (for known loss doctrine to apply, the insured must know more than the fact that there has been an occurrence that has caused damage to a third party). Obviously, the nature and degree of risk affects an insurer's decision on whether to insure the risk and the premium to be charged; however, the mere presence and awareness of risk simply does not preclude the ability to insure the risk. And, while the insurer's assessment of the risk may depend on the disclosure by the insured of material information regarding the risk, any failure to disclose/misrepresentation of such information involves a question of fraud—not a question of basic insurability or "fortuity." Not surprisingly, courts have rejected just such attempts by insurers to convert the known loss rule into a "known risk" rule. *See, e.g., City of Johnstown,* 877 F.2d at 1152-54 (refusing to adopt "known risk" defense and rejecting the notion that a risk, once "known," is uninsurable); *The Stroh Companies,* 265 F.3d at 109 (same); Peck, 363 F. Supp. 2d at 144-47 (rejecting insurer's attempt to expand the known loss rule into a "known risk" rule); *Kayser-Roth,* 770 A.2d at 415 (same).

The illogical notion that mere knowledge of acts/events that might give rise to liability is also contrary to established underwriting practices. The *MGM Grand* case discussed above shows that carriers can, and do, provide coverage for liabilities that may result from events known to have already occurred before the policy's inception. Moreover, the retroactive date in many claims-made policies specifically provides coverage for claims based on acts occurring prior to the policy's inception. Claims-made policies also include an option for the insured to obtain an "Extended Reporting Period" to provide coverage for claims that are not asserted until after the policy has expired or been cancelled, but which are based on acts occurring prior to cancellation or non-renewal. These underwriting practices demonstrate that insurers have no problem insuring and accepting premiums for a "known risk" when it suits their purpose.

In short, the standards articulated in *Franklin* for application of the known loss and loss-in-progress rules to liability policies are simply wrong. Unfortunately, some Texas courts (and other federal courts purporting to apply Texas law) have simply cited and relied on these erroneous standards. *See, e.g., Warrantech Corp. v. Steadfast Ins. Co.,* 210 S.W.3d 760, 766 (Tex. App.—Fort Worth 2006, pet. filed); *Travis*, 68 S.W.3d at 76-77; *Westchester*, 64 S.W.3d at 614; *RLI Ins. Co. v. Maxxon Southwest, Inc.*, 265 F. Supp. 2d 727 (N.D. Tex. 2003), *aff'd*, No. 03-10660, 2004 WL 1941757 (5th Cir. Sep. 1, 2004); *Matagorda Ventures, Inc. v. Travelers Lloyds Ins. Co.,* 208 F. Supp. 2d 687, 691 (S.D. Tex. 2001).

It should also be noted that *Franklin* (like *Two Pesos*) involved both the duty to indemnify and the duty to defend under an occurrence based general liability policy. In making its determination that the "loss in progress" doctrine precluded liability coverage, the court considered extrinsic evidence (which may not be considered in determining the duty to defend), including evidence that that (a) prior to the inception of the policy, the insured had already received a demand letter that it cease from infringing the plaintiff's patent and misappropriating its trade secrets, (b) the insured admittedly had knowledge of the claim prior to purchasing the policy and, in fact, had tried to resolve the claim; and (c) the insured failed to disclose the existence of the claim to the insurer.[7]

Scottsdale v. Travis

Thus, while the courts in *Two Pesos* and *Franklin* erroneously applied the known loss and loss-in-progress doctrines to general liability policies, neither of these courts held that the known loss doctrine may be invoked in the context of the eight corners rule to defeat the *duty to defend* based solely on allegations in the underlying complaint of misconduct preceding the policy's inception. Instead, that leap was made by the Dallas Court of Appeals in *Scottsdale Ins. Co. v. Travis,* 68 S.W.3d 72 (Tex. App.—Dallas 2001, pet. denied) (citing *Two Pesos* and *Franklin*), which held that the duty to defend in an occurrence based general liability policy was defeated by allegations in the petition of *purely intentional misconduct* predating the policy's inception. *Travis*, 68 S.W.3d at 77. *Travis* involved claims against the insured for tortious interference, misappropriation of trade secrets, breach of fiduciary duty and conversion. In applying the "fortuity doctrine," the court in *Travis* posited the relevant question as simply "whether the wrongdoing occurred

before or after the purchase of the insurance." *Id*. at 72. The court concluded that "the allegations in the petition exclude coverage, under both the specific terms of the insurance policy covering events occurring during the policy period and under the fortuity doctrine as a 'loss in progress.'" *Id*. at 77.

Thus, through a progression of errors, the known loss rule morphed from one requiring proof that the insured had actual knowledge of an actual loss prior to the policy's inception, into one invoked based on nothing more than unproven allegations of a third party that the insured engaged in intentional misconduct prior to the policies inception. Whatever the problems were in the courts' application of the "fortuity doctrine" in *Two Pesos, Franklin* and *Travis*, however, they did not effect the outcome of the cases when applied to the general liability policies at issue in those cases. Because general liability policies cover only "offenses" committed during the policy period or "occurrences" taking place during the policy period, the claims based on conduct predating the policy were not covered anyway. Thus, the courts merely stated or held that the known loss and loss-in-progress doctrines would preclude coverage which was otherwise barred by the policy itself.

Warrantech v. Steadfast

The court in *Warrantech Corp. v. Steadfast Ins. Co*., 210 S.W.3d 760 (Tex. App.—Ft. Worth 2006, pet. filed), however, took these erroneous standards even further by (1) applying them to a claims-made liability policy, and (2) holding that the known loss may be invoked even where the underlying complaint alleges that the insured acted *negligently*. The underlying complaint in *Warrantech* alleged alternative claims against the insured for fraud and negligent misrepresentation arising out of Warrantech's administration of product warranties. The claims-made policy at issue specifically provided coverage for claims made during the policy period arising from acts/conduct predating the policy's inception, back to the policy's retroactive date. Citing *Franklin*, the court in *Warrantech* erroneously viewed the "loss" at issue as the alleged injury to the third party (not the insured's liability). Then, because the underlying petition alleged misconduct by the insured/injury to the third party predating the policy's inception, the court held that the known loss doctrine precluded the insurer's duty to defend. Significantly, the court's opinion specifically assumes for the sake of argument that the insurer would "otherwise owe [the insured] a duty to defend the underlying claim," but holds that the "fortuity doctrine" nevertheless precludes that duty. *Id*. at 767.

The problems with the ruling in *Warrantech* are obvious. First, claims-made policies cover claims made during the policy period, *regardless of when the liability inducing act or event occurred*. Many such policies (including the policy at issue in *Warrantech*), through the retroactive date, specifically provide coverage for claims arising from conduct predating the policy's inception. Thus, applying the known loss and loss-in-progress doctrines to such claims-made policies based solely on allegations in the underlying complaint of misconduct/injury preceding the policy's inception destroys the fundamental nature of the policies and renders them illusory. Policy language is rendered meaningless, and claims-made policies are, in effect, converted to policies requiring both that the claim be made, and that the underlying conduct occur, during the policy period. *See Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Cary Comm. Consol. Sch. Dist. No. 26,* No. 93-C-6526, 1995 WL 66303, at *6 n.1 (N.D. Ill., Feb. 15, 1995) (cases applying the known loss doctrine to "occurrence" policies are not applicable to "claims-made" policies); *Buckeye*, 839 N.E.2d at 104-09 (holding that the known loss doctrine did not defeat coverage which otherwise existed under a claims-made liability policy).[8] Second, the court's holding that, under the eight corners rule, the known loss rule may preclude a duty to defend which otherwise exists under the policy means that the allegations in underlying complaint may both *invoke* coverage (under the policy terms) and, at the same time, *negate* coverage (under the known loss rule). This is an impossible result under the eight corners rule, whereby there is a duty to defend if *any* allegations in the complaint even *potentially* state a covered claim.

In addition to holding that the known loss doctrine can defeat a duty to defend which otherwise exists under the policy, the court in *Warrantech* did something else no court before it had done. The court applied the known loss doctrine to defeat the duty to defend even though the underlying complaint alleged that the insured acted negligently. In doing so, the court stated that application of the fortuity doctrine does not hinge on whether the insured knew a particular act was wrongful, but instead whether it knew before the inception of coverage that an act—knowingly wrongful or otherwise—resulted in a loss (which the court erroneously viewed as the alleged injury to the third party). *Id*. at 768. However, viewing the allegations liberally in favor of coverage, as required by the eight corners rule, it simply cannot be said that an insured alleged to have acted negligently *knew* of any "loss." Negligence is, by definition, a "fortuitous" act or event. If an insured was acting merely negligently, it cannot *necessarily* be said that he either knew his conduct was wrongful or that he knew his conduct would result in liability. Indeed, at least two Texas courts have specifically held that allegations in the underlying complaint that the insured acted negligently preclude application of the known loss rule to defeat the duty to defend. *See Burlington Ins. Co. v. Texas Krishnas, Inc*., 143 S.W.3d 226, 231 (Tex. App.—Eastland 2004, no pet.); *Westchester Fire Ins. Co. v. Gulf Coast Rod Reel & Gun Club,* 64 S.W.3d. 609, 614 (Tex. App.—Houston [1st Dist.] 2001, no pet.).

In the end, the *Warrantech* decision stands out as the worst among an already confusing and erroneous body of Texas law regarding the application of the "fortuity doctrine" to liability policies and extends the scope of the known loss and loss-in-progress principles well beyond anything justified or reasonable. Under the *Warrantech* decision, the known loss doctrine would defeat coverage every time the underlying complaint alleges that the insured did something wrong before the policy's inception, even when those same allegations state a covered claim under the policy. The *Warrantech* decision is currently pending before the Texas Supreme court via Warrantech's petition for review. Hopefully, the Texas Supreme Court will grant the petition and provide some much needed correction and guidance in this terribly muddled area of Texas law.

CONCLUSION

The known-loss and loss-in-progress rules, when properly applied, serve the legitimate purpose of preventing fraud in the procurement of insurance. And, when properly applied, the known loss and loss-in-progress rules reflect the fortuity requirement of all insurance contracts. The *misapplication* of the known loss and loss-in-progress rules (under the name "fortuity doctrine") urged by insurers and adopted by some Texas courts, however, is directly at odds with both the fortuity principle and the known loss rule as articulated by the Texas Supreme Court in Burch. The result is the creation of a new extra-contractual "known risk" defense based on the absurd notion that mere knowledge of a risk of liability precludes the ability to purchase insurance for that risk. Moreover, when applied in the context of the duty to defend, this defense allows insurers to go beyond the policy language to defeat an existing duty to defend without ever having to prove that the insured misrepresented or concealed any information when purchasing the insurance. Under this new defense, an insurer who believes he has done nothing wrong and, in fact has done nothing wrong, is subject to a known loss defense based solely on the allegations in the underlying complaint -- even though those same allegations invoke the duty to defend under the policy language. This makes no sense, especially considering that the duty to defend is itself a form of litigation insurance against even baseless claims.

1. Texas courts considering this new defense have adopted the term "fortuity doctrine" and have stated that it encompasses both the known loss and loss-in-progress rules.

2. The known loss rule reflects the fortuity principle in that the fraud results from knowingly insuring a *certainty*.

3. The court in *General Housewares* defines "substantially certain" to mean "virtually inevitable." According to the court, "The inquiry should be more of temporality than probability – when an event will occur, not whether an event will occur." *Gen. Housewares*, 741 N.E.2d at 414.

4. Most of the non-Texas cases considering the application of the known loss and loss-in-progress rules to liability policies involved environmental/pollution claims under general liability policies. Faced with increasing state and federal environmental claims, insurers sought ways to go beyond the policy language to defeat coverage. In those cases using the "substantial probability of liability" standard, the courts focused on evidence of such things as the extent of contamination that existed before the policy's inception, to what extent the insured knew about the contamination and whether the insured knew or had reason to know that a probable loss or liability would occur due to the contamination.

5. *Inland Waters*, a case involving coverage for an environmental/pollution claim under a general liability policy, does not even use the term "fortuity doctrine." Instead, the court purports to apply the known loss and loss-in-progress doctrines, and states that the known loss doctrine is sometimes referred to as the "known risk" doctrine. *Inland Waters,* 997 F.2d at 177 n.3. Thus, the *Inland Waters* court erroneously equates "known risk" with "known loss." The court held that the loss-in-progress doctrine operates "only where the insured is aware of a threat of loss so immediate that it might fairly be said that the loss was in progress and that the insured knew it at the time the policy was issued or applied for." *Id*. at 178. The court also made it clear that this is inherently a question of fact—a point apparently lost on Texas courts applying this erroneous standard to the duty to defend.

6. Unfortunately, other Texas courts have simply adopted the objective knowledge test from *Two Pesos*. *See, e.g., Westchester Fire Ins. Co. v. Gulf Coast Rod, Reel & Gun Club*, 64 S.W.3d 609, 613 n.2 (Tex. App.—Houston [1st Dist.] 2001, no pet.) ("A 'loss in progress' is is [sic] an on ongoing progressive loss that the insured is or should be aware of at the time the policy is purchased. . . . A 'known loss' is a loss that has already occurred and that is known or should be known by the insured when the policy is purchased.") (citations omitted); *Scottsdale Ins. Co. v. Travis,* 68 S.W.3d 72, 75 (Tex. App.—Dallas 2001, pet. denied) ("Insurance coverage is precluded where the insured is or should be aware of an ongoing progressive or known loss at the time the policy is purchased.") (citation omitted).

7. Likewise, the holding in *Matagorda* that the known loss doctrine barred coverage was based on *evidence* of (1) the insured's pre-policy receipt of a demand letter warning them of potential liability for its continued trademark and copyright infringement, and (2) the insured's failure to disclose that demand letter to the insurer. 28 F. Supp. 2d at 691 . *Compare Ryland Group, Ins. v. Travelers Indem. Co. of Ill.*, No. Civ. A-00-CA-233 JRN, 2000 WL 33544086 (W.D. Tex. Oct. 25, 2000), holding that the known loss doctrine did not defeat coverage and stating:

> The Court finds the facts in the instant case fundamentally different from those presented in *Two Pesos* and *Franklin*. As noted above, in *Two Pesos* the insured purchased the insurance policy after the judgment in the underlying suit had already been entered against it. Similarly, in *Franklin*, the insured purchased the policy one year after it had been notified in writing by the plaintiff in the underlying suit that it was violating the plaintiff's patent . . . The Court finds that there is an important difference between an insured purchasing an insurance policy after having been notified that he is violating a copyright, as was the case in *Two Pesos* and *Franklin*, and an insured purchasing an insurance policy after committing acts which may later be found to be infringement but before actually being accused of copyright infringement, as is the situation in the instant suit.

Id. at *7.

[8] By amendment to the policy exclusion for fraudulent/knowingly wrongful conduct, the policy at issue in *Warrantech* also specifically obligated the insurer to *defend* against claims alleging such conduct unless and until a final adjudication established that the conduct, in fact, occurred. *Id*. at 768. Nevertheless the court relieved the insurer of its duty to defend based on nothing more than unproven allegations in the underlying petition.

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BY JOHN TOLLEFSON[1]

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Suits by Insurers Against Insurers: Questions Abound After *Mid-Continent v. Liberty Mutual*

In *Mid-Continent Insurance Company v. Liberty Mutual Insurance Company,* 236 S.W.3d 765 (Tex. 2007), the Texas Supreme Court was faced with the question of what to do when two liability insurers disagree over whether to settle a claim against their mutual insured, one pays the entire settlement, and then tries to recoup the pro rata share from the other based on contribution or contractual or equitable subrogation principles. Relying on settled law, it dispatched the idea that contribution could provide the basis for recoupment. But, it further held that the settling insurer could not rely on subrogation to recover the appropriate share of a reasonable settlement against a carrier that had been determined to have acted unreasonably. Thus, some commentators have asserted that in one ill-reasoned, ill-advised stroke the Court mandated that insurers should engage in a game of "chicken" when faced with this situation, with the more bullheaded insurer benefiting. If so, this is bad law, unsound public policy and an inequitable result that will have bad consequences reaching into other areas of insurance law. It is suggested, however, that the breadth of the opinion may not be as far reaching as some have proclaimed, and the Court's ruling may be read as being limited to its precise, somewhat unusual fact pattern.

FACTS AND PROCEEDINGS IN *LIBERTY MUTUAL*

In *Liberty Mutual* the facts were these: in November 1996, an automobile accident occurred in the construction zone of a State of Texas highway project. A westbound car driven by Tony Cooper on the lanes narrowed by construction crossed into oncoming traffic and collided with an eastbound car driven by James Boutin and occupied by his family. All members of the Boutin family suffered substantial injuries. Kinsel Industries was the general contractor on the highway project. Crabtree Barricades was Kinsel's subcontractor responsible for signs and dividers. The Boutin family sued Cooper, the State, Kinsel, and Crabtree in the state district court of Liberty County, Texas, for damages resulting from the accident. Kinsel was the named insured under Liberty Mutual Insurance Company's $1 million comprehensive general liability (CGL) policy. Significantly, Liberty Mutual also provided Kinsel with $10 million in excess liability insurance. Crabtree was the named insured under Mid-Continent Insurance Company's $1 million CGL policy. Mid-Continent's policy identified Kinsel as an additional insured for liability arising from Crabtree's work.

Kinsel, therefore, was a covered insured under two CGL policies, both of which provided Kinsel with $1 million in indemnity coverage for the underlying suit. The insurers had no contract between them that was implicated by the automobile accident. The CGL policies contained identical "other insurance" clauses providing for equal or pro rata sharing up to the co-insurers' respective policy limits if the loss is covered by other primary insurance.[2] Each policy also contained a "voluntary payment" clause, a subrogation clause, and a version of the standard "no action" clause.[3]

Liberty Mutual and Mid-Continent did not dispute that each owed some portion of Kinsel's defense and indemnification. The insurers agreed that a total verdict for the Boutins against all defendants would be around $2 to $3 million, but they disagreed on the settlement value of the case against Kinsel. Initially both insurers estimated Kinsel's percentage of fault between ten percent and fifteen percent, but as the case progressed Liberty Mutual increased its estimate to sixty percent. After repeated refusals by Mid-Continent to increase its contribution to a settlement, Liberty Mutual agreed at a mediation with the Boutins to settle on behalf of Kinsel for $1.5 million (sixty percent of a $2.5 million anticipated verdict). Liberty Mutual demanded Mid-Continent contribute half, but Mid-Continent continued to calculate the settlement value of the case against Kinsel at $300,000 and agreed to pay only $150,000. Liberty Mutual, therefore, funded the remaining $1.35 million, paying $350,000 more than its $1 million CGL policy limit. Liberty Mutual reserved the right to seek recovery against Mid-Continent for its portion of the settlement. Sometime later, before trial, Mid-Continent settled the Boutins' claim against Crabtree for $300,000. Liberty Mutual sued Mid-Continent seeking to recover Mid-Continent's pro rata share of the sum paid to settle the Boutin family's claim against Kinsel. Mid-Continent timely removed the case to federal court on diversity grounds. After a bench trial, a federal District Court judge in the Northern District of Texas concluded that Liberty Mutual was entitled through subrogation to recover $550,000 from Mid-Continent. *Liberty Mut.*, 236 S.W.3d at 770.

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Relying on *General Agents Insurance Co. of America v. Home Insurance Co. of Illinois*, 21 S.W.3d 419 (Tex. App.—San Antonio 2000, pet. dism'd by agr.), the District Court determined that each insurer owed a duty to act reasonably in exercising its rights under the CGL policies. *Liberty Mut. Ins. Co. v. Mid-Continent Cas. Co.*, 266 F. Supp. 2d 533, at 542 (N.D. Tex 2003). It found Mid-Continent was objectively unreasonable in assessing Kinsel's share of liability, and Liberty Mutual was reasonable in its assessment and in accepting the Boutins' settlement offer. *Id.* at 543-44. Specifically, the District Court held: "Mid-Continent's recalcitrance to consider any change, despite the changing circumstances, was unreasonable, causing it to unreasonably assess its insured's exposure," while on the other hand Liberty Mutual, "[b]y agreeing to settle for [$ 1.5 million]… resolved the case within policy limits, based on a reasonable estimation of Kinsel's liability, and avoided the real potential of joint and several liability." *Id.* at 544. Therefore, the District Court concluded that, whether apportioned pro rata or in equal shares, Mid-Continent was liable in subrogation for $750,000, one-half of the $1.5 million settlement with Kinsel. *Id.* at 546. Because Mid-Continent already paid $450,000 of its $1 million policy limit in settlement ($150,000 for the suit against Kinsel and $300,000 for the suit against Crabtree), the District Court ordered Mid-Continent to pay only $550,000. *Id.* Although this amount is $50,000 short of Mid-Continent's $750,000 share of the Kinsel settlement, the District Court found no justification for increasing Mid-Continent's total liability above its $1 million policy limit. *Id.* Mid-Continent appealed and the Fifth Circuit certified questions of law to the Texas Supreme Court, which accepted the certified questions. *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.*, 236 S.W.3d 765, 770-771 (Tex. 2007)

Relying on *Employers Casualty Co. v. Transport Ins. Co.*, 444 S.W.2d 606, 610 (Tex. 1969), the Court reiterated the rule in Texas that there is no right of contribution among co-primary insurers. It then turned to the issue of subrogation and held that there was no right of subrogation either explaining: "Because the insured had been fully indemnified, the insured had no contractual rights that could be asserted via subrogation." Even though it did not express any disagreement with the District Court's ruling that Liberty Mutual acted reasonably and Mid-Continent acted unreasonably, it rejected appeals to equity based on *Employers* and *American Centennial Ins. Co. v. Canal Ins Co.*, 843 S.W.2d 480, 482-483 (Tex. 1992), because Liberty Mutual occupied the role of excess carrier as well as primary carrier and so, in the high court's opinion[4], it was protecting its own excess exposure, and not its insureds' exposure, by settling. *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.*, 236 S.W.3d 765, 776 (Tex. 2007).

It is submitted that the *Liberty Mutual* opinion should be limited to those facts, and there is substantial indication from the Court that it was intended to be limited to those circumstances when an insurer occupying both the excess and primary position settles and seeks reimbursement from a primary insurer. And, conversely, where the settling insurer has issued no excess policy, it acts to protect its common insured, and the equity that Justice Wainwright found lacking in *Liberty Mutual* is still present, then the holding of *Liberty Mutual* should *not* apply. Therefore, the prior law, established forty years ago in *Employers*, permitting equitable/contractual subrogation between primary insurers should still be viable in Texas. The right to equitable and contractual subrogation among co-primary insurers is well-settled in the law and is also based on sound public policy, equitable, and legal principles. Four decades of jurisprudence, sound public policy and fundamental principles of fairness and reasonable insurance practice should not be swept off the board on the basis of an overly broad reading of Justice Wainwright's opinion.

THE TEXAS SUPREME COURT HAS RECOGNIZED SUBROGATION BETWEEN LIABILITY INSURERS FOR DECADES AND NO SUBSTANTIAL REASON EXISTS FOR DEPARTING FROM THIS HISTORY.

In 1969, in *Employers Casualty Co. v. Transport Ins. Co.*, 444 S.W.2d 606, 610 (Tex. 1969), the Texas Supreme Court held that although there is no right of contribution among co-primary insurers, there is a right of contractual subrogation if the suing insurer's policy contains a subrogation provision or, if it does not, a right to equitable subrogation.[5] In *Employers,*

Prior Products, Inc., which was insured by Employers Casualty Company and Transport Insurance Company, was sued. Transport denied that Prior Products was an insured and refused to defend the suit. Employers assumed the defense, negotiated a settlement, and subsequently sued Transport for contribution. *Id*. Because Employers failed to meet the requirements necessary to be entitled to contribution, the trial court's summary judgment was affirmed. The Texas Supreme Court noted that Employers was not without a remedy: "Its remedy for recovery from Transport of a pro rata part of the payment to the Siegels, as clearly indicated by the many cases listed above from other jurisdictions, lies in a suit asserting its right to payment through contractual or conventional subrogation to the right of the insured." *Id*. at 610. The opinion further indicates that whether the payment is voluntary is immaterial for purposes of the subrogation claim. *Employers* establishes that subrogation is the proper theory for one co-insurer to assert when seeking to recover from the other co-insurer the payment the first co-insurer made in excess of its pro rata share.

In 1992, the Texas Supreme Court re-affirmed the existence of those rights, noted the scores of other jurisdictions that do likewise, and extended the right of equitable subrogation to the excess insurer vs. primary insurer context:

> Although a question of first impression in Texas, many other states have considered whether the doctrine of equitable subrogation permits actions between carriers. Under this theory, the insurer paying a loss under a policy becomes equitably subrogated to any cause of action the insured may have against a third party responsible for the loss. The excess insurer would thus be able to maintain any action that the insured may have against the primary carrier for mishandling of the claim. **Equitable subrogation has been recognized in Texas, although not in this [excess vs. primary] particular context.** *See, e.g., Employers Casualty Co. v. Transport Ins. Co*., 444 S.W.2d 606, 610 (Tex. 1969); *Interfirst Bank Dallas, N.A. v. United States Fidelity and Guar. Co*., 774 S.W.2d 391, 397 (Tex. App.—Dallas 1989, writ denied); *International Ins. Co. v. Medical-Professional Bldg. of Corpus Christi,* 405 S.W.2d 867, 869 (Tex. Civ. App.—Corpus Christi 1966, writ ref'd n.r.e.).
>
> While many states recognize an action by an excess carrier against a primary insurer, a majority of those permitting suit do so on grounds of equitable subrogation. In recognizing a cause of action for equitable subrogation, these courts have sought to encourage fair and reasonable settlement of lawsuits. See *Northwestern Mut. Ins. Co. v. Farmers Ins. Group,* 76 Cal. App. 3d 1031, 1050-51, 143 Cal. Rptr. 415, 427 (1978); *Ranger Ins. Co. v. Travelers Indem. Co*., 389 So. 2d 272, 275 (Fla. Dist. Ct. App. 1980). If the excess carrier had no remedy, the primary insurer would have less incentive to settle within the policy limits.

American Centennial Ins. Co. v. Canal Ins Co., 843 S.W.2d 480, 482-483 (Tex. 1992)(*"American Centennial"*)(footnotes deleted)(emphasis added).

THE COURT'S PRIOR PRONOUNCEMENTS OF PUBLIC POLICY PRINCIPLES CONTINUE TO APPLY IN PRIMARY VS. PRIMARY CASES

In *American Centennial*, the Supreme Court recognized that such a right is necessary and beneficial as a matter of public policy, and equity, to protect the excess insurer from the primary gambling with the excess insurer's money:

> While many states recognize an action by an excess carrier against a primary insurer, a majority of those permitting suit do so on grounds of equitable subrogation. In recognizing a cause of action for equitable subrogation, these courts have sought to **encourage fair and reasonable settlement of lawsuits**. *See Northwestern Mut. Ins. Co. v. Farmers Ins. Group,* 76 Cal. App. 3d 1031, 1050-51, 143 Cal. Rptr. 415, 427 (1978); Ranger Ins. Co. v. Travelers [*483] Indem. Co., 389 So. 2d 272, 275 (Fla. Dist. Ct. App. 1980). **If the excess carrier had no remedy, the primary insurer would have less incentive to settle within the policy limits.** *Hartford Accident & Indem. Co. v. Aetna Casualty & Sur. Co*., 164 Ariz. 286, 792 P.2d 749, 757 (Ariz. 1990); *Commercial Union Ins. Co. v. Medical Protective Co*., 426 Mich. 109, 393 N.W.2d 479, 483 (Mich. 1986) ("Allowing the excess insurer to enforce the primary insurer's duty to settle in good faith serves the public and judicial interests in fair and reasonable settlements of lawsuits by discouraging primary carriers from 'gambling' with the excess carrier's money when potential judgments approach the primary insurer's policy limits."). Additionally, the wrongful failure to settle would likely result in increased premiums by excess carriers. … These courts have also employed equitable subrogation "to prevent an unfair distribution of losses among primary and excess insurers." … Because we find the reasoning of these

> cases persuasive, we hold that an excess carrier may bring an equitable subrogation action against the primary carrier. This does not, however, impose new or additional burdens on the primary carrier, since our prior decisions in *Stowers* and *Ranger County* imposed clear duties on the primary carrier to protect the interests of the insured. **The primary carrier should not be relieved of these obligations simply because the insured has separately contracted for excess coverage**. … In this situation, where the insured has little incentive to enforce the primary carrier's duties, the excess carrier should be permitted to do so through equitable subrogation.

American Centennial, 843 S.W.2d at 482-483 (emphasis added). The Court again recognized the right in *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994).[6]

So, according to *American Centennial*, the principles underpinning the right of one insurer (be it primary or excess) to subrogate against a recalcitrant primary are:

- to encourage fair and reasonable settlement of lawsuits;
- to discourage primary carriers from 'gambling' with the excess carrier's money when potential judgments approach the primary insurer's policy limits;
- if the excess carrier had no remedy, the primary insurer would have less incentive to settle within the policy limits;
- to prevent an unfair distribution of losses among primary and excess insurers; and
- the primary carrier should not be relieved of these obligations simply because the insured has separately contracted for excess coverage.

These principles apply with like force when a primary seeks equitable or contractual subrogation against a co-primary.[7] Each should be addressed in order:

Encouraging fair settlements is a principle that pertains equally when the insured is protected by co-primary insurers as when she is protected by primary and excess insurance. So, there is no basis to distinguish *American Centennial* on this point.

Discouraging primary carriers from 'gambling' with the co-primary carrier's money when potential judgments approach the primary insurer's policy limits is as legitimate a concern as discouraging primary carriers from 'gambling' with the excess carrier's money. If the co-primary carrier has no remedy, the other primary insurer would have less incentive to settle within the policy limits. In that instance, it may well induce the otherwise reasonable co-primary to join in the refusal to settle, knowing that if it joins in refusing to pay then the other carrier might "chicken out" and, even if does not, they would only share *Stowers* liability for the excess judgment against the co-insured.

One primary carrier should not be relieved of its obligations simply because the insured has separately contracted for co-primary coverage. This is particularly so where, as is often the case, the person or entity insured is a mere additional insured on the settling insurer's policy and paid nothing for the coverage.

One primary carrier should not be relieved of its obligations simply because the insured has separately contracted for co-primary coverage.

Further, the principle of preventing an unfair distribution of losses among primary and excess insurers applies with equal force to allowing equitable subrogation between co-primary insurers. First, it would seem at least an equally laudable goal to avoid unfairly distributing losses from insurers who refuse to share in paying reasonable[8] demands within limits to insurers who pay to settle such cases in order to protect their insureds from excess judgments. Second, most insurers write both excess and primary policies, often for the same insured. The *Liberty* case is itself an example. There, Liberty Mutual wrote both the primary and the excess insurance for the insured it had in common with Mid-Continent.[9] (More on this below). There are few who deal only in one or the other. It is simply a misperception of the marketplace to assume that by protecting "excess insurers" at the expense of "primary insurers" one is encouraging a special group. Even if it were the case, there is no legal, rational or equitable reason for affording excess carriers some special favored status in the law. They underwrite, accept premiums and risk, and sometimes, but obviously not as often, pay defense costs and claims, just as primary insurers do.

Finally, reading *Liberty Mutual* so as to judicially immunize all recalcitrant carriers who unreasonably refuse to share in paying reasonable settlement demands works against the well-recognized benefit of economic loss spreading, which is the governing principle of all insurance, and does so for no good reason. Further, subrogation is favored in the law and is to be given a liberal application.[10] One court noted: "The courts of Texas have always been peculiarly hospitable to the right of subrogation and have been in the forefront of upholding it."[11]

The doctrine of subrogation is supposed to be given a liberal application and is broad enough to include every instance in which one person, not acting voluntarily, has paid a debt for which another was primarily liable and which in equity and good conscience should have been discharged by the latter.[12] The Texas Supreme Court has held that subrogation has been properly invoked to prevent "unjust enrichment."[13] Historically, the high court of Texas has never rejected any of these principles, and has repeatedly embraced them. A general application of *Liberty Mutual*, however, does nothing but undermine them.

Proponents of a broad reading may assert that the insured remains protected by *Stowers* even without the "pay and chase" procedure established by *Employers* and its progeny. And, it is true that if both co-primary insurers decide to refuse to pay, having been emboldened by a broad reading of the Court's ruling, *Stowers* remains as protection for the insured.[14] But, would Texas really rather have more *Stowers* cases? Why is it good policy to encourage situations in which insureds suffer an excess judgment, have their credit ruined, and then have to pay lawyers to initiate and prosecute a *Stowers* claim, in separate litigation, all while their assets are subject to execution? Is it not better to have the case against the insured settled, freeing the insured and the injured person to go on about their business, while the paying primary carrier and the recalcitrant carrier, both well-funded, professional risk takers can then litigate "reasonableness" between themselves? If read broadly, the Court's ruling encourages two lawsuits instead of one. Most Texas citizens, and certainly most trial courts, would prefer having one. Further, the novel *Stowers* procedure sketched out by Justice Wainwright in *dicta* (discussed below) seems unworkable in most cases.

There is no basis to distinguish the *American Centennial* principles from the general case set out in *Employers* on any point. And yet in *Liberty Mutual* the Court reached the exact opposite result. So, what is the solution? The author suggests it is to simply recognize the *Liberty Mutual* opinion as being limited to cases in which the settling insurer is both a primary and an excess carrier – that is, limited to the facts presented in *Liberty Mutual*. Indeed, it appears that is exactly what the Court intended, as will be discussed in the next section.

THE *LIBERTY MUTUAL* OPINION ITSELF INDICATES IT IS LIMITED TO THE FACTS PRESENTED

Perhaps the best solution now is to read the Court's opinion in a limited way, and this may be the way it was intended: it appears the Court intended to foreclose equitable subrogation between co-primaries under only the factual situation before them in *Liberty Mutual* (i.e., where the paying insurer is both primary *and* excess) and no more. How can the decision be read in this way? First, in the key part of the decision the Court held that *unless equity demands a different result,* a fully indemnified insured has no right to recover an additional pro rata portion of a settlement from an insurer regardless of that insurer's contribution to settlement and therefore contractual subrogation rights notwithstanding, an insurer paying more than its pro rata has no right to which it can be subrogated. It then found that the situation at hand *in that case* was not such that equity demands a different result.[15] "Different" here is in contrast to *American Centennial* in which equity demanded the exact opposite result. And what was the "negative equity" situation in *Liberty Mutual* to which the court referred? It seems to be: when the paying carrier (Liberty Mutual in this case) also occupies the role of excess insurer, and is not protecting its insured, *but rather its own coffers*, then this result is apparently mandated. In other words, the right set out in *Employers* exists and is owned by all paying insurers as a general rule, but it can only be exercised by those acting altruistically and not burdened by the "negative equity" of "self interest."

What indication do we have that this is the case? The language of the decision itself. First, the Court indicated that it was not overruling the recognition of the right of subrogation by primary carriers against each other recognized in *Employers Casualty* to the facts then before it:

> In *Employers Casualty*, after precluding a right to contribution, we said that the co-insurers' remedy for reimbursement would lie in contractual or equitable subrogation. 444 S.W.2d at 610. In *Hicks Rubber*, a case relied upon in *Employers Casualty*, we said that when several insurance policies covering the same loss contain pro rata clauses, none of the co-insurers has a right to contribution from the others, "nor will the payment of the whole loss by any of them discharge the liability of the others." 169 S.W.2d at 148. **This language suggests that payment of the insured's entire loss by one co-insurer does not relieve the other co-insurers' contractual obligations to the insured to pay their pro rata share of the loss. *Id*. The implication is that the insured would still have a right to enforce the contractual obligation, and presumably, that the co-insurer seeking reimbursement could be subrogated to this right.**
>
> **Having a right to subrogation, however, is distinct from the ability to recover under that right.** *See Esparza v. Scott & White Health Plan*, 909 S.W.2d 548, 551 (Tex. App.—Austin 1995, writ denied) ("While an insurance contract providing expressly for subrogation may remove

> from the realm of equity the question of whether the insurer has a right to subrogation, it cannot answer the question of when the insurer is actually entitled to subrogation or how much it should receive."). In *Hicks Rubber* and *Employers Casualty* we did not apply the particular facts to the elements of the suggested right to subrogation to determine if the overpaying co-insurer could actually recover. **Doing so here, we determine that the facts preclude recovery because Liberty Mutual cannot meet the elements of subrogation.**

Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co., 236 S.W.3d 765, 774 (Tex. 2007)(emphasis added).

Second, the *Liberty Mutual* court held that "in *Canal*, we recognized equitable subrogation as a basis for an excess insurer's recovery against a primary insurer to prevent a primary insurer from taking advantage of an excess insurer, acting solely as such, when a potential judgment approaches the primary insurer's policy limits." *Liberty Mutual*, 236 S.W.3d at 776. This is found in the following language of the Court in distinguishing *American Centennial*:

> In this case, however, Liberty Mutual played a dual role as primary insurer and excess insurer and was in a position to negotiate a good faith settlement on Kinsel's behalf. Equity demanded a remedy for the excess insurer in *Canal*, but here equity does not favor such a remedy. A reasonable primary insurer, which did not improperly handle the claim, would not pay more than its primary policy limits. In paying $350,000 more than its 1 million dollar policy limits, Liberty Mutual seems to have been motivated by concern for its excess insurance policy. Mid-Continent cannot be required to agree to a settlement that requires payment in excess of its remaining coverage to protect Liberty Mutual's excess insurance interests.

Liberty Mutual, 236 S.W.3d at 776.

So, although not as fully elucidated as it might have been, it appears that the Court recognizes that subrogation still exists between liability insurers, as established in *Employers*, and confirmed in *American Centennial*, but the right may only be exercised when certain equity-driven circumstances exist in the particular case presented, and that the equities are against the right to exercise the right of subrogation when the paying insurer is also an excess carrier, and is presumed to have paid out of self interest. Presumably, this means that these negative equities are simply not present in the more common primary (only) vs. primary (only) lawsuit. The bottom line is the Texas Supreme Court did not have before it a case of one of two primary (only) carriers settling a case to protect its insured from what it reasonably believed was a strong chance of a judgment well in excess of limits. So, in addition to not deciding the case on this basis, it could not have reached this issue without engaging in an advisory opinion based on hypothetical facts.

Instead, it appears that in the more routine primary (only) vs. primary (only) situation, *Employers v. Transport* still governs. The equitable principles in such an instance are equivalent to those set out in *American Centennial*. The result, therefore, should be the same as in those cases, and not as in the special circumstance found in *Liberty Mutual*. In sum, even after *Liberty Mutual*, co-primary insurers should still be given the opportunity to prove the settlement was reasonable, and upon so doing, to recover from recalcitrant co-primary insurers the just portion of their payment on behalf of their common insured.

READING *LIBERTY MUTUAL* BROADLY WOULD UNDERMINE THE PRINCIPLE OF SUBROGATION IN TEXAS

There are other good reasons to strictly limit *Liberty Mutual* to the precise facts set out in it. The key part of the ruling holds that because Liberty Mutual's payment relieved the co-insurer's common insured of any potential for liability, there was nothing to which *Liberty Mutual* could be subrogated. The Court explained:

> Liberty Mutual argues it is subrogated to the contractual right of Kinsel to enforce language in Mid-Continent's policy imposing a duty upon Mid-Continent to defend and indemnify Kinsel and to pay a pro rata share of settlement. We agree that the co-insurers' contractual duties to Kinsel were specified in the CGL policies and included, as discussed above, a several and independent duty to pay a pro rata share of a covered loss up to their respective policy limits. ... But this duty cannot be viewed independent of the purpose of a pro rata clause, nor without consideration of the rules of indemnification. As Mid-Continent validly asserts, Kinsel has no right, after being fully indemnified, to enforce Mid-Continent's duty to pay its pro rata share of a loss.
>
> ***
>
> Equity does not demand a different result here. We hold, therefore, that a fully indemnified insured has no right to recover an additional pro

> rata portion of settlement from an insurer regardless of that insurer's contribution to the settlement. Having fully recovered its loss, an insured has no contractual rights that a co-insurer may assert against another co-insurer in subrogation.

Liberty Mutual, 236 S.W.3d at 776.

Were this adopted as the general law of Texas, it could be argued that subrogation would simply cease to exist as a concept of law. **Any** time the insured is paid by an insurer, the insured no longer has anything to lose. Why should it matter that the obligor is a co-primary insurer rather than a common tortfeasor? When a careless smoker negligently burns down one's building, and the owner's property insurer pays for all of the damage, is not the owner fully indemnified, eliminating the right of the property insurer to recover their payment?

The answer is, obviously, no. An insurer's payment of an obligation owed by another does not mean that the right to satisfy that obligation is extinguished. It just means that the insured has sold and transferred those rights to its insurer. Payment by an insurer does not destroy the obligation owed to the insured by the persons who have damaged it. It simply transfers the right to a different entity. So, when the Supreme Court stated that "the liability of the remaining insurers to the insured ceases, even if they have done nothing to indemnify or defend the insured,"[16] the Court was simply wrong as a matter of fundamental insurance law or at least should have parsed the issue more carefully. It is self-contradictory to read the Court's ruling as saying that it is not overruling *American Centennial*, that it recognizes that subrogation still exists, and that it meant to effect the broad consequence of this pronouncement. If the insured's rights against third parties ceases when it is paid by its insurer, then, when an excess carrier (like American Centennial) pays its insured's debt, to what is the excess carrier subrogated?

If the Court has truly chosen to set out creating new legal roads, it seems it would have provided a better roadmap.

Finally, the Court's justification for the elimination of the right of subrogation is strained, at best. It stated that if a co-insurer pays the recalcitrant insurer's obligation, the paying insurer cannot enforce it because, having received payment from a co-insurer, the insured could not enforce this right because the anti-double recovery purpose of the pro rata "other insurance clauses" would not be served.[17] If it were the case that the insured or its subrogee were in fact seeking to recover more than the pro rata share, the point might be well made. However, that was not the case. Liberty Mutual only sought the portion of the settlement it paid in excess of the part it owed. No "double recovery" was sought or threatened. It is ironic that the Court would limit or eliminate subrogation rights in an effort to thwart "double recovery" by the insured, as the Court has long held that "[t]he underlying justification for such a subrogation suit is to prevent the insured from receiving a double recovery." *Ortiz v. Great S. Fire & Cas. Ins. Co.*, 597 S.W.2d 342, 343 (Tex. 1980). This seems a shaky footing for such a towering jurisprudential beacon.

THE "PARTIAL *STOWERS*" DICTA

Other problems arise from reading the *Liberty Mutual* as setting the rule for the general case. In its ukase against contribution, the Court apparently recognized that insurers now have the right to refuse to pay all of their policy limits towards a *Stowers* demand when there are co-insurers,[18] and instead to offer only their proportionate share towards the demand. This evidently now imposes upon insureds the right/obligation/burden to chase the recalcitrant carriers for their share, to fund it themselves, or refuse to settle and face the potential of an excess judgment (with the cold comfort of prosecution of a suit for some kind of partial *Stowers* liability):

> With independent contractual obligations, the co-insurers do not meet the common obligation requirement of a contribution claim – each co-insurer contractually agreed with the insured to pay only its pro rata share of a covered loss; the co-insurers did not contractually agree to pay each other's pro rata share. ... In addition, the co-insurer paying more than its contractually agreed upon proportionate share does so voluntarily; that is, without a legal obligation to do so. Thus, a co-insurer paying more than its proportionate share cannot recover the excess from the other co-insurers. ... The effect is not the same with respect to the insured's right of recovery. When an insured is covered by multiple policies containing pro rata clauses, and the insured has not been fully indemnified, the insured may enforce this contractual obligation to recover the multiple insurers' shares of the covered loss, so long as the shares are within the respective insurers' policy limits.

Liberty Mutual, 236 S.W.3d at 772.

So, presumably this means that if the carrier that wants to settle pays its share, it is free of any further contractual obligation and, presumably, free of any *Stowers* liability. How could it be otherwise? The Court has held that "each co-insurer contractually agreed with the insured to pay only its pro rata share of a covered loss" and if they pay more they do so as a volunteer. But what does the paying carrier get in return? If it pays the claimant, does it get a release for its insured? No, because that would end the case for half of what is owed. Does it get a release for half the claim? That is doubtful. What claimant, possessing a true excess case, would take that? And, does that not seem to be an excellent incentive for shenanigans between the parties such as the Supreme Court tried to end in *Gandy*? Perhaps the answer is that payment of part of the primary limits should relieve the paying insurer of all further obligations under the policy and all *Stowers* obligations, create a credit against a judgment against the insured, and leave the recalcitrant insurer on the hook for all of its pro rata of limits and *all* of the excess liability under *Stowers*.

But who does the paying insurer pay? The plaintiff? The insured? The registry of the court? Does this constitute "exhaustion of limits" sufficient to cut off the paying insurer's defense obligations? If the Court has truly chosen to set out creating new legal roads, it seems it would have provided a better roadmap. If these new rights/obligations are truly a new regime, then it is difficult to see how the result fosters the principle of encouraging settlement and reducing litigation about litigation. Further, this is punishing the insured, giving it less coverage and more litigation because it committed the "sin" of having two policies instead of one.

Perhaps the only comforting thing about this portion of the opinion is that it is obiter dicta. Recall that the case did not involve an excess judgment – indeed, there was no judgment at all – because Liberty Mutual settled the underlying case. When there is no judgment involved, there is no *Stowers* doctrine involved.

CONCLUSION

The rule of law announced in *Liberty Mutual* should be read as this and no more: where a primary insurer has also issued an excess policy covering an insured and another primary insurer has issued a primary insurance policy to that same insured, any settlement that is offered that would relieve the insured, and is paid by the primary/excess carrier, that primary/excess carrier has no right of subrogation against the other primary carrier. The same equitable considerations simply do not apply in a true primary vs. primary case. We will learn very quickly if the courts of Texas agree.

1. John Tollefson is a partner in the Dallas Texas law firm, Tollefson Bradley Ball & Mitchell, LLP. The views set out herein are his and not necessarily those of his clients or firm.

2. 4. Other Insurance.
   If other valid and collective insurance is available to the insured for a loss we cover under Coverages A ['Bodily Injury and Property Damage Liability'] or B of this Coverage Part, our obligations are limited as follows:
   a. Primary Insurance
   …If this insurance is primary our obligations are not affected unless any of the other insurance is also primary. Then, we will share with all that other insurance by the method described in c. below.
   c. Method of Sharing
   If all of the other insurance permits contribution by equal shares, … each insurer contributes equal amounts until it has paid its applicable limit of insurance or none of the loss remains, whichever comes first.
   If any of the other insurance does not permit contribution by equal shares, we will contribute by limits. Under this method, each insurer's share is based on the ratio of its applicable limit of insurance to the total applicable limits of insurance of all insurers.

3. The "voluntary payment" clauses provided, "No insureds will, except at their own cost voluntarily make a payment, assume any obligation, or incur any expense, other than for first, aid, without our consent." The subrogation clauses provided, "If the insured has rights to recover all or part of any payment we have made under this Coverage Part ['Bodily Injury or Property Damage Liability'], those rights are transferred to us." "A person or organization may sue us to recover on an agreed settlement or on a final judgment against an insured obtained after an actual trial; but we will not be liable for damages that are not payable under the terms of this Coverage Part ['Bodily Injury or Property Damage Liability'] or that are in excess of the applicable limit of insurance. An agreed settlement means a settlement and release of liability signed by us, the insured and the claimant or the claimant's legal representative."

4. No evidence of this intent was referred to in the record. Indeed, the district court's findings made plain that Liberty Mutual was acting reasonably and Mid-Continent unreasonably. *See Liberty Mut. Ins.*, 266 F. Supp. 2d at 544.

5. *Employers Casualty*, 444 S.W.2d at 610:
   Employers Casualty was not, and is not, without a remedy. Its remedy for recovery from Transport of a pro rata part of the payment to the Siegels, as clearly indicated by the many cases listed above from other jurisdictions, lies in a suit asserting its right to payment through contractual or conventional subrogation to the right of the insured. … Its policy contains the following provision: "Subrogation. In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefore against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights. "When its claim is asserted in virtue of its right of subrogation, whether its payment of more than its pro rata part of the loss was compulsory or voluntary is immaterial. This is the holding in *Commercial Standard Ins. Co. v. American Employers Ins. Co.*, 209 F.2d 60, at 66 (CA 6th Cir. 1956) where the court said: "Whether the payment of the debt of another is for the purpose of protecting an interest of the one who pays the debt; whether it is paid because of a moral obligation; whether it is a payment by a volunteer – all of these considerations are irrelevant in a case of conventional subrogation." And, if the subrogation provision in its policy does not authorize recovery by Employers Casualty from Transport of a pro rata part of the sum paid as an attorney's fee in defense of the Siegel suit, equitable subrogation does.

6. "If a single occurrence triggers more than one policy, covering different policy periods, then different limits may have applied at different times. In such a case, the insured's indemnity limit should be whatever limit applied at the single point in time during the coverage periods of the triggered policies when the insured's limit was highest. The insured is generally in the best position to identify the policy or policies that would maximize coverage. Once the applicable limit is identified, all insurers whose policies are triggered must allocate funding of the indemnity limit among themselves according to their subrogation rights." *Id* at 855. See also *Liberty Mut. Ins. Co. v. General Ins. Corp.*, 517 S.W.2d 791, 797 (Tex. App. 1974, writ ref'd n.r.e.); *Foremost County Mut. Ins. Co. v. Home Indem. Co.*, 897 F.2d 754, 762 (5th Cir. 1990); *CNA Lloyds v. St. Paul Ins. Co.*, 902 S.W.2d 657, 661 (Tex. App. Austin 1995, writ dism'd)("St. Paul did not voluntarily contribute to the settlement amount; pursuant to its insurance policy, St. Paul had a contractual duty to defend any claim against Storm. St. Paul protested from the outset that its contribution toward settlement should not exceed nine percent and reserved its rights to proceed against CNA. Because it was not a volunteer, St. Paul was entitled to equitable subrogation against CNA.").

7. It would seem that this would be especially apropos where the insurer seeking subrogation did not even receive a premium from the insured, and instead only named it as an additional insured on a policy issued to a third person.

8. The reader should recall in all of this that it will always be the case that co-primary carriers will always have to prove that its settlement was reasonable. Cf. *Liberty Mut. Ins. Co. v. General Ins. Corp.*, 517 S.W.2d 791, 798 (Tex. Civ. App.—Tyler 1974, writ ref'd n.r.e.); *General Agents Ins. Co. of Am. v. Home Ins. Co.*, 21 S.W.3d 419, 424 (Tex. App.—San Antonio 2000, pet dism'd by agr). Again, the district court in *Mid-Continent v. Liberty Mutual* expressly found that Liberty Mutual acted reasonably and Mid-Continent acted unreasonably. See *Liberty Mut. Ins.*, 266 F. Supp. 2d at 544. This apparently made no impression on the Supreme Court.

9. *Liberty Mutual*, 236 S.W.3d at 776. ("In this case, however, Liberty Mutual played a dual role as primary insurer and excess insurer and was in a position to negotiate a good faith settlement on Kinsel's behalf.")

10. "'The doctrine of subrogation is given a liberal application, and is broad enough to include every instance in which one person, not acting voluntarily, has paid a debt for which another was primarily liable and which in equity and good conscience should have been discharged by the latter.' *Lusk v. Parmer,* 114 S.W. 2d 677 (Tex.Civ.App.—Amarillo, 1938, writ dism'd)"; *see also* 53 Tex. Jur. 2d, Subrogation, Section 5 (1964); *Liberty Mut. Ins. Co. v. General Ins. Corp.,* 517 S.W.2d 791, 797 (Tex.App.—Tyler, 1974, writ ref'd n.r.e.).

11. *Argonaut Ins. Co. v. Allstate Ins. Co.*, 869 S.W.2d 537, 541 (Tex.App.—Corpus Christi 1993, writ denied), citing *McBroome-Bennett Plumbing, Inc. v. Villa France, Inc.,* 515 S.W.2d 32, 36 (Tex.Civ.App.—Dallas 1974, writ ref'd n.r.e.); *Yonack v. Interstate Sec. Co. of Texas,* 217 F.2d 649, 651 (5th Cir. 1954).

12. *Argonaut Ins. Co.*, 869 S.W.2d at 541-542.

13. *Smart v. Tower Land and Inv. Co.*, 597 S.W.2d 333, 337 (Tex. 1980).

14. *Liberty Mutual*, 236 S.W.3d at 776. ("An insurer's common law duty in this third party context is limited to the Stowers duty to protect the insured by accepting a reasonable settlement offer within policy limits.")

15. "Equity does not demand a different result here. We hold, therefore, that a fully indemnified insured has no right to recover an additional pro rata portion of settlement from an insurer regardless of that insurer's contribution to the settlement. Having fully recovered its loss, an insured has no contractual rights that a co-insurer may assert against another co-insurer in subrogation." *Id*. at 776.

16. *Id*, at 775, quoting *Fireman's Fund Ins. Co. v. Md. Cas. Co.*, 65 Cal. App. 4th 1279, 77 Cal. Rptr. 2d 296, 305 (Cal. Ct. App. 1998).

17. "A liability policy obligates an insurer to indemnify the insured against a covered loss arising from the insured's own legal liability. …An insured's right of indemnity under an insurance policy is limited to the actual amount of loss. … Where two different policies provide coverage for a loss, the pro rata clause does not create an exception to the principle of indemnity, but rather implements that principle by eliminating the potential for double recovery by the insured. See *Ortiz v. Great Southern Fire and Cas. Ins. Co.,* 597 S.W.2d 342, 343 (Tex. 1980) ("One reason that the right of equitable subrogation is granted to an insurer is to prevent the insured from receiving a double recovery."); *Fireman's Fund Ins. Co. v. Md. Cas. Co.*, 65 Cal. App. 4th 1279, 77 Cal. Rptr. 2d 296, 305 (Cal. Ct. App. 1998) ("The fact that several insurance policies may cover the same risk does not increase the insured's right to recover for the loss, or give the insured the right to recover more than once."). [W]here there are several policies of insurance on the same risk and the insured has recovered the full amount of its loss from one or more, but not all, of the insurance carriers, the insured has no further rights against the insurers who have not contributed to its recovery. Similarly, the liability of the remaining insurers to the insured ceases, even if they have done nothing to indemnify or defend the insured." *Id* at 776.

18. Compare, *American Physicians,* quoted *supra*, in which the Court held that the insured could seek funding from one of several common insurers, leaving the carriers to allocate among themselves through subrogation.

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Comments FROM THE EDITOR

BY CHRISTOPHER W. MARTIN
Martin, Disiere, Jefferson & Wisdom, L.L.P.

I need to express a special word of thanks to Kimberly Steele and Pamela Hopper for their help in editing the articles in this issue of The Journal. Kim Steele is a Partner in the Dallas office of Sedgwick, Detert, Moran & Arnold and has been an active member of the Council of the Insurance Law Section for several years. Pamela Hopper is Senior Counsel to the Austin office of Nickens, Keeton, Lawless, Farrell & Slack. Both did an excellent job assisting me in editing the articles in this issue and for that I want to publicly express my sincere appreciation. Editing this publication is a difficult job and their efforts to lighten the load made it possible for our members to receive it timely.

We have some great CLE programs coming up this summer. The short program the Section will do at the Annual Meeting of the State Bar will provide a great opportunity for those attending the Annual Meeting to get several hours of insurance CLE credit on the cutting edge issues affecting our practice. I am also very excited about the joint CLE program the Section is holding with our friends from TTLA on South Padre Island in August. The dual perspectives provided on many hot topics of interest to those who practice insurance law will be both entertaining and educational.

Finally, I want to thank our chair, Karen Keltz, for the great job she has done leading the Insurance Law Section this year. Karen has been very active in the Section over the last decade and her leadership, her creativity, and her hard work this year as our Chair were exemplary. As she passes the baton of leadership to Brian Martin, she leaves the Section vibrant, member-focused, and strong. Karen has done a great job leading the Section this year and, on behalf of all of our members, I want to thank her for her many years of tireless service and her particularly of strong leadership over the past year. Karen, our Section is stronger because of you and we thank you.

Christopher W. Martin,
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