Journal of Texas Insurance Law

Fall 2016 Volume 14, Number 2

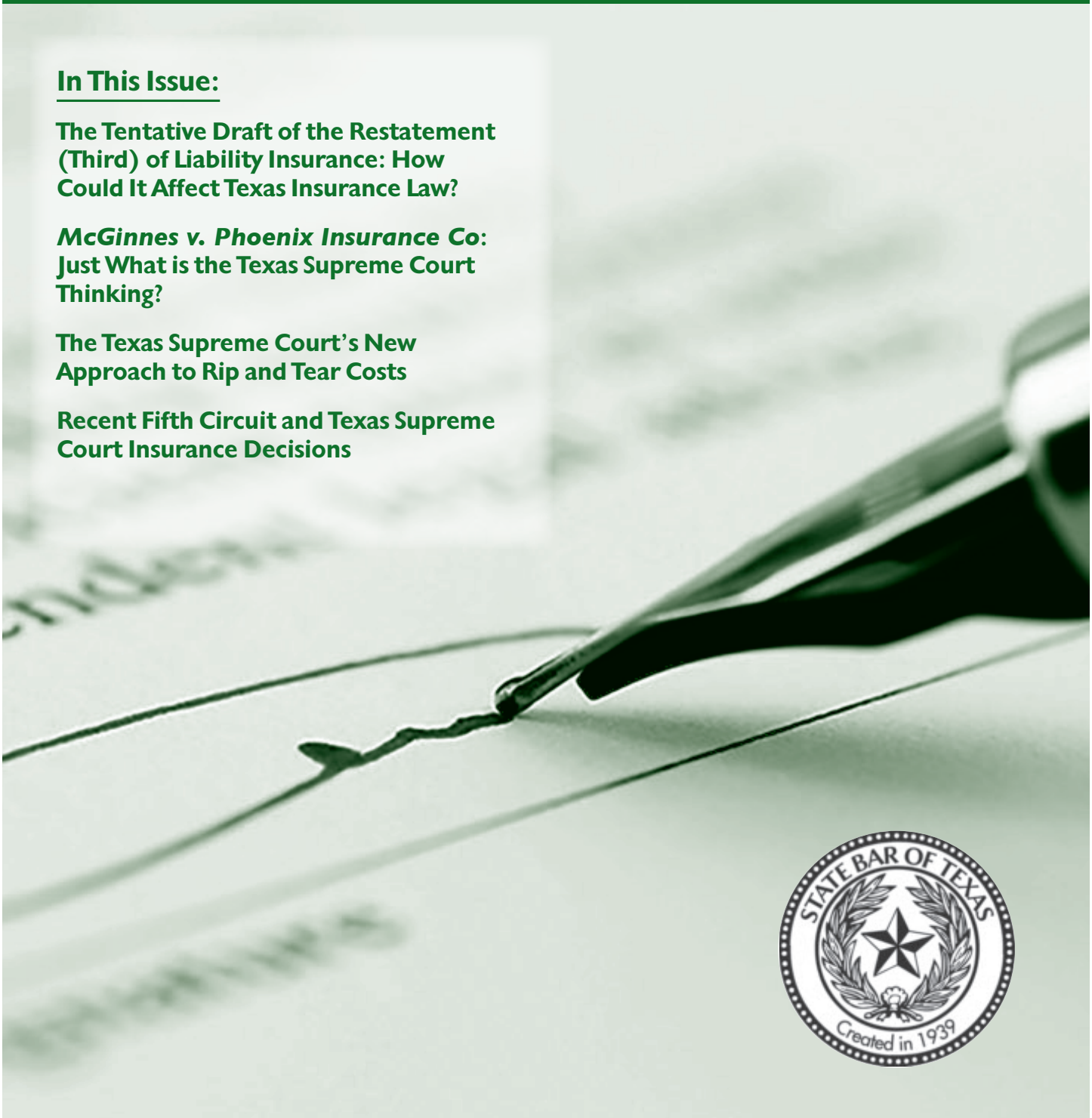
In This Issue:

The Tentative Draft of the Restatement (Third) of Liability Insurance: How Could It Affect Texas Insurance Law?

McGinnes v. Phoenix Insurance Co: Just What is the Texas Supreme Court Thinking?

The Texas Supreme Court's New Approach to Rip and Tear Costs

Recent Fifth Circuit and Texas Supreme Court Insurance Decisions



Official publication of the Insurance Law Section of the State Bar of Texas

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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 Pamella Hopper, Editor In Chief, at (512) 617-4504 or by email at phopper@mcguirewoods.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.

Journal of Texas Insurance Law

FALL 2016 • VOLUME 14, NUMBER 2

TABLE OF CONTENTS

Comments from the Editor 1
By Pamella A. Hopper

Comments from the Chair 2
By L. Kimberly Steele

The Tentative Draft of the Restatement (Third) of Liability Insurance: How Could It Affect Texas Insurance Law? 3
By Roger W. Hughes

***McGinnes v. Phoenix Insurance Co*: Just What is the Texas Supreme Court Thinking?** 15
By Bob Cunningham

The Texas Supreme Court's New Approach to Rip and Tear Costs 25
By Robert J. Witmeyer

Recent Fifth Circuit and Texas Supreme Court Insurance Decisions 29
By Rachelle H. Glazer and John P. Atkins

MISSION STATEMENT

The Insurance Law Section serves to promote the understanding and development of Texas insurance law by providing high quality educational resources to the bench, bar, and public and by promoting collegiality among those with an interest in insurance law.

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Comments

FROM THE EDITOR

By Pamella A. Hopper
McGuireWoods LLP

This issue of the *Journal*, Texas's premier journal of insurance law, represents my first as your official editor-in-chief. I am immensely grateful to our esteemed outgoing editor-in-chief, Dr. Bill Chriss, under whose tutelage I have had the good fortune to serve for the past several years. Under Bill's direction, the *Journal* has continued to publish thoughtful, cutting-edge articles to assist in fulfillment of the Texas Insurance Law Section's Mission: "to promote the understanding and development of Texas insurance law by providing high quality educational resources to the bench, bar, and public." I also want to thank my fellow Officers, Council members, and Section members for allowing me to assume the editorship of the *Journal*, an endeavor I am thrilled and honored to undertake.

In this issue of the *Journal* you will find Roger Hughes's discussion of potential effects of the forthcoming ALI Restatement of Liability Insurance on Texas insurance law, Bob Cunningham's analysis of the Texas Supreme Court decision in *McGinnes v. Phoenix Insurance Co.*, Robert Witmeyer's review of *U.S. Metals v. Liberty Mutual*, and Rachelle H. Glazer and John P. Atkins's review of recent Fifth Circuit and Texas Supreme Court insurance decisions.

Thanks go to all these authors, and to Associate Editors Rebecca DiMasi, Jason McLaurin, and Candace Ourso, whose help with this issue was indispensable. I want to extend a special thank you to my assistant, Alyson Wagner, for whose help in getting the *Journal* to print I am always grateful.

I continue to be impressed by the quality writing and scholarship of our members and welcome submissions from you on any subject relating to Texas insurance law. Please email articles or proposed topics to phopper@mcguirewoods.com.

Pamella A. Hopper
Publications Editor

Pamella A. Hopper is Senior Counsel in the Austin office of McGuireWoods LLP. Her over 20-year practice is devoted exclusively to representing corporate policyholders in a wide variety of first- and third-party insurance coverage-related disputes and litigation, including environmental and other long-tail claims, construction, business interruption, and directors and officers. Her previous experience includes working for numerous years as an insurance coverage lawyer and adjuster on behalf of the insurance industry.

Comments

FROM THE CHAIR

By L. Kimberly Steele

I am excited and honored to serve as Chair of the Insurance Law Section for the 2016–2017 year. Thanks to Past Chair, Jim Cooper, the Section's Executive Committee and Council, and our Committees and volunteers, for continuing the Section's ongoing efforts to expand and improve. I have some big shoes to fill.

If you are reading this, you most likely have an interest in insurance law. This is a good thing because insurance impacts virtually every legal practice area and is often the catalyst behind-the-scenes that facilitates the resolution of countless individual and commercial disputes. The far-reaching effects of insurance, and the numerous topics and underlying cases that it involves, make the Insurance Law Section unusual and one that, frankly, all legal practitioners can benefit from.

Because of the diversity of issues and matters involving insurance, our Section is likewise diverse. While the Section does attract practitioners who largely focus on insurance-specific issues, many of our members do not. Some of our members concentrate on personal injury, construction, workers' compensation, product liability, general civil litigation and appellate law, to name a few. Some litigate, some do not. Some work for large national law firms, while others work in small or solo practices or serve as in-house corporate counsel.

The Insurance Law Section has a lot to offer its members. In addition to the seasonal Journal you are reading now, the Section issues weekly "Right Off The Press" email blasts that provide summaries of and links to the most recent Texas state and federal decisions which touch upon insurance-related issues. Additionally, the Section has worked extremely hard over the past several years to improve its website, www.insurancelawsection.org, and to make it more user-friendly. On the home page of the website you will find, among other things, a calendar of upcoming events, links to biographical information about the Section's members, additional case links and summaries, informative articles, Section-related news, a listing of upcoming webinars, podcasts and CLE's and links to prior issues of the Journal. Section members also have access to additional archived materials, including legal education course materials, that the general population does not.

The Section also co-sponsors several continuing legal education courses each year, including the Advanced Insurance Law Course (and Casino Night networking event), which will be held at the wonderful Hyatt Hill Country Resort in San Antonio on June 8–9, 2017. Additionally, the Section now offers a rotating one-day insurance basics course. This new course was met with rave reviews this past February in McAllen and will be offered in El Paso in February of 2017.

Although our numbers and breadth have grown over the past several years due to the able leadership and hard work of my predecessors and our current Council and members, the continued success and development of our Section depends upon the involvement and participation of new members—members with fresh perspectives and new ideas—members just like you. There are no contributions too small and no practice, locale or age restrictions.

So, if you would like to become involved in a diverse Section with much to offer, and you are not already a member, I invite you to consider joining our section today. I look forward to working with you!

Best,

L. Kimberly Steele
Chair, Insurance Law Section

By Roger W. Hughes

THE TENTATIVE DRAFT OF THE RESTATEMENT (THIRD) OF LIABILITY INSURANCE: HOW COULD IT AFFECT TEXAS INSURANCE LAW?

In May 2016, the American Law Institute ("ALI") and membership approved chapter 1 and portions of chapters 2 and 3 of the Restatement (Third) of Liability Insurance (Tentative Draft No. 1, April 11, 2016) ("Draft"). Sections 13 (duty to defend), 34 (coverage for aggravated fault), and 37 (notice of claim) are being revised for further discussion. Section 44 (allocation for ongoing harm claims) and 45 (contribution) remain under discussion. A chapter 4 on damages is forthcoming. The ALI's Restatement series is intended as a clear formulation of the common law and its statutory constituents, reflecting the law as it currently stands or as a court might plausibly state it. The ALI's influence is demonstrated by the widespread adoption of strict products liability in the wake of Restatement (Second) of Torts Section 402A.

The proposed Restatement is the product of considerable effort over the past six years. In 2010 the ALI commissioned the project as a "Principles of the Law of Liability Insurance." Principles are aspirational, intended by ALI to state what it believes the law ought to be. After the ALI Council and membership approved tentative drafts of the Principles, at the October 2014 annual meeting the Council voted to reclassify the project as a Restatement. A Council Draft was proposed in 2015.

The earlier April 2015 Council Draft provoked considerable debate over its position on policy interpretation, determining the duty to defend and indemnify, control of the insured's defense, liability for breach, contribution among insurers, etc.[1] Because the Texas Supreme Court often considers the Restatement as persuasive authority, the final text could influence the direction for Texas insurance law as well as upset settled law. The potential impact extends to all types of insurance and to substantive tort law.

The role of insurance in public policy and tort liability cannot be understated. In a fictitious opinion over an auto accident, British legal humorist A.P. Herbert wrote:

> This dispute, as is usual at the present time, is only nominally between the parties named, the real litigants being two insurance companies. If it were not for the insurance companies there would be very little litigation of any kind to-day, and the members of the legal professional owe them a debt which we can only repay by careful labour and clear decisions.[2]

This 1935 tongue-in-cheek observation remains true. Policy interpretation drives what risks the policy potentially covers, ultimately dictating who may be sued and on what grounds. The remedies for failure to defend or indemnify directly bear on when and how lawsuits are settled.

This article surveys the tentative Draft Restatement approved to date and points out how its adoption could affect Texas common-law. It does not discuss or analyze in depth each provision or how the Restatement (once it is finally adopted) might affect all Texas common-law on liability insurance. It omits discussion of the sections on rescission for misrepresentation, interpreting specific conditions and exclusions, determining policy limits and deductibles, and excess insurance exhaustion and drop down. The goal is outlining the more important general provisions and how they might change both basic and unsettled Texas insurance law.

I. Policy Interpretation, Ambiguity, and Extrinsic Evidence

A. General principle—plain meaning is the preferred interpretation.

Under section 2, policy interpretation is the process to determine the meaning of policy terms; enforcement is determined by other substantive law.[3] Absent other law to the contrary, the ordinary rules of contract interpretation apply.[4]

Under section 3, there is a presumption that the "plain meaning" controls.[5] "Plain meaning" is the single meaning, if any, of a policy term to which the language is reasonably

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susceptible to the dispute at hand, in the context of the entire policy, without reference to extrinsic evidence.[6] The presumption favoring "plain meaning" applies unless the court determines a reasonable person clearly would give the term a different meaning.[7] The alternative meaning must be one to which the language is reasonably susceptible after considering extrinsic evidence.[8]

Policy interpretation is a distinct subset of contract interpretation rules.[9] The justification for this distinction is that insurance policies are mass-marketed and deeply entwined in the civil justice system.[10] Also, after the loss policyholders cannot obtain additional coverage to compensate for the injury.[11]

The objectives of interpretation are facilitating resolution of coverage and claims disputes, encouraging accurate description of insurance policies, and providing clear guidance on meanings to promote fair and efficient pricing, underwriting, and claims handling.[12] Because policies are mass-marketed standard forms, interpreting a term affects the scope of similar policies; interpretive rules that give the same meanings to terms in all contexts are preferred.[13] Financial responsibility law may require certain forms of liability insurance, which sets practical limits on liability and a justification for applying traditional interpretation rules.[14] This does not justify strained interpretations to provide compensation to injured persons.[15]

B. Using extrinsic evidence under section 3 to establish a more reasonable interpretation

Sections 2 and 3 work between two extremes. At one end is interpretation from the text alone when there is only one obvious meaning; at the other is interpretation from extrinsic evidence when there are multiple obvious meanings; and in between are terms with meanings that are not obvious but would be obvious to the parties in context.[16] The "plain meaning" is preferred, but the court may consider a plausible, nonobvious meaning of a term that a reasonable person would clearly give that term in context.[17]

Sections 2 and 3 strike a compromise between two views. Under the pure "plain meaning" view, if the text provides one obvious meaning, that is applied and extrinsic evidence is invariably excluded.[18] Under the "context" approach, any extrinsic evidence is admissible to establish the term is ambiguous.[19] Section 3 permits extrinsic evidence only to show another *more* reasonable interpretation exists; it is not admitted to establish ambiguity.[20] Section 4 on ambiguity controls when no plain meaning exists.[21] Under section 3, a plain meaning that disfavors coverage controls over an alternative but less reasonable meaning favoring coverage.[22] If there is no plain meaning (i.e., facial ambiguity), then it is construed under the ambiguity rules in section 4; the meaning favoring the non-supplying party (usually the insured) generally controls.[23]

Section 3 is not a factual presumption; it is a rule of decision to defer to plain meaning.[24] The presumption favoring "plain meaning" is "rebutted" only when the court considering extrinsic evidence concludes that (1) a reasonable person in the policyholder's position would clearly give that term that meaning, and (2) the term is reasonably susceptible to that interpretation in the circumstances.[25] The plain meaning is displaced only when the court finds it less reasonable; if the court cannot determine which one is more reasonable, plain meaning wins.[26]

"Plain meaning" is that the understanding of that term that a reasonable person in the policyholder's position would give if that person read the relevant policy provisions in light of the claim.[27] The inquiry focuses on the single meaning a reasonable person would assign to the term if the person read it carefully.[28] It does not vary with the actual policyholder's sophistication or knowledge.[29] However, when considering the possibility of a latent, more reasonable meaning, the court may consider a policyholder's observable, objective circumstances and actual sophistication, but not the policyholder's subjective beliefs and expectations.[30]

Section 3 does not displace the parol evidence rule. Under section 3(2), extrinsic evidence is admitted to inform the court what the term means; it is not admissible to contradict the term.[31] The parol evidence rule excludes extrinsic evidence to contradict the policy term; in that sense, section 3(2) does not affect it.[32]

C. Resolving facial ambiguity under section 4

Under section 4, a term is ambiguous if the language is reasonably susceptible to more than one meaning when applied to the claim without resort to extrinsic evidence.[33] An ambiguous term is construed against the party that supplied the term, unless that party persuades the court that interpretation is unreasonable based on extrinsic evidence.[34] The court will presume terms in a standard-form policy were supplied by the insurer, regardless of who supplied it, unless the policyholder agrees to the contrary in writing.[35] In that case, a term supplied by the policyholder is construed according to the rule specified in writing.[36]

A term is ambiguous if the language is reasonably susceptible of two or more interpretations when applied to the claim and without regard to extrinsic evidence.[37] Section 4 enforces the insured's reasonable expectations concerning meanings of which the terms are reasonably susceptible; it rejects enforcing expectations that are contrary to policy terms.[38]

Section 4 does not permit the use of extrinsic evidence to create ambiguity, i.e., "ambiguity in context." If there is a plain meaning, section 3 determines when extrinsic evidence is admissible to interpret a term.[39]

Under section 4 the issue is whether a "pro-coverage"

interpretation is one that a reasonable person in the policyholder's position would give to those terms if that person has read the terms carefully.[40] That allows the court to consider the parties' sophistication and what information they ought to have, including actual knowledge of trade usages.[41] Meaning is determined without reference to a party's subjective beliefs, unless both parties shared the same subjective belief.[42]

The *contra proferentem* applies to standard forms, even when the insured selects them.[43] It applies to even sophisticated policyholders.[44] Section 4(2) rejects a mechanical *contra proferentem* and allows the insurer to show an ambiguous term should be construed against coverage.[45] The insurer is allowed to show a pro-coverage interpretation is unreasonable under the circumstances and in fact inconsistent with the insured's reasonable expectations.[46]

Section 4(3) does not permit an outright waiver of the *contra proferentem* rule.[47] Section 4(3) permits the parties to negotiate that terms selected by the policyholder be interpreted against that party, provided the intent appears in an endorsement.[48] Interpretation is a question of law and the courts have final authority; a provision that waives *contra proferentum* is evidence about negotiating and drafting.[49]

To resolve ambiguity, the court may consider objective evidence of the term's purpose, e.g., treatises, case-law, trade literature, expert testimony, etc.[50] The court also may consider the ease or difficulty to redraft the terms to eliminate ambiguity.[51]

The Restatement's "plain meaning" rule may not be a panacea or even a simpler analytical framework to construe policy language.

D. The Restatement's "plain meaning" rule is not simple or mathematically precise.

The Restatement's "plain meaning" rule may not be a panacea or even a simpler analytical framework to construe policy language. The Restatement goals do not provide a clear guiding rationale for discerning the singular "plain meaning."[52] Arguably there is a tension between the objectives of accuracy to determine precise meaning and ease of use in conflict resolution.[53] The goals may not harmoniously mesh to produce one "plain meaning." Policy choices may have to be made between those objectives before a single "plain meaning" emerges from the text.

It has been asserted the "plain meaning" presumption is not justified by an assumption of actual mutual agreement; rather it is based on the meaning that would be acceptable to a reasonable policyholder that read the policy.[54] As such, the "plain meaning" is a construct that imputes to the policyholder knowledge of policy terms and relevant coverage issues that most insureds lack.[55] As a safety value, section 3 permits the insured to use extrinsic evidence to show how such an informed policyholder would interpret the terms.[56]

Still, the "plain meaning" trumps a construction of the terms to which they are not "reasonably susceptible," regardless of extrinsic evidence.[57] Because "reasonably susceptible" is not defined, this leaves it to the court to articulate a unifying principle—one that justifies a single plain meaning based on the text while allowing extrinsic evidence to establish a plausible alternative construction for the text.[58]

E. Comparison to Texas law

Adopting the Restatement standard could not be confined to liability insurance policies. Texas' policy interpretation rules apply to all types of policies; it is unlikely the courts would carve out special rules for liability insurance.

Texas' analysis is guided by the principles of contract construction; the primary goal is to determine the parties' intent through the policy's language.[59] Unless terms are defined, the court looks to the ordinary, everyday meanings of the words to the general public. [60]

Texas' rule for using extrinsic evidence to construe policy terms is murky. Generally, extrinsic evidence is inadmissible to construe the policy unless the policy is ambiguous.[61] Extrinsic evidence is admissible when the policy is ambiguous on its face or becomes ambiguous when applied to the subject matter.[62] However, extrinsic evidence of the circumstances existing when the policy was negotiated may be admissible to inform concerning the meaning of the text but not vary it; these include the commercial setting and objectively determined facts about context.[63] The extent to which such circumstances are admissible to construe terms or prove latent ambiguity is uncertain, and difficult to apply at best.[64]

Texas holds the language is ambiguous only if, after examining the policy as a whole and using rules of construction, there are two reasonable interpretations.[65] This allows the court to use the rules of construction to eliminate otherwise plausible interpretations.[66] If there are two or more reasonable interpretations, Texas's *contra proferentem* rule requires the court choose the interpretation most favorable to the insured without regard to which is more reasonable.[67] Thus it is a rule of last resort when construction rules fail to eliminate an otherwise reasonable interpretation. [68]

Adopting the Restatement would change Texas law. First, it would focus construction away from determining intent and toward construing the "plain language" and relying on

general rules of contract construction. Second, the "plain language" presumption can be rebutted by using extrinsic evidence to show a more reasonable construction exists consistent with the contract language. "Reasonable" is an objective standard determined by reference to a reasonable policyholder who has carefully read the policy. This permits a limited use of extrinsic evidence, but not to determine actual intent.

The Restatement elevates *contra proferentem* to a presumption when language is ambiguous, but then dilutes its strictness. In standard form policies, ambiguous terms are construed against the insurer regardless of who chose them; however, the policy can agree to a different rule to interpret terms selected by the policyholder. Otherwise, ambiguous terms are construed against the party that chose them, but extrinsic evidence can be used to show that interpretation is unreasonable. Thus, the Restatement allows exceptions to *contra proferentem* that Texas law rejects.

II. Waiver and Estoppel

A. Waiver under section 5; post-loss waiver; waiver of conditions and exclusions; and retraction of waiver

Under section 5, a party may waive a right under the policy if, with actual or constructive knowledge of the right, the party (a) either expressly relinquishes the right or engages in conduct that would reasonably be regarded by the other party as relinquishing the right, and (b) that waiver is communicated to the other party.[69]

Waiver permits the enforcement of terms different from the original contract or bars enforcement of such terms without creating a new contract.[70] A party may waive only terms that benefit it; thus, the insured cannot waive policy conditions.[71] The law of agency determines when the agent's words or conduct binds the principal and waives its rights.[72] Waiver necessarily requires extrinsic evidence.[73]

The insurer can waive policy conditions or exclusions post-loss, e.g., undertaking to defend without reserving a right to deny coverage.[74] This changes the general rule of no post-loss waivers of exclusions or lack of coverage.[75] The risk that policyholders may lie about pre-loss promises is balanced against the potential harm to them for false assurances of coverage.[76]

Waiver is not limited to technical deadlines and conditions.[77] However, the general rule is that waiver cannot create coverage where none would exist absent the waiver; i.e., waiver cannot expand the covered risks.[78] That general rule continues to apply to claims the insurer waived an exclusion or agreed to cover liability from an unscheduled auto.[79] In those cases, the insured must prove estoppel under section 6.[80]

Once communicated, the waiver is binding—unless retracted.[81] If the waiver involves a condition, there must be sufficient time after the retraction is communicated to fulfill the condition.[82] If the policyholder detrimentally relied, there can be no waiver.[83]

B. Estoppel combined with promissory estoppel; post-loss representations; estoppel may expand coverage.

Under section 6, a party who makes a representation or promise that can be reasonably expected to induce detrimental reliance to another party to the policy is estopped to deny the representation or promise if the other party reasonably and detrimentally relies.

The function of estoppel is the protection of reliance interests.[84] This distinction between estoppel and implied waiver is detrimental reliance.[85]

Comment e acknowledges the prevailing rule that estoppel cannot expand coverage, but asserts coverage can be expanded if statements or conduct induces detrimental reliance. Estoppel can arise for pre-loss misrepresentations that the policy covers risk that the actual terms exclude, provided the insured relied and the promised coverage was possible.[86] Because it is possible that the insured can reasonably rely on post-loss representations and promises, estoppel applies to them as well.[87] Post-loss statements and conduct may give rise to estoppel that expand coverage.[88] Post-loss statements may be as misleading and induce reasonable reliance as pre-loss misrepresentations.[89] If there is reasonable detrimental reliance on representations or promises, coverage can be expanded beyond the risks defined by the policy; e. g., an insurer that undertakes to defend without reserving its rights cannot belatedly raise an exclusion.[90]

Section 6 melds misrepresentation of facts and promissory estoppel.[91] It applies to both factual assertions and promises of future conduct.[92] The policyholder generally may rely on the agent's representations and promises that are contrary to the policy and the insured never reads the policy.[93] An exception to this rule exists when the policyholder reasonably should be aware the agent is inviting collusion.[94]

C. Comparison to Texas law

The Restatement would modify Texas law concerning waiver and post-loss representations. Currently, post-loss representations on coverage generally do not prejudice the insured.[95] Estoppel will not create coverage where none exists, unless the insurer assumes control of the defense and prejudices the insured.[96] Waiver can apply to policy conditions, but it cannot be used to expand coverage.[97]

The Restatement recognizes the abstract possibility that post-loss representations or actions may estop the insurer to deny the existence of coverage or waive conditions and exclusions. However, its only concrete post-loss example about estoppel is an agent's misrepresentation concerning oral notice of suit that estops the insurer from invoking a policy requirement

to give written notice.[98] Likewise, its only concrete example of post-loss waiver is undertaking to defend without an adequate section 15 reservation of rights.[99] It is unclear that post-loss representations that the loss is covered can estop the insurer from invoking an exclusion or waive it.

Moreover, the Restatement melds ordinary estoppel with promissory estoppel by eliminating the distinction between representations of fact and of future conduct. [100]

III. Duty to Defend; Control of the Defense; and Settlement Duties

A. Insurer's right to defend and control the defense: sections 10–16

Section 10 provides that, if the policy gives the insurer a right to defend, that right includes (1) the authority to direct all activities of the defense of any claim for which there is a duty to defend, and (2) the right to receive from defense counsel all information relevant to the defense or settlement.[101] Section 14(2) permits the liability insurer to defend suing its own employees, unless there is a duty under section 16 to provide an independent defense.[102] If the policy requires the insurer to defend, section 14(1) requires the insurer make reasonable efforts to defend the insured from all causes of action.[103]

Section 10(2) gives the insurer a right to receive information from defense counsel. Section 11(1) provides that the attorney-client privilege, work product immunity, and confidentiality protection are not waived by providing such information to the insurer or an intermediary.[104] However, section 11(2) provides the insurer has no right to such privileged or confidential information if it could be used to benefit the insurer at the insured's expense.[105] Provided there is adequate insurance and full coverage for the claim, the interests of the insurer, insured, and defense counsel are aligned; the insurer's contractual right of control is complete because it bears the risk and it has the greater capacity to direct the defense than all but the most sophisticated insureds.[106] This changes when the claimant asserts damages in excess of limits or some of the claims or damages are not covered.[107] The insured faces a different calculus because the insurer does not face substantially all of the risk.[108]

Reserving rights changes these rights. Section 15(1) provides the insurer that undertakes to defend must give notice to the insured, before undertaking the defense, of any grounds to contest coverage of which it knows or should know.[109] This applies to any ground to contest coverage, without regard to the distinction between conditions and coverage provisions.[110] The insurer should know of information in its file and that could be obtained by reasonable investigation.[111] Section 15(4) permits a temporary general notice of reservations, if the insurer must undertake the defense before it can complete its investigation.[112] It has a reasonable time to complete the investigation and then must provide a more detailed notice.[113]

The insured may not reject a defense tendered under a section 15 notice.[114] Other sections protect the insured from the potential conflicts of interest.[115]

If a section 15 notice is given and the facts common to both the coverage grounds and the claim are such that the claim could be defended so as to benefit the insurer at the insured's expense, section 16 then requires that the insurer provide an independent defense.[116] Not every reservation of rights triggers section 16; independent counsel is required when the conflict would encourage the insurer to actively manage the defense to avoid coverage—to sabotage the defense rather than merely underinvest in defense expenses.[117] A demand for damages in excess of limits will not require an independent defense.[118] Neither will a demand for punitive damages unless the defense against punitive damages is the major focus for the defense.[119]

When an independent defense is required under section 16, the insured may select counsel and service providers and the insurer must pay their reasonable fees.[120] While the insurer does not then have the right to defend, it may associate in the defense.[121] Under section 23, the insurer's right to associate gives it the right to receive information reasonably necessary to assess the insured's potential liability and whether the defense is conducted commensurate with that liability, and to be consulted on majority decisions on the claim's defense.[122] It is not entitled to receive information that could be used to benefit the insurer at the policyholder's expense.[123] Any information it receives remains privileged; there is no waiver of the policyholder's right to confidentiality vis a vis third parties.[124]

B. Determining the duty to defend and which insurer defends

Draft section 13 on the duty to defend is being revised; it has not received final approval.

As currently drafted, under Draft section 13 the duty to defend includes defending any claim based in whole or in part on alleged facts that, if proven, would be covered regardless as to the merits of the allegations or legal theory.[125] Draft section 13 bases the duty to defend on (1) the allegations in the complaint or comparable document stating the claim, and (2) any additional allegations that a reasonable insurer would regard as an actual or potential basis for any part of the claim.[126] The insurer must defend if it knows or should know of facts that could be alleged and that would require a defense.[127] This is a one-way rule—it does not justify a refusal to defend.[128] Draft section 13(3) permits one exception to using extrinsic evidence to justify refusing to defend. An insurer must defend unless undisputed facts not at issue in the action at issue establish as a matter of law the

action is not covered; otherwise, the insurer must defend.[129] A fact is "undisputed" when there is not genuine dispute such that summary judgment would be available.[130]

Under section 20, if multiple insurers have a duty to defend, the insured may select one and that insurer must defend.[131] If the policies' "other insurance" clauses establish a priority of defense obligations or practices within the market establish a priority, then the insurer selected to defend may ask those with the primary duty to take over defense and has a right of contribution for defense costs against other insurers with the same priority or that are primary.[132] If the policies' "other insurance" clauses do not establish a priority, then the insurers are jointly and severally liable, the insurer selected by the insured has a right of contribution for defense costs, and the unselected insurers must pay their pro-rata share of defense costs.[133]

A reasonable offer is one that would be accepted by a person who bears sole financial responsibility for the entire potential judgment.

Section 20 provides a practical approach to "other insurance" clauses to give effect to priority of defense duties, give a clear rule to determine priority, minimize the need to hire coverage counsel to determine which insurer to ask for a defense, and provide for contribution among the insurers.[134] Insurers who participate in the defense who mistakenly, but in good faith, determine priority have not breached their duties to defend.[135]

C. Responsibility for the defense and settlement decisions; damages for breach

1. Insurer's responsibility for counsel's malpractice

Under section 12, the insurer providing a defense is liable for defense counsel's malpractice if (1) counsel is the insurer's employee acting with the scope of employment, or (2) the insurer negligently selects or supervises counsel, including hiring counsel that carries inadequate liability insurance.[136]

Section 12 follows the general agency laws concerning the principal's vicarious liability for employee-attorneys and direct liability when counsel are independent contractors.[137] Liability insurers are vicariously liable for malpractice by employee counsel without regard to level of control. Liability under section 12(2) for outside counsel focuses on direct liability; the principal's own fault or wrongdoing.[138] Section 12(2) protects against hiring the judgment-proof, uninsured agent or contractor, who may be more attractive because they may be cheaper.[139] While the liability insurer has an incentive to hire insured counsel to reduce the insurer's exposure caused by malpractice, the malpractice limits amount necessary to cover the insurer's risk varies from case to case and may not cover the policyholder's exposure to an excess judgment.[140]

2. Insurer's duty to make reasonable settlement decisions

Under section 24, a liability insurer with authority to settle has a duty to make reasonable settlement decisions with respect to claims that expose the insured to liability in excess of policy limits.[141] The duty is owed only to the insured; claimants have no separate common-law right for breach of the duty.[142] Likewise, there is no duty to excess insurers; they have a right of subrogation under section 28.[143] The duty is owed only for cases that expose the insured to damages in excess of limits.[144] This is not a duty to settle every claim, but rather a duty to make reasonable decisions about settlement.[145] Section 24 rejected terms like "good faith" or "bad faith."[146] Rather, the duty is to give equal consideration to the insured's exposure in excess of limits.[147] This may include a duty to make offers when a reasonable insurer would do so, but there is no hard and fast rule.[148] There is no causation absent evidence the claimant would have accepted the offer, a difficult call in hindsight.[149]

Instead, under section 24 "reasonable" means a settlement decision that would be made by a reasonable person who bears the sole financial responsibility for the full amount of the potential judgment.[150] This requires the insurer give equal consideration to the insured's pecuniary interests if the claim potentially exceeds limits.[151] This includes a duty to accept reasonable demands limited to contributing an amount no greater than its limits; if the settlement exceeds its limits, the duty includes contributing to a reasonable settlement of a covered claim.[152] A reasonable offer is one that would be accepted by a person who bears sole financial responsibility for the entire potential judgment.[153] There is no duty to make or accept offers in excess of limits, or to contribute to an unreasonable demand that exceeds limits.[154]

If there are multiple actions that would count toward a single policy limit, the insurer has a duty under section 26 to make a good-faith effort to settle the claims in a manner than minimizes the insured's overall exposure.[155] This rejects the "first-come-first-served" rule that allowed the insurer to accept the first reasonable offer within limits.[156] Section 26(2) creates a "safe harbor." This duty can be satisfied by interpleading limits between all known potential claimants and continuing to defend the insured until the claims are settled or adjudicated, or it is adjudicated the insurer has no duty to defend.[157]

Under section 25(1), a reservation of rights does not relieve the insurer of its section 24 duty to make reasonable settlement decisions. If the insurer has reserved the right to contest coverage, section 25(3) affords the insured a right to settle without the insurer's consent if (a) the insurer is given the opportunity to participate in the settlement process,

(b) the insurer declines to withdraw its reservation after getting notice of the proposed settlement, (c) a reasonable person with the sole responsibility to pay the full potential judgment would have accepted the settlement, and (d) if part of settlement includes noncovered claims, and the part of the settlement allocated to the covered claims is reasonable.[158] Section 25(3) allows the insured to protect itself while preserving the insurer's right to contest both coverage and the reasonableness of settlement.[159] If there are covered and noncovered components, then reasonableness is evaluated on the value of the covered component.[160] If the offer is reasonable based on the covered portion of the claim, rejection is unreasonable; if the offer is unreasonable for the covered portion of the claim, rejection alone does not breach the duty section 24.[161] An insurer that fulfills its duty to defend by defending under a reservation of rights has no duty to pay an unreasonable settlement to which it did not consent.[162] This would include a duty to advise the insured that the insurer will contribute to the overall settlement.[163]

Absent an agreement with the insured, the insurer has no right to recoup settlement monies if the claim on the grounds of no coverage.[164]

3. Damages and remedies for breach of duty to defend

If the insurer breaches the duty to defend, it loses the right to control defense and settlement; also, if the failure to defend lacked a reasonable basis, the insurer forfeits its coverage defenses.[165] Reimbursement of defense costs and other contract damages were deemed insufficient to deter insurers from abandoning the defense when the insurer believed its coverage facts were strong.[166] The imbalance is cured by exposing the insurer to the risk that it must pay the full claim.[167]

Section 19 does not define the monetary damages for a breach of the duty. Chapter 4 is being drafted that will set out the consequential damages, which may include costs of defense, the amount of noncovered settlements or judgments resulting from the failure to defend, etc.[168]

4. Damages and remedies for failure to make reasonable settlement decisions

Under section 27, an insurer that breaches the duty to make reasonable settlement decisions is liable for the full amount of damages assessed against the insured without regard to limits and other foreseeable harm.[169] If there is no excess judgment, the insurer is not liable for any loss caused by unreasonable settlement decisions.[170] Section 27 rejects the 'judgment-proof' defendant rule; the insurer will be liable for excess judgment without regard to the insured's assets.[171] Moreover, "foreseeable harm" includes the award of punitive damages without regard to their insurability.[172]

The insured may assign the claim for breach.[173] An excess insurer is equitably subrogated for incurred loss from the underlying insurer's breach.[174]

D. Comparison to Texas law

The Restatement proposes to alter the well-known eight-corners rule and its prohibition on extrinsic evidence. First, Draft section 13 would require the insurer to consider extrinsic allegations that a reasonable insurer would regard as an actual or potential basis for the action. This allows consideration of potential allegations that plead into coverage, but not vice versa. Second, Draft section 13 permits consideration of undisputed facts that are not at issue or potentially at issue in the claim and that prove as a matter of law a lack of coverage. Currently, *GuideOne* suggests that courts may consider extrinsic evidence that is relevant to an independent and discrete coverage issue that does not touch on the merits of the underlying claim.[175] Draft section 13 is broader and more general.[176] The litmus test is whether the fact is undisputed and not in issue or potentially in issue in the claim.

Next, the Restatement modifies the current reservation of rights practice. The insured may not refuse the tender and demand an unqualified defense. The insured's remedy is a right to an independent counsel at the insurer's expense if (a) the coverage dispute and underlying lawsuit have common fact questions, and (b) the insurer could possibly manipulate the defense to its benefit at the insured's expense on coverage. Even then the insurer is entitled to participate in the defense.

The Restatement expands the insurer's derivative liability for retained counsel's misconduct. Currently, Texas treats counsel as an independent contractor; the insurer is not vicariously liable for counsel's conduct.[177] Under section 12, it would be liable not only for negligent selection and for employee-counsel, but also for conduct by an underinsured outside counsel.

The Restatement would fundamentally alter the *Stowers*[178] doctrine for rejecting settlement demands. Currently, the insurer is obligated to only accept a demand within policy limits that completely releases the insured if an ordinarily prudent insurer would accept it. It does not require the insurer to initiate offers.[179] When faced with multiple demands and inadequate proceeds to cover them all, the insurer may accept a reasonable settlement offer from some of the claimants, even if the settlement exhausts coverage and leaves the insured exposed to the remaining claims.[180] Although the Insurance Code section 541.060(a)(2)(B) imposes liability for not attempting in good faith to effect a prompt, fair, and equitable settlement when liability is reasonably clear, this has been interpreted as identical to the *Stowers* doctrine.[181]

The Restatement would greatly expand the *Stowers* doctrine

from a duty to accept offers to a duty to make reasonable settlement decisions. It would abrogate *Soriano*'s "first-come-first-served" approach in favor maximizing the settled claims. Finally it provides more nuanced, but clearer method for responding to settlement offers on lawsuits with uncovered claims. Section 25 would limit the insured's ability in Texas to simply settle the case without the insurer's knowledge or participation.

Finally, the Restatement takes a broader view of the consequences from a breach of the duty to defend. Currently, Texas treats the breach of the duty defend as a contract claim.[182] A wrongful failure to defend exposes the insurer to waiver of policy conditions and paying the insured's reasonable defense expenses. Absent a refusal to accept a reasonable settlement demand, the insurer is not exposed to indemnity in excess of limits. The Restatement encourages defending under a reservation of rights by imposing additional consequences. Section 19(2) penalizes a failure to defend without a reasonable basis with forfeiture of any grounds to defeat coverage that a reservation of rights could have preserved. The insurer loses the right to control defense and settlement; the policyholder may enter into a reasonable, noncollusive settlement.[183] The insurer is bound by any judgment on the issues of liability or damages, and may not relitigate them.[184] Although the Restatement sections defining damages remain to be drafted, section 19 comment j notes that consequential damages for breach of the duty to defend may include the amount by which an uncovered settlement or judgment is larger due to the breach.

IV. Occurrence coverage; contribution between insurers

A. Section 33 on occurrence

Most liability ability policies are "occurrence" type, covering an occurrence that causes injury or damages during the policy period. Determining when the occurrence has caused harm, coverage for continuous or ongoing harm, and contribution among applicable policies remains unresolved.

Under section 33, when coverage is based on the timing of harm, event, occurrence, etc., it is a fact question when the harm, event, occurrence, etc., took place.[185] Determining the triggering event is a question of law; determining when it happened is a fact question.[186]

The policy may define the triggering event to take place at specific time even though it would have been determined to occur at a different time for other purposes.[187] This allows policies to have a clause that certain events are "deemed" to have occurred at a specific time without regard to the facts.[188] Section 33 recognizes—without resolving—the special difficulties for "long-tail harm" cases under occurrence policies, i.e., ongoing bodily injury or property damage from continuous exposure to harmful conditions over multiple years.[189]

B. Section 43 and contribution between concurrent policies

With respect to indemnity, section 43(1) provides that if more than one policy applies, the insurers are jointly and severally liable to the insured up to the limits of their policies.[190] Section 43(1) applies to concurrent policies when the loss occurs in the same or overlapping policy periods; it does not apply to successive policies when the loss occurs over successive policy periods.[191] Joint and several liability is the default rule.[192] Section 43(2) permits "other insurance" clauses that alter the default rule, but they are enforceable only if they can be harmonized and the allocation to the insured (e.g., deductible, self-insured retentions, etc.) is no worse than under the most favorable policy.[193]

C. Draft sections 44 and 45 and contribution among successive policies

ALI continues to discuss how sections 44 and 45 will resolve contribution between insurers and "long tail harm."

Draft section 44(1) creates a default rule for indivisible harm that occurs over multiple years for occurrence policies triggered by bodily injury or property damage during the policy period: the judgment or settlement will be allocated pro rata equally over the years beginning on the first year in which harm occurred and ending in the last year in which the harm would trigger an occurrence policy.[194] The ordinary rules applicable to deductible, policy limits, and exhaustion apply to each policy.[195] However, Draft section 44 disagrees with the "all sums" approach under which the insurer is liable for the entire loss, including damage outside the policy period.[196] Thus, Draft section 44 adopts the pro-rata-by-years or "time on risk" approach to allocate among successive policies.[197] Insurers within that year settle only the pro-rata loss allocated to that period.[198] The policyholder bears the risk for any uninsured periods.[199] Within each year, Draft section 44(1) favors "vertical exhaustion"—when the primary's deductible is satisfied and limits are exhausted, then the policyholder must proceed to that year's next layer until the tower is exhausted.[200]

Draft section 44(2) permits the policy to alter the default rule, except to the extent it cannot be harmonized with the terms of another applicable policy. Generally, "other insurance" clauses will not apply to successive policies.[201] Opting out of the default rule will require special drafting.[202]

Draft section 45(1) gives an insurer a right of contribution to other insurers owing indemnity if the first insurer has paid more than its share of indemnity costs, the other insurer has not settled with the insured, and the other insurer has not paid its share of indemnity cost.[203] Draft section 45 governs contribution between insurers, not section 43 or section 44.[204]

Draft section 45(2) provides that to determine the share of indemnity costs, the principles of unjust enrichment and

restitution apply, subject to any contract terms.[205] Section 45, comment b incorporates Restatement (Third) of Restitution and Unjust Enrichment section 24, illustration 17, for an example of pro rata contribution amount liability insurers.[206]

The Restatement (Third) of Restitution and Unjust Enrichment section 24(1) provides for restitution to prevent unjust enrichment when a claimant renders to a third party a performance for which the defendant is independently liable to perform for the third person; section 24(2) provides the enrichment is unjust to the extent the claimant acts to protect its own interest and the part for which restitution is sought is primarily the defendant's obligation.[207] Section 24, comment b treats contribution as a risk within the rules of equitable contribution even though the insurers' overlapping duties to the insured may be independent.[208] Restitution should be available whether the insurers are jointly liable to perform or have independent duties.[209] Thus, if two primary insurers separately insure the policyholder for the same risk with the same limits, the one that defends is entitled to contribution from the other for half the defense costs.[210]

D. Comparison to Texas Practice

Adopting the Restatement may not change significantly how Texas determines when an occurrence policy is triggered. It definitely would clarify, if not outright change, Texas law on contribution between overlapping and successive policies.

Section 33 does not adopt any of the various approaches to determine when injury or damage occurs; instead it leaves that as a question of law on construing the policy language. The current Texas approach is to start with the policy definitions of "bodily injury" or "property damage"; it has construed the prevalent property damage definition to hold that it occurs when actual physical damage occurred.[211]

Neither *Don's Building Supply* nor section 33 take a position whether a continuing injury is a continuous trigger for each successive policy. Both leave open the potential to draft a policy that changes the "actual injury" rule, but it remains to be decided what language would clearly alter the "actual injury" rule. Draft section 44(1) would not resolve when and how successive policies are triggered for ongoing injury problems. Instead it would adopt the pro-rata by year approach and require vertical exhaustion within each year.

On contribution, the Draft sections 44 and 45 would be a major change. Under Texas law, when an indivisible injury triggers successive policies, the insured may pick which policy year must defend and pay; the primary and excess insurers for that policy period must allocate funding defense and indemnity among themselves according to their subrogation rights.[212] Under the vertical exhaustion rule, the stack of policies for that period cover the entire loss, not just the loss during the policy period.[213]

Under *Mid-Continent*, concurrent liability insurers who both bind themselves to pay the entire loss have right of contribution against each other; however, the standard "other insurance" clause bars contribution because each insurer has agreed with the insured to pay only its "pro-rata" share.[214] If the insured is fully indemnified by one insurer, then that insurer has no right of contractual subrogation because the insured has suffered no injury.[215] The U.S. Fifth Circuit has limited *Mid-Continent* to its facts; if one insurer refuses to defend and indemnify, an insurer that does defend and pay may be entitled to subrogate for reimbursement.[216] Texas has not authoritatively resolved contribution (contractual or equitable) between consecutive policies.

Draft section 45 divorces the right to contribution from whether policy language allows or alters joint liability. It substitutes an equitable right based on unjust enrichment when the insurer has paid more than its pro-rata share of indemnity under section 44 or section 45. The Restatement Draft section 45 would effectively abolish the *Mid-Continent* rule that an "other insurance" clause bars equitable subrogation. Draft sections 44 and 45 would also abolish *Markel*'s "all sums" approach in favor of pro-rata-by-year. The default common-law rule would be that insurers within each policy period jointly owe only the pro-rata share allocated to that year; insurers who pay more than that share have a right of contribution against insurers who pay less than their share. The policies may adjust joint liability for overlapping policies and for the pro-rata sharing for successive policies. However, equity law would control their contribution rights.

1 *See, e.g.*, Jay Feinman Restatement of the Law of Liability Insurance: Introduction, 68 Rutgers L. Rev. 1 (Fall 2015); William T. Barker, *The American Law Institute Principles of the Law of Liability Insurance: Part II— Selected Comments from an Insurer Prospective*, New Appleman on Insurance: Current Critical Issues in Insurance Law #1 (Spring 2015); Lorelie Masters et al., *The American Law Institute Principles of the Law of Liability Insurance: Part III—Selected Comments from a Policyholder Prospective*, New Appleman on Insurance: Current Critical Issues in Insurance Law 1 (Summer 2015).

2 A.P. Herbert, *Rumpleheimer v. Haddock: Port to Port*, The Uncommon Law, at 237 (1935).

3 Restatement (Third) of the Law of Liab. Ins. § 2(1) (ALI, Tentative Draft No. 1, April 11, 2016).

4 *Id.* § 2(3).

5 *Id.* § 3(2).

6 *Id.* § 3(1).

7 *Id.* § 3(2).

8 *Id.* § 3(2).

9 *Id.* § 2, cmt. h.

10 *Id*. § 2, cmt. h.

11 *Id*. § 2, cmt. h.

12 *Id*. § 2, cmt. c.

13 *Id*. § 2, cmt. d.

14 *Id*. § 2, cmt. e.

15 *Id*. § 2, cmt. e.

16 *Id*. § 2, cmt. b.

17 *Id*. § 2, cmt. b.

18 *Id*. § 3, cmt. a.

19 *Id*. § 3, cmt. a.

20 *Id*. § 3, cmt. a.

21 *Id*. § 3, cmt. d.

22 *Id*. § 3, cmt. d.

23 *Id*. § 3, cmt. d.

24 *Id*. § 3, cmt. c.

25 *Id*. § 3, cmt. c.

26 *Id*. § 3, cmt. c.

27 *Id*. § 3, cmt. e.

28 *Id*. § 4, cmt. e.

29 *Id*. § 3, cmt. e.

30 *Id*. § 3, cmt. e.

31 *Id*. § 3, cmt. g.

32 *Id*. § 3, cmt. g.

33 *Id*. § 4(1).

34 *Id*. § 4(2).

35 *Id*. § 4(3).

36 *Id*. § 4(3).

37 *Id*. § 4, cmt. a.

38 *Id*. § 4, cmt. b.

39 *Id*. § 4, cmt. c.

40 *Id*. § 4, cmt. e.

41 *Id*. § 4, cmt. e.

42 *Id*. § 4, cmt. f.

43 *Id*. § 4, cmt. o.

44 *Id*. § 4, cmt. k.

45 *Id*. § 4, cmt. j.

46 *Id*. § 4, cmt. j.

47 *Id*. § 4, cmt. o.

48 *Id*. § 4, cmt. n.

49 *Id*. § 4, cmt. o.

50 *Id*. § 4, cmt. d incorporating § 3, cmt. f.

51 *Id*. § 4, cmt. m.

52 Mark Geistfeld, *Interpreting the Rules of Insurance Contract Interpretation*, 68 Rutgers L. Rev. 371, 372 (Fall 2015)

53 Griestfeld, 68 Rutgers L. Rev. at 376.

54 Griestfeld, 68 Rutgers L. Rev. at 379, 402.

55 *Id*. at 377.

56 *Id*. at 378.

57 *Id*. at 380.

58 *Id*. at 381.

59 *State Farm Life Ins. Co. v. Beaston*, 907 S.W.2d 430, 433 (Tex. 1995); *Forbau v. Aetna Life Ins. Co.*, 876 S.W.2d 132, 133 (Tex. 1994).

60 *Progressive County Mut. Ins. Co. v. Sink*, 107 S.W.3d 547, 551 (Tex. 2003).

61 *Nat'l Union Fire Ins. Co. v. CBI Ind., Inc.*, 907 S.W.2d 517, 520 (Tex. 1995).

62 *Progressive County Mut. Ins. Co. v. Kelly*, 284 S.W.3d 805, 807-08 (Tex. 2009); *CBI Indus.*, 907 S.W.2d at 520.

63 *Houston Exploration Co. v. Wellington Underwriting Agencies, Ltd.*, 352 S.W.3d 462, 469–70 (Tex. 2011).

64 *See, e.g.*, *Houston Exploration*, 352 S.W.3d at 474–75 n.2 (Jefferson, C.J., dissenting); *Fiess v. State Farm Lloyds*, 202 S.W.3d 744, 747 (Tex. 2006).

65 *Beaston*, 907 S.W.2d at 430.

66 *Barnett v. Aetna Life Ins. Co.*, 723 S.W.2d 663, 555 (Tex. 1987).

67 *RSUI Indem. Co. v. Lynd Co.*, 466 S.W.3d 113, 118–19 (Tex. 2015).

68 *Beaston*, 907 S.W.2d at 433; *Grain Dealers Mut. Ins. Co. v. McKee*, 943 S.W.2d 455, 458 (Tex. 1997).

69 Restatement § 5.

70 *Id*. § 5, cmt. a.

71 *Id*. § 5, cmt. a.

72 *Id*. § 5, cmt. b.

73 *Id*. § 5, cmt. e.

74 *Id*. § 5, cmt. d.

75 *Id*. § 5, cmt. d.

76 *Id*. § 5, cmt. c.

77 *Id*. § 5, cmt. i.

78 *Id*. § 5, cmt. j.

79 *Id*. § 5, cmt. j.

80 *Id*. § 5, cmt. j.

81 *Id*. § 5, cmt. h.

82 *Id*. § 5, cmt. k.

83 *Id*. § 5, cmt. k.

84 *Id*. § 6, cmt. a.

85 *Id*. § 6, cmt. g.

86 *Id*. § 6, cmt. e.

87 *Id*. § 6, cmt. g.

88 *Id*. § 6, cmt. g.

89 *Id*. § 6, cmt. g.

90 *Id*. § 6, cmt. e.

91 *Id*. § 6, cmt. b.

92 *Id*. § 6, cmt. b.

93 *Id*. § 6, cmt. c.

94 *Id*. § 6, cmt. c.

95 *Royal Globe Ins. v. Bar Consultants,Inc.*, 577 S.W.2d 688, 594 (Tex. 1979)

96 *Gilbert Tex. Constr., L.P. v. Underwriters at Lloyd's London*, 327 S.W.3d 118, 137–38 (Tex. 2010); *Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773, 779–82 (Tex. 2008).

97 *Ulico Cas. Co.*, 262 S.W.3d at 781–82.

98 See Restatement § 6, cmt. g, ill. and Reporter's Notes on cmt. g.

99 *Id*. § 5, cmt. d, and Reporters Notes on cmt. d.

100 *Id*., § 6, cmt. b.

101 *Id*., § 10.

102 *Id*. § 14(2).

103 *Id*. § 14(1).

104 *Id*. § 11(1).

105 *Id*. § 11(2).

106 *Id*. § 10, cmt. b.

107 *Id*. § 10, cmt. c.

108 *Id*. § 15, cmt. a.

109 *Id*. § 15(1, 3).

110 *Id*. § 15, cmt. b.

111 *Id*. § 15, cmt. b.

112 *Id*. § 15(4).

113 *Id*. § 15(4), cmt. d.

114 *Id*. § 15, cmt. e.

115 *Id*. § 15, cmt. e.

116 *Id*. § 16.

117 *Id*. § 16 cmt. b.

118 *Id*. § 16 cmt. c.

119 *Id*. § 16, cmt. d.

120 *Id*. § 17.

121 *Id*. § 17.

122 *Id*. § 23(1)(a).

123 *Id.* § 23(1)(a).

124 § § 17(5), 23(2).

125 *Id*. § 13(1) (draft).

126 *Id*. § 13(2) (draft).

127 *Id.* § 13 cmt. b (draft).

128 *Id*. § 13 cmt. b (draft).

129 *Id*. § 13(3) cmt. c (draft).

130 *Id*. § 13(3) cmt. c (draft).

131 *Id*. § 20(1, 3).

132 *Id*. § 20(4).

133 *Id*. § 20(5).

134 *Id*. § 20, cmt. a.

135 *Id*. § 20, cmt. d.

136 *Id*. § 12.

137 George Cohen, *Liability of Insurers for Defense Counsel Malpractice*, 68 Rutgers L. Rev. 118, 124–25 (Fall 2015).

138 Cohen, 68 Rutgers L. Rev. at 130–13.

139 Cohen, 68 Rutgers L. Rev. at 135–36.

140 Cohen, 68 Rutgers L. Rev. at 135–36, 137–38.

141 *Id*. § 24(1).

142 *Id*. § 24, cmt. k.

143 *Id*. § 24, cmt. j.

144 *Id*. § 24, cmt. a.

145 *Id*. § 24, cmt. a.

146 *Id*. § 24, cmt. c.

147 *Id*. § 24, cmt. b.

148 *Id*. § 24, cmt. e.

149 *Id*. § 24, cmt. f.

150 *Id*. § 24(2).

151 *Id*. § 24, cmt. b.

152 *Id*. § 24(3, 4).

153 *Id*. § 24, cmt. b.

154 *Id*. § 24, cmt. i.

155 *Id*. § 26(1).

156 *Id*. § 26, cmt. a.

157 *Id*. § 26(2).

158 *Id*. § 25(3).

159 *Id*. § 25, cmt. e.

160 *Id*. § 25, cmt. b.

161 *Id*. § 25, cmt. b.

162 *Id*. § 25, cmt. e.

163 *Id*. § 25, cmt. b.

164 *Id*. § § 21, 25(2).

165 *Id*. § 19(1, 2).

166 *Id*. § 19, cmt. b.

167 *Id*. § 19, cmt. b.

168 *Id*. § 19, cmt. j.

169 *Id*. § 27(1).

170 *Id*. § 27, cmt. b.

171 *Id*. § 27, cmt. c.

172 *Id*. § 27, cmt. d.

173 *Id*. § 27, cmt. e.

174 *Id*. § 28.

175 *GuideOne Elite Ins. Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305 (Tex. 2006).

176 Restatement § 13, cmt. c.

177 *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 628 (Tex. 1998).

178 *Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved).

179 *Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co.*, 77 S.W.3d 253, 261–62 (Tex. 2002).

180 *Tex. Farms Ins. Co. v. Soriano*, 881 S.W.3d 312 (Tex. 1994).

181 *Rocor Int'l, Inc.*, 77 S.W.3d at 262.

182 *Traver*, 980 S.W.2d at 629; *Maryland Ins. Co. v. Head Indus. Coatings & Servs.*, 938 S.W.2d 27, 28–29 (Tex. 1996). The Texas Supreme Court has held that breach of the duty to defend violates the Prompt Payment Act under the section 542 of the Texas Insurance Code, subjecting the insurer to the 18% penalty and attorneys' fees. *See Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1 (Tex. 2007). Alexandra Fernandez, *Emerging Issues in the Calculation of Interest under the Texas Prompt Payment of Claims Act*, 14 J. Tex. Ins. L. 19, Summer 2016.

183 Restatement § 19, cmt. i.

184 *Id*. § 19, cmt. i.

185 *Id*. § 33(1).

186 *Id*. § 33, cmt. d.

187 *Id*. § 33(2).

188 *Id*. § 33, cmt. e.

189 *Id*. § 33, cmt. f.

190 *Id*. § 43(1).

191 *Id*. § 43, cmt. a.

192 *Id*. § 43, cmt. b.

193 *Id*. § 43, cmt. d.

194 *Id*. § 44(1)(a) (draft).

195 *Id*. § 44(1)(b) (draft).

196 *Id*. § 44, cmt. h, i, j (draft).

197 *Id*. § 44, cmt. c, e (draft).

198 *Id*. § 44, cmt. j (draft).

199 *Id*. § 44, cmt. c (draft).

200 *Id*. § 44, cmt. j (draft).

201 *Id*. § 44, cmt. k (draft).

202 *Id*. § 44, cmt. l (draft).

203 *Id*. § 45(1) (draft).

204 *Id*. § 45, cmt. a (draft).

205 *Id*. § 45(2) (draft).

206 *Id*. § 45, cmt. b (draft).

207 Restatement (Third) of Restitution and Unjust Enrichment § 24 (2011).

208 *Id*. § 24, cmt. b.

209 *Id*. § 24, cmt. b.

210 *Id*. § 24, cmt. b, ill. 17.

211 *Don's Bldg. Supply, Inc. v. OneBeacon Ins. Co.*, 267 S.W.3d 20, 22 (Tex. 2008).

212 *A.P.I.E. v. Garcia*, 876 S.W.2d 842 (Tex. 1994).

213 *Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d 750 (Tex. 2013).

214 *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.*, 236 S.W.3d 765, 772 (Tex. 2007).

215 236 S.W.3d at 775–76.

216 *See, e.g.*, *Cont'l Cas. Co. v. N. Am. Capacity Ins. Co.*, 683 F.3d 79, 85–86 (5th Cir. 2012).

By Bob Cunningham

MCGINNES V. PHOENIX INSURANCE CO: JUST WHAT IS THE TEXAS SUPREME COURT THINKING?

Texas recently joined the majority of states whose highest courts hold that decades-old standard form liability policies require insurers to defend their policyholders from letters the Environmental Protection Agency ("EPA") issues under the federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980 ("CERCLA") that notify the policyholder that it is a Potentially Responsible Party ("PRP") and seeks to compel information and contribution of costs in a pollution clean-up action.

In *McGinnes Industrial Maintenance Corp. v. Phoenix Insurance Co. and Travelers Indemnity Co.*,[1] a bare majority of the Texas Supreme Court decided that these EPA letters and orders constitute a "suit" triggering the insurers' "right and duty to defend any suit against the insured seeking damages," pursuant to policy wording.[2] Four members of the court dissented.[3]

The specific result is important for the litigants and for insurance matters involving EPA pollution actions, of course. But the majority and dissent's strikingly different interpretations are of more general interest to insurance coverage practitioners to illuminate divergences in how the court is addressing challenges of insurance wording. Of particular note is what the court did not do: neither the majority nor the dissent approached the problem from an "ambiguity" perspective.

I. Background and Legal Issue Presented to the Court

The Fifth Circuit posed the issue to the Texas Supreme Court, seeking guidance on certified question:

> Whether the EPA's PRP letters and/or unilateral administrative order, issued pursuant to CERCLA, constitute a "suit" within the meaning of the CGL policies, triggering the duty to defend.[4]

As the Fifth Circuit outlined, McGinnes released waste into ponds located adjacent to the San Jacinto River.[5] During the period from 1967–71, Phoenix and Travelers provided coverage for McGinnes under standard form commercial general liability (CGL) policies.[6] The policies all provided that:

> [Insurer] shall have the right and duty to defend any suit against [McGinnes] seeking damages on account of ... property damage, even if any of the allegations of the suit are groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient....[7]

The policies did not define the term "suit."

The EPA sent a "General Notice Letter" to McGinnes in 2007 identifying it as a PRP that disposed of hazardous waste at the sites, advising that McGinnes may be required to perform cleanup or pay for cleanup performed by the EPA, and inviting negotiations towards settlement.[8]

In 2008, the EPA sent a "Combination General Notice Letter and 104(E) Information Request Letter" repeating many aspects of the first letter, and also requiring response to a host of questions relating to McGinnes's waste-disposal activities and its relationship with Waste Management. That letter indicated that McGinnes could incur fines of up to $32,500 per day if it failed to timely respond, and could suffer criminal liability if it furnished false statements.[9]

In 2009, the EPA sent a "Special Notice Letter" intended to facilitate settlement by PRPs; providing McGinnes with the opportunity to enter into negotiations because the EPA believed McGinnes might be responsible for the cleanup of the site under CERCLA; and requesting a "good-faith offer" to settle with the EPA within sixty days. That notice letter indicated the EPA had already incurred response costs at the site exceeding $350,000 and demanded that McGinnes pay such costs.[10]

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When McGinnes allegedly did not provide the requested good faith offer, the EPA sent a final letter attaching a "Unilateral Administrative Order" requiring McGinnes to conduct a Remedial Investigation and Feasibility Study at the site; advising that McGinnes would be subject to civil penalties for each day it refused to comply with the order without cause, together with possible punitive damages; and stating that the EPA reserved the right to bring an action to recover any response costs incurred at the site.[11]

All of the letters sent and actions taken by the EPA were under the authority of CERCLA.

Insurers declined McGinnes's demand for defense under the CGL policies against the actions taken by the EPA. McGinnes filed suit against insurers for defense fees and for declaratory judgment, and the parties filed cross motions for partial summary judgment as to the duty to defend.

The district court held for insurers, finding that at the time the policies were issued, no administrative action existed for pollution clean-up as CERCLA had not yet been promulgated. Therefore, the parties would have understood "suit" to mean a court proceeding before a neutral jurist, and so the duty to defend correspondingly applied only to a court proceeding and not to EPA actions.

The Fifth Circuit accepted interlocutory appeal but found that unlike many other states, Texas courts provided almost no guidance on this particular issue.[12] Nor could the Fifth Circuit readily discern which arguments the court might find persuasive among those posed by the respective parties.[13]

McGinnes, relying on dictionary definitions of "suit," contended that it is ambiguous and should be interpreted in favor of the policyholder because one meaning is narrow and requires formal legal action while another meaning is broader and means any effort to gain an end by legal process. McGinnes also noted Fifth Circuit jurisprudence upholding pollution cleanup costs as "property damage," to argue that it would be highly anomalous not to trigger the duty to defend an action seeking damages that are within coverage. McGinnes also contended that Texas law should follow the majority of other jurisdictions that have interpreted "suit" broadly to cover these types of EPA actions.

Insurers agreed with the district court's point that "suit" was understood to mean a court proceeding at the time the policies were issued and reflected that intention by the parties. They argue that prior Texas precedent and certain portions of CERCLA using the term "suit" to mean a court proceeding should govern the meaning ascribed in the insurance contract. Insurers further contended that the broad interpretation of "suit" advocated by McGinnes does not differentiate it from the term "claim" as used in distinction from "suit" elsewhere in the policies.[14] And the insurers argued that an EPA action did not have the characteristics of complaint allegations, so could not trigger the "eight corners rule" for determining whether a duty to defend is owed. With respect to the majority of cases in other states in agreement with McGinnes's position, the insurers argued that the minority employed superior textual interpretation more consistent with Texas law.

The parties expanded but essentially perpetuated these arguments in their briefing to the Texas Supreme Court and in oral argument. The court issued its opinion on June 26, 2015 and denied motion for rehearing on January 22, 2016.

II. The Issues Joined: Majority, Dissent, and Comment

The majority opinion first determined that an EPA action is a "suit" so that insurers must defend McGinnes.[15] Second, the majority examined whether pollution cleanup costs were covered as damages by the policies, and, finding that they were, determined that it would be anomalous if an EPA action seeking such damages did not also trigger the duty to defend. Third, the majority acknowledged that the great majority of other courts have likewise decided in favor of the policyholder, as another factor for Texas to follow in the interests of uniformity and predictability.

The dissent essentially followed the majority's argument framework, but disagreed with the majority's conclusions as to each point.[16]

A. Does an EPA proceeding constitute a "suit" for purposes of defense under CGL?

1. Whether an EPA action is a "suit"—Majority Opinion

The majority prefaces its argument on "suit" with a short treatment of how pollution proceedings were pursued procedurally prior to CERCLA when the policies were issued, and describes the extensive authorities granted the EPA in supplanting the traditional relief afforded through the courts prior to that statute. Then at the outset of its examination of the term "suit," the majority as much as admits and agrees with insurers that the ordinary meaning describes a court proceeding, with only a passing recognition that a broader meaning may also be ascribed.[17]

Here, a student of Texas jurisprudence would anticipate the court to apply the "plain meaning" standard and hold in favor of the insurers, or alternatively give sufficient credence to the alternative definition to find the broader interpretation reasonable and therefore rule in favor of the policyholder on the basis of an ambiguity. But no. Instead, the majority returns to the historical theme, emphasizing that at the time the policies were issued, the type of pollution damages sought in a modern EPA action were available only as a court proceeding under state statute or common law; that is, through a true "suit."

The key portion of this argument is this:

> One effect of CERCLA was to authorize the EPA to conduct on its own what otherwise would have amounted to pretrial proceedings, but without having to initiate a court action until the end of the process. The PRP notice letters serve as pleadings . . . .
>
> And part of the judicial function is ceded to the EPA by limiting a PRP's opportunity for review until the end of the process, and then limiting that review to an abuse of discretion by the EPA, based on its own record.
>
> McGinnes argues that EPA proceedings are the functional equivalent of a suit, but in actuality, they are the suit itself, only conducted outside a courtroom.[18]

This approach turns the "intent" question on its head. In the majority's view, the expectation of the parties at the time of contracting was that these sorts of pollution damages would be pursued in courts. Therefore it would be unfair to the policyholder to deprive it of a defense it would have enjoyed under the policies, by virtue of CERCLA having transferred court proceedings to the EPA as an equivalent administrative proceeding.

Employing this perspective, the majority disposes of the insurers' argument that EPA proceedings are simply demand letters or pre-suit settlement mechanisms. "The point is that before CERCLA those mechanisms were available to the EPA only in judicial proceedings."[19] This is emphasized again in the majority's observation that not all demand letters, enforcement proceedings, or administrative actions constitute "suits"; rather, an EPA enforcement proceeding is unusual because not only are they *like* judicial proceedings, they *were* judicial proceedings before CERCLA was enacted.[20]

2. Whether an EPA action is a "suit"—Dissenting View

In an extensive preamble to its reasoning, the dissent spares no feelings in enunciating its frustration that the majority seemingly ignores longstanding rules of contract interpretation, and accuses the majority of exchanging objective analysis and freedom of contract in preference for rewriting the policy to achieve results-oriented conclusions. This exposition cites numerous Texas precedents on the tools for contract interpretation—effectively throwing them in the majority's face—while strongly heralding the court's typical text-based analysis that examines the words of the contract to determine intent in virtual isolation from other factors. [21]

In contrast to the majority's novel approach, the dissent employs traditional interpretative tools to criticize the holding and advocate for a narrow construction. For the dissent, the plain and ordinary meaning of "suit" requires a court proceeding, and the alternative definition posited by McGinnes fails to hold up to common sense or close scrutiny.[22]

The dissent examines the "intent" issue by looking at what the parties would have expected the policy to cover as a "suit" for pollution damages at the time they were issued; as described by the majority, that meant court proceedings. The parties could not have foreseen—and therefore did not intend—for the policy to provide a defense for a "suit" other than an actual court proceeding. The dissent finds that dictionary definitions of "suit" likewise encompass or contemplate a form of court proceeding, and points to Texas and other court opinions that likewise use the term "suit" as co-extensive with court proceedings.

The dissent similarly rejects McGinnes's argument that defense is owed because EPA proceedings are the "functional equivalent of a suit," summarily observing that the policies provide defense for a "suit"; not for its "equivalent." For the dissent, the contemporaneous contracting intention is centered on the term "suit" and what the parties reasonably thought it meant when the policies were issued; since CERCLA did not yet exist, they could not have intended for the term to apply to EPA actions created by CERCLA. Indeed, the dissent observes that the insurance industry demonstrated a distinct aversion to covering CERCLA damages by initiating extensive CGL policy revisions severely limiting and even eliminating pollution coverage once that statutory regime came into effect.

Finally, the dissent challenges how courts can use the majority's guidance in determining what sorts of administrative actions constitute "suits," and which do not. Simply, the dissent does not appreciate that EPA actions have the same sort of hallmark characteristics as lawsuits, so as to effectively segregate those actions into their own category substituting for traditional lawsuits and different from other forms of administrative proceeding.

3. Consideration of Majority and Dissent on "suit"—Commentary

The majority and dissent seem to be talking past each other, with neither grappling effectively with the other's point of view. To an extent, the majority seems to recognize this with an attempt to address by footnote what they believe is the dissent's misunderstanding of their position. A lengthy quotation is helpful, as this seems to be at the heart of the divergence:

> The dissent argues that we are rewriting McGinnes's policies under the assumption

> that, had it and the insurers anticipated CERCLA, they would have agreed that the insurers would have the right and duty to defend those proceedings. We assume no such thing. The parties used the word "suit" to refer to the kinds of proceedings the insurers had the right and duty to defend. When the policies issued, before CERCLA, the duty to defend would have covered cleanup enforcement proceedings in the only place they could be brought—in court. We hold that the parties' intention should not be defeated by a subsequent federal regulatory statute that authorizes the EPA to conduct those same proceedings itself before going to court. The dissent argues that the real meaning of "suit"—the proceedings and costs it actually entails—and thus the parties' bargain can be changed over time by a federal regulatory statute like CERCLA. We disagree, not despite our duty to interpret the policies as the parties intended in the text, but because of it.[23]

In response, the dissent challenges whether EPA actions really did substitute for court proceedings, and in all events declines the opportunity to "rewrite" the policy to achieve those ends even if it did. But the bottom line seems to be that the dissent is simply unpersuaded by the majority's approach, and finds it inconsistent with precedent that prescribes text-based tools for determining contractual intent.[24]

Perhaps the problem is that the dissent misapprehends that the majority are equally committed to text-based interpretation. Had the majority been inclined, they could simply have advocated the alternative definition McGinnes proposed and determined that the policy was ambiguous—and therefore must be interpreted in McGinnes's favor—because dictionaries define "suit" to mean an "effort to gain an end by legal process," which includes administrative proceedings. That was the argument McGinnes advocated, and which other high courts have adopted, as the majority acknowledged.[25] It is remarkable that the majority declined this opportunity and held for McGinnes, despite essentially finding that the plain meaning of "suit" refers to strict court proceedings. Indeed, the majority appear to actively avoid finding the term ambiguous.

On closer view, the majority opinion seems to be employing an analysis based on a broad investigation of the "circumstances of contracting" that existed at the time of the policy issuance. The point the majority is making seems based more on the "function" that the insurance was supposed to play at the time it was issued, than on the words chosen to implement that purpose. So, for the majority, the core question is whether the CGL coverage of the time functioned to provide coverage for pollution costs and damages; having found that it did for formal court proceedings, the majority then concludes that the same functional expectation has simply been transferred to EPA proceedings, and should be honored.

Had the dissent perceived that this sort of "functional" test is at the heart of the majority's analysis, they likely would have responded by citing the myriad Texas precedents decrying any dependence on extrinsic evidence where used to interpret plain and ordinary contract wording contrary to its obvious textual intent.[26] The lack of any such argument may indicate that the dissent does not appreciate the "functional" approach apparently being taken by the majority.

A similar dichotomy distinguishes the approaches by majority and dissent in *RSUI Indemnity Co. v. The Lynd Co.*,[27] decided a month prior to *McGinnes*. Justice Boyd wrote for the majority, utilizing a detailed textual analysis of the insurance policy in an attempt to harmonize various provisions before declaring it ambiguous and ruling in favor of the policyholder. Chief Justice Hecht wrote for the dissent (including Justices Green and Brown, who join in the *McGinnes* majority), decrying the majority's overemphasis on every "jot and tittle" of the text while giving "no consideration to whether an unrealistic interpretation is reasonable" and characterizing that interpretive exercise as one of "linguistic ingenuity and absorption with minutiae" untroubled by realities and consequences.

While not so plainly as in *McGinnes*, perhaps, the divergence of approaches in *Lynd* similarly seems based on whether the court should give full weight to "text" as the primary or even exclusive interpretive tool, or whether consideration of "function" should be an equivalent factor in determining the intent and purpose of the contractual wording.[28] Because that issue was not clearly joined and debated on those terms as between the *McGinnes* majority and dissent, the case does not provide particular guidance on debates within the court or how its jurisprudence may be trending. But especially when combined with *Lynd*, these apparent differences in approach raise questions warranting further observation by alert practitioners.

B. Are pollution clean-up costs "damages" under the CGL?

1. Pollution costs as "damages"—Majority View

Upon determining that an EPA proceeding substitutes for judicial proceedings existing at the time of policy issuance—and therefore should be considered a "suit" triggering the duty to defend—the majority considered whether pollution costs sought by the EPA under CERCLA are "damages" covered by the form CGL policies.

Textually, the duty to defend applies only to "suits" seeking

property damages for which the insurers have to pay. But the majority nowhere indicates that they examined the issue for the purpose of textual completeness. Rather, the majority proposed that if the insurer ultimately is required to pay damages, it creates perverse incentives for both parties if the insurer does not also have a concomitant duty to defend the action seeking those damages.[29]

On the one hand, McGinnes could ignore the EPA action, decline to defend at its own cost, and then impose any ultimate award of damages upon the insurers who had not themselves defended. On the other hand, insurers likely would accuse McGinnes of failing in its obligations to cooperate to avoid damages. The majority seems less concerned with whether these are likely scenarios, as much as pointing out the problem with a duty to indemnify having no accompanying duty or right to defend.

The majority does not actually decide affirmatively that such damages are indeed covered under CGL policies. The issue was not before the court. But the majority noted that insurers did not dispute that pollution costs were damages (although they objected that the damages did not result from an accident or occurrence). And the majority noted with approval a number of Fifth Circuit and other federal cases so holding.

2. Pollution costs as "damages"—Dissenting View

The dissent objected to ruling on a question that the court has never decided and that is not presented in this case, and noted that not all courts have agreed that CERCLA cleanup costs are "damages" under a CGL policy. Since the issue was not properly before the court, the dissent's view was the court need not—and indeed could not—rule on it.

Second, the dissent noted that Texas draws a sharp distinction between the separate duties to defend and indemnify.[30] Regardless whether the court's approach represents better policy and better alignment of the parties' interests and incentives, the distinction must be respected and not collapsed.

Finally, the dissent did not recognize particularly skewed incentives if the duty to defend did not accompany a duty to pay. In that circumstance, the insurers nonetheless retain an incentive to join negotiations and take measures to minimize their own risk of paying an untoward judgment. Moreover, under the policies' wording there is no question but that insurers are entitled to investigate and participate in negotiations for settlement of any "claim or suit" that would encompass the EPA "claim" for pollution costs, whereas the question before the court is different and strictly addresses whether a duty to defend is owed solely for a "suit." For the dissent, answering whether pollution costs are "damages" does not resolve whether an EPA proceeding is a "suit."

3. Pollution costs as "damages"—Commentary

It is not entirely clear what the majority hopes to accomplish by its quasi determination on "damages" coverage for pollution costs under the CGL wording. The discussion does not advance the question before the court to determine whether an EPA proceeding is a "suit" as a matter of textual analysis. And it is rather extraordinary for the court to rely on conclusions that are "relatively well settled" and even cite with approval the conclusions reached by other courts, while nonetheless not ruling definitely itself on an issue not actually before it.

This approach makes more sense, however, if appreciated as another example of the hypothesis that the majority is employing a "functional purpose" rubric. While the majority's discussion may not advance an interpretation based on textual analysis, it does add to a perspective based on achieving a common sense purpose underlying the contractual agreement and relationship between insurer and policyholder. From that larger perspective, the court's observations provide another reason why the duty to defend should be conjoined with the apparent obligations to pay for ultimate damages, as a means of advancing the overall purpose and structure of the parties' respective obligations. Again, though, this approach seems rather far afield from the court's typically rigorous text-based interpretive principles.

C. Promoting uniformity for interpretation of standard insurance provisions

1. Promoting uniformity with non-Texas decisions—Majority View

The majority counts thirteen of sixteen high courts of other states adopting *McGinnes*'s view and rejecting the insurers' restriction of "suit" to court proceedings, only. And the majority notes the trend is strongly in that direction among federal and lower courts, as well as more modern ones, with the remaining courts relegated to older precedents.[31]

While complete unity was impossible, the majority recognized and stressed the importance of uniformity when identical insurance provisions will necessarily be interpreted in various jurisdictions, and so determined that insureds in Texas should not be deprived of the coverage insureds have in thirteen other states.[32] Thus, the majority asserted that Texas should join with the majority in holding that an EPA proceeding constitutes a "suit" under standard CGL wording.

2. Promoting uniformity with non-Texas decisions—Dissenting View

The dissent acknowledges that Texas strives for uniformity, but finds it does not exist among the diverse opinions in the non-Texas cases. Where unanimity cannot be achieved, Texas should not bend its "plain meaning" interpretive principles

in a futile effort to conform to other court's interpretations of common policy wording.[33] More importantly, the dissent appreciates that the minority opinions rely upon a text-based approach that is more congruent with Texas jurisprudence, in concluding that EPA proceedings do not constitute a "suit."[34]

3. Promoting uniformity with non-Texas decisions—Commentary

Both the majority and dissent assert traditional Texas treatment when considering non-Texas cases interpreting insurance policies. That is, both recognize that Texas strives for uniformity when a clear view emerges on the interpretation of standard wording used across the country. This affords both policyholders and insurers the heightened predictability of a body of interpretive case law.

But this approach is not relevant or persuasive where policy wording is non-standard but varies by insurer or policyholder, or where consensus would not be enhanced by Texas's acquiescence in a perceived majority view.[35] Adhering to a consensus also requires that a majority rule actually can be discerned in the non-Texas cases, and that upon close examination they actually address the wording and circumstances before the court.[36]

So while Texas joins in the conclusion reached by the majority of other courts, the unique basis for its decision hardly provides the sort of predictability intended by favoring uniformity.

Where a real consensus exists among non-Texas courts interpreting standard policy wording, Texas often will agree.[37] Here, the majority recognizes a clear majority of high courts approving defense coverage for EPA proceedings as a "suit" under standard CGL wording, with the recent trend likewise moving in that direction. Conversely, the dissent perceives divergences from the prevailing approach, with the minority opinions utilizing text-based interpretation more closely aligned with principles of contract construction in Texas.

Ironically, the core argument made by the majority—that an EPA proceeding should be considered a "suit" because it replaced the court proceeding under which such damages were available at the time the policies issued—seems to be a novel concept that is not asserted the same way by any of the other state high court. So while Texas joins in the conclusion reached by the majority of other courts, the unique basis for its decision hardly provides the sort of predictability intended by favoring uniformity.

4. Divergence of opinions as evidence of ambiguity—Commentary

Since neither the majority nor the dissent found the policy terms ambiguous, neither side asserts the standard disclaimer that a policy provision is ambiguous only if it is subject to more than one reasonable interpretation and not merely because the parties or other courts differ over its interpretation.[38]

In the course of oral argument in *McGinnes*, however, the question was directly posed to insurer's counsel: If ambiguity exists when an insurance policy provision is susceptible to two or more reasonable interpretations, how should the court deal with differing opinions by multiple courts interpreting the same provision? Must the court hold that opinions of other jurists are necessarily unreasonable, if they differ from the opinion held by the court's own majority?[39]

For insurance jurisprudence, the question holds a special significance. When ambiguity is found in other contracts, Texas courts allow development of extrinsic evidence to determine the parties' actual intent as a factual question.[40] But when an insurance policy is susceptible to competing reasonable interpretations of the contract, Texas courts must adopt the construction that favors the insured without any further fact-finding of intent.[41]

Despite identifying in oral argument the apparent ambiguity created by multiple differing court opinions, neither the majority nor the dissenting opinions in *McGinnes* dealt with the question in those terms.[42] Rather, the argument between the divergent opinions in *McGinnes* centered on implementing unanimity where possible to achieve consensus and predictability in national interpretation of standard policy provisions.

Aside from simply declaring that diversity of other opinions does not preclude a court from reaching its own conclusion, the court does not seem to have grappled with the problem in a particularly principled fashion. The default position is simply protective of the court's independence to reach its own conclusions of law based on its own interpretive analysis.[43]

In other words, the court reserves to itself the right to decide whether or not a particular interpretation is subject to "genuine uncertainty" or any other indices of ambiguity, and essentially relegates divergent judicial opinions to the level of arguments made by the parties which can be dismissed out of hand unless independently persuasive. Or, to put a finer point on it, the court reserves to itself—that is, to a simple majority in a given case—the sole role as arbiter of what is plain, unambiguous, and reasonable even in the face of multiple other courts that find the same wording has a different reasonable meaning in the same context.

So, for example, it has rather breezily been proposed that: "It is inevitable in human affairs that reasonable people sometimes disagree; thus, it is also inevitable that they will sometimes disagree about what reasonable people can disagree

about."[44] The ultimate source of this quote, *City of Keller v. Wilson*, is not from an insurance or contract interpretation case, but involves the test of legal sufficiency for directed verdict, dependent upon the jurist's determination whether evidence at trial would enable reasonable and fair-minded people to reach the verdict under review.[45]

The point being made in *City of Keller* has nothing to do with ignoring diversity of opinion among courts regarding standard policy wording, but simply emphasizes the cogent point that the duty remains with the judge to make hard decisions, as the court illustrates with an extensive quotations from former Chief Justice Calvert:

> But since questions of negligence are questions of degree, often very nice differences of degree, judges of competence and conscience have in the past, and will in the future, disagree whether proof in a case is sufficient to demand submission to the jury. The fact that [one] thinks there was enough to leave the case to the jury does not indicate that the other [is] unmindful of the jury's function. The easy but timid way out for a trial judge is to leave all cases tried to a jury for jury determination, but in so doing he fails in his duty to take a case from the jury when the evidence would not warrant a verdict by it. A timid judge, like a biased judge, is intrinsically a lawless judge.[46]

The purpose of insisting on judicial independence, then, is not to foster undue hubris in the judiciary, but to encourage making hard decision.

Clearly, the court is justifiably concerned about preserving its judicial independence to determine cases, including insurance wording, without having the court's role wholly preempted by other courts that have prejudged the wording differently. This concern is not necessarily undermined, however, by recognizing that ambiguity is more likely than not present whenever serious judicial reasoning of different courts have reached different conclusions about the same insurance wording in similar circumstances. In any event, conserving its own judicial independence does not necessarily or automatically mean that the court should simply ignore the existence of contrary and divergent jurisprudence in the course of its project to determine whether a clause has plain meaning or is ambiguous.

What could the court do differently if it took seriously the problem posed by Justice Boyd at oral argument, and acknowledged that divergence among precedents is itself powerful evidence of ambiguity? One option could be for the court to determine plain meaning and reject ambiguity in the face of differing judicial opinions, only after honestly concluding that the court's own interpretation not only is more correct, but is singularly unambiguous in differentiation from other precedent.[47] Perhaps the court could even impose a heightened standard of persuasion where insurance policy wording has generated multiple differing interpretations, akin to that imposed on contractual indemnities against one's own negligence.[48]

More commonly, however, the court's jurisprudence does not demonstrate any such deep regard for the problem that divergent judicial opinions are strongly suggestive of ambiguity. Rather, the court has seemed solely interested in protection of its own unfettered independence, and largely has been content to reach its own conclusions about ambiguity of particular wording in the face of divergent judicial reasoning without taking seriously that such divergence—in and of itself—must illustrate that alternative reasonable interpretations more likely than not must exist.

The few lower Texas courts that have addressed the problem have, at least, grappled more directly with the implications of divergent precedent when determining whether insurance wording is ambiguous and therefore must be interpreted strictly in favor of the policyholder. For example, the Houston appellate court has looked to decisions from other states interpreting the subject wording excluding activities "in connection with" certain premises, in the absence of Texas precedent.[49] Noting that those cases reached differing results—some favoring the insurer and some agreeing with the policyholder's interpretation—the court concluded that the policy wording was susceptible of two reasonable constructions. Thus, the court felt compelled to construe the exclusionary clause in favor of the policyholder and against the insurer.

Similarly, the same appellate court recognized that an insurance policy is not ambiguous as a matter of course just because two parties disagree over the proper construction, but that the problem is more serious when courts from several jurisdictions interpret similar policy provisions and reach different results.[50] The court reviewed precedent from other states in the absence of Texas precedent on "sudden and accidental" wording in a case involving leakage caused by pipe corrosion. The court's own reading of the policy was consistent with an interpretation favoring the policyholder, but even if that had not been the case the court was persuaded that differing interpretations by various other courts demonstrated ambiguity in the wording that required a holding against the insurer.

These opinions do not seem entirely consistent, however, with a prior approach taken by that same court rejecting policyholder's argument that a "business risk" exclusion was necessarily ambiguous as a matter of law because courts that have dealt with the same issue have interpreted it differently.[51] After reviewing existing Texas precedent that supported the insurer's contrary interpretation, that panel

of the court noted that opinions from other jurisdictions likewise supported the insurer, and distinguished the remaining cases cited by the policyholder. Agreeing with the interpretation of the clause in prior Texas Supreme Court precedent, the court found the exclusion to be clear and unambiguous, and denied coverage.

More interestingly, the court queried how a rule would be applied that found ambiguity on the basis of divergent judicial opinions. So, the court wondered:

> [E]ven in those cases where legitimate, differing interpretations of the same language result, at what point the language becomes ambiguous as a matter of law. Is that point reached when the jurisdictions are split evenly, when there is a 40%, 30% or 20% minority; or can a court no longer consider the issue for itself when only one other court reaches an opposite conclusion? This court prefers the alternative which allows each court to decide the issue in light of the policy terms and the facts before it.[52]

Another opinion from Houston's Fourteenth District noted with some sympathy the insurer's argument that if judicial disagreement established policy wording as ambiguous, then insurance law jurisprudence would be established by the "lowest common denominator" favoring policyholders on a given coverage issue, so that even a small number of decisions would render moot any need for analysis by any other court.[53] The court found the point well-taken, but believed it was bound with respect to the particular interpretive question by Texas Supreme Court precedent.

Ultimately, the Fourteenth District reached a definitive approach to the problem en banc, rejecting the argument that differing opinions interpreting contract provisions necessarily render them ambiguous.[54] Once again, the policyholder had argued that its interpretation was necessarily a reasonable one because at least one court from another jurisdiction has adopted it.

Relying simply on a citation to *McKee*, the en banc court held that insurance policy provisions are not susceptible to more than one reasonable interpretation, and thus ambiguous, "merely" because other jurisdictions have reached differing conclusions about similar provisions. Rather, although the reasoning of such other courts might be persuasive, ambiguity should be decided independently. As further rationale, the court argued that core principles of judicial independence otherwise would be compromised:

> If the interpretation of a policy provision by another jurisdiction automatically rendered that interpretation reasonable, then . . . Texas courts would always be bound by the decision of whatever other jurisdiction has interpreted a given provision most favorably for the insured. On the contrary, while Texas courts may certainly draw upon the precedents of any other federal or state court, they are obligated to follow only higher Texas courts and the United States Supreme Court.[55]

The en banc majority reviewed and noted that two precedents from other jurisdictions had sided with the insurer, distinguished all but one precedent, and simply disagreed with the rationale of the sole remaining case cited by the policyholder. The majority further found there was a reasonable basis for the insurer to impose the exception at issue, thus undermining the precedential effect of that case. Thus having satisfied itself that the exclusion/exception were clear and unambiguous and should be applied as written, the court denied coverage.

Where does Texas law stand at the end of this discussion? Based on *McKee* and the en banc decision of the Fourteenth Court of Appeals in *Betco*, it seems the most that can be said with some certainty is that Texas courts are not compelled to determine an insurance clause ambiguous simply because other courts or judges have held divergent opinions. Certainly, nobody on the court in *McGinnes* even hinted that the divergence of opinion by other jurisdictions on the issue, of itself rendered the term "suit" ambiguous.

This is not nearly the same, however, as saying that differing judicial opinions should have no greater weight than the differing opinions of the parties with their acknowledged interests in the outcome, one would think. The current jurisprudence seems to leave some latitude for a policyholder to argue that divergent opinions should at least be taken by Texas courts as weighty evidence that a particular policy interpretation is ambiguous, even if the fact of such divergence is not in and of itself determinant of the issue of ambiguity.

Neither McGinnes nor insurers asserted this argument in their briefing, and so the court was not prepared to address it directly notwithstanding Justice Boyd's question at oral argument. Perhaps on another occasion an advocate will urge the court to grapple with the issue more seriously, to strike a proper balance that honors the court's independence of judgment while also acknowledging that ambiguity is deeply implicated where a question of interpretation engenders a multiplicity of differing judicial opinions.

1 477 S.W.3d 786 (2016).

2 *See id*. at 790 for specific policy language.

3 *Id.* at 794.

4 *McGinnes Indus. Maint. Corp. v. Phoenix Ins. Co.*, 571 F. App'x 329, 335 (5th Cir. 2014).

5 *Id.* at 330.

6 *Id.*

7 *Id.* at 330–31.

8 *Id.* at 331. The EPA letter was addressed to McGinnes's indirect parent, Waste Management, but reference will be made simply to McGinnes throughout.

9 *Id.*

10 *Id.* at 332.

11 *Id.*

12 The circuit cited only a single district court case, which held that "suit" in CGL policies was sufficiently broad to include PRP letters in CERCLA-type proceedings. *Gulf Metals Indus. Inc. v. Chi. Ins. Co.*, No. 96–04673, slip op. at 13 (126th Jud. Dist. Ct. Mar. 13, 1998), aff'd on other grounds, 993 S.W.2d 800 (Tex. App.—Austin 1999, pet. denied).

13 This article assumes that the reader is familiar with the standard litany of Texas's interpretive rules governing examination of insurance policies. For a thoughtful, detailed and recent treatment of these issues, *see* Lyndon F. Bittle, *Interpreting Insurance Policies in Texas: It's Not That Hard*, 72 The Advoc. (Texas) 62 (2015), responding to R. Brent Cooper, *Principles for Interpreting Insurance Policies*, 71 The Advoc. (Texas) 34 (2015).

14 The policy wording provides the insurer has the right and duty to defend any "suit" but may in its discretion investigate or settle any "claim or suit."

15 Majority opinion authored by Hecht, CJ joined by Justices Green, Willett, Devine, and

Brown.

16 Dissenting opinion authored by Justice Boyd, joined by Justices Johnson, Guzman, and Lehrmann.

17 "We agree with the Insurers that 'suit' commonly refers to a proceeding in court. Although the word is sometimes defined more generally as 'the attempt to gain an end by legal process,' the more specific connotation is an attempt through process in court." *McGinnes*, 477 S.W.3d at 791 (citations omitted).

18 *Id.*

19 *Id.* at 792.

20 *Id.*

21 *Id.* at 794–97.

22 *Id.* at 797–02.

23 *Id.* at 791 n.29.

24 *See Id.* at 800 ("None [of the majority's arguments] convinces me, but more importantly, our well-established rules of construction do not recognize any of the court's reasons as a legitimate basis for ignoring or rewriting the unambiguous language of an insurance policy.").

25 *See, e.g.*, *Travelers Cas. & Sur. Co. v. Alabama Gas Corp.*, 117 So. 3d 695, 708–09 (Ala. 2012); *R.T. Vanderbilt Co. v. Cont'l Cas. Co.*, 273 Conn. 448, 464–65, 870 A.2d 1048, 1059–60 (2005); *A.Y. McDonald Indus., Inc. v. Ins. Co. of N. Am.*, 475 N.W.2d 607, 627–28 (Iowa 1991); *Aetna Cas. & Sur. Co. v. Kentucky*, 179 S.W.3d 830, 837 (Ky. 2005), as modified on reh'g (Jan. 19, 2006); *C.D. Spangler Const. Co. v. Indus. Crankshaft & Eng'g Co.*, 326 N.C. 133, 153–55, 388 S.E.2d 557, 569–70 (1990).

26 While beyond the scope of this article, the distinction is not always so clearcut between permissible evidence of circumstances to illuminate intent in the context of contracting, and impermissible extrinsic evidence to alter and render ambiguous an otherwise clear and explicable term. *See, e.g.*, *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. CBI Indus.*, 907 S.W.2d 517, 521 (Tex. 1995) ("extrinsic evidence is inadmissible to contradict or vary the meaning of the explicit language of the parties' written agreement" but "extrinsic evidence may ... be admissible to give the words of a contract a meaning consistent with that to which they are reasonably susceptible, i.e., to 'interpret' contractual terms"); *see also Houston Expl. Co. v. Wellington Uw. Agencies, Ltd.*, 352 S.W.3d 462 (Tex. 2011).

27 466 S.W.3d 113 (Tex. 2015).

28 A similar difference might be seen in the approaches taken and pointed remarks made by majority and dissent (joined by then-Justice Hecht) advocating text-based interpretation and functional purpose respectively, in *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1 (Tex. Aug 31, 2007).

29 *McGinnes* at 792.

30 *Id.* (citing *King v. Dallas Fire Ins. Co.*, 85 S.W.3d 185, 187 (Tex. 2002)). Inexplicably, no citation is made to the principal case more specifically on point, *D.R. Horton–Tex., Ltd. v. Markel Int'l Ins. Co.*, 300 S.W.3d 740, 743–44 (Tex. 2009), distinguishing between the defense duty predicated solely on allegations alleged in pleadings as contrasted with duty to defend predicated on all facts presented for judgment.

31 *McGinnes* at 793.

32 *Id.* at 794 (citing *Zurich Am. Ins. Co. v. Nokia, Inc.*, 268 S.W.3d 487, 497 (Tex. 2008)).

33 *Id.* (citing *United States Fid. & Guar. Co. v. Goudeau*, 272 S.W.3d 603, 608 (Tex. 2008) (stating that where many different tests already in use by other courts render uniformity impossible, the court adheres to the law of Texas in applying the plain meaning of "occupying" in a standard automobile policy)).

34 *Id. at* 803–05.

35 *RSUI Indem. Co. v. Lynd Co.*, 466 S.W.3d 113, 138 (Tex. 2015), reh'g denied (Sept. 11, 2015).

36 *Lamar Homes, Inc. v. Mid–Continent Cas. Co.*, 242 S.W.3d 1, 14–15 (Tex. 2007).

37 *See, e.g.*, *U.S. Metals, Inc. v. Liberty Mut. Grp., Inc.*, 490 S.W.3d 20, 26–27 (Tex. 2015), reh'g denied (June 17, 2016) (agreeing with 10 of 12 state high courts that have interpreted the term "physical injury" in standard CGL to reject simple incorporation of defective work or product into a larger product or system, and counting several other state and federal courts that reach the same conclusion).

38 *U.S. Metals, Inc. v. Liberty Mut. Grp., Inc.*, 490 S.W.3d 20, 24 (Tex. 2015), reh'g denied (June 17, 2016) (citing *Grain Dealers Mut. Ins. Co. v. McKee*, 943 S.W.2d 455, 459 (Tex. 1997) ("We reject [policyholder's] position that the policy provisions are ambiguous and susceptible to more than one reasonable interpretation merely because other jurisdictions have reached differing conclusions about similar policy provisions. Opinions from other states about insurance policy interpretation can be persuasive, but ambiguity is for this court to decide.")).

39 Transcript of oral argument held January 15, 2016 at 14: "Justice Jeffrey S. Boyd: So 21— 'cause I do wanna get to my question—21 [decisions of other courts siding with policyholder's interpretation] and 7 on your side. And the ambiguity exists if a word is susceptible to two or more reasonable interpretations. And so, why doesn't your argument mean that we have to hold that 21 other courts are just simply not reasonable?" 2015 WL 457824 at *10; or see http://www.search.txcourts.gov/SearchMedia.aspx?MediaVersionID=63e65fb2-eb92-4a46-aa60-edf9ecc3bd0a&coa=cossup&DT=ORAL%20ARGUMENT&MediaID=05a6cde5-ede8-4aaf-b98b-07af-1da20a3b.

40 *R & P Enters. v. LaGuarta, Gavrel & Kirk Inc.*, 596 S.W.2d 517, 519 (Tex.1980). *See also Jhaver v. Zapata Off–Shore Co.*, 903 F.2d 381, 384–86 (5th Cir.1990).

41 *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Hudson Energy Co.*, 811 S.W.2d 552, 555 (Tex. 1991)

42 As discussed in greater detail above, the majority authored approached the issue as one of national uniformity and predictability, *McGinnes* at 793–04, while the dissent challenged that the interest in uniformity was misplaced where other courts varied in their interpretations and outcomes and could not overcome a textual interpretation, *McGinnes* at 804–05.

43 *Grain Dealers Mut. Ins. Co. v. McKee*, 943 S.W.2d at 459.

44 *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d at 24 n.18 (dissent).

45 *City of Keller v. Wilson*, 168 S.W.3d 802, 828 (Tex. 2005).

46 *Id.* (quoting Robert W. Calvert, "No Evidence" & "Insufficient Evidence" Points of Error, 38 Tex. L. Rev. 361, 364 n.12 (1960)).

47 For example, the court might recognize ambiguity in association with divergent precedent as illustrated by *State Farm Fire & Cas. Co. v. Reed*, 873 S.W.2d 698, 701 (Tex.1993), or might distinguish between outmoded rationales of a prior cultural period in favor of a more modern reality to reject the majority position and side with the minority of jurisdictions in reaching the "plain meaning" of policy terms, *Id. at* 703–04 (dissent).

48 *See Ethyl Corp. v. Daniel Constr. Co.*, 725 S.W.2d 705, 706–07 (Tex. 1987) (discussing comparative standard of "clear and unequivocal" test and concluding that indemnities against an actor's negligence demand more stringent express wording).

49 *Bonner v. United Servs. Auto. Ass'n*, 841 S.W.2d 504–07 (Tex. App.—Houston [14th Dist.] 1992, writ denied).

50 *Pioneer Chlor Alkali Co., Inc. v. Royal Indem. Co.*, 879 S.W.2d 920, 935 (Tex. App.—Houston [14th Dist.] 1994, no writ).

51 *T.C. Bateson Const. Co. v. Lumbermens Mut. Cas. Co.*, 784 S.W.2d 692, 698 (Tex. App.—Houston [14th Dist.] 1989, writ denied).

52 *Id.* at 698 (quoting *Stillwater Condominium Ass'n v. Am. Home Assurance Co.*, 508 F. Supp. 1075, 1080 (D. Mont. 1981)).

53 *Vaughan v. State Farm Lloyds*, 950 S.W.2d 205 (Tex. App.—Houston [14th Dist.] 1997), rev'd, *State Farm Fire & Cas. Co. v. Vaughan*, 968 S.W.2d 931 (Tex. 1998).

54 *Betco Scaffolds Co., Inc. v. Houston United Cas. Ins. Co.*, 29 S.W.3d 341, 344 (Tex. App.—Houston [14th Dist.] 2000, no pet.) (en banc).

55 *Id.* at n.2.

By Robert J. Witmeyer

THE TEXAS SUPREME COURT'S NEW APPROACH TO RIP AND TEAR COSTS

The Texas Supreme Court's opinion in *U.S. Metals, Inc. v. Liberty Mutual Group, Inc.*[1] represents the current law in Texas for "property damage" and the "impaired property" exclusion under a CGL policy. But the court's opinion likely will be most cited for an issue the court did not fully analyze—insurance coverage for rip and tear costs.

I. The *U.S. Metals* Opinion

In *U.S. Metals*, the insurance coverage dispute arose from U.S. Metals' sale of approximately 350 custom-made flanges to ExxonMobil for use in constructing non-road diesel units at ExxonMobil's refineries. The flanges were supposed to meet industry standards and were designed to be welded to piping. After they were welded together, the pipes and flanges were then covered with a special high-temperature coating and insulation.

In post-installation testing, several flanges leaked, and it was determined that the flanges did not meet industry standards. Given this determination, ExxonMobil decided it was necessary to replace all of the flanges to avoid the risk of fire and explosion. For each flange, this process involved stripping the temperature coating and insulation (destroyed in the process), cutting the flange out of the pipe, removing the gaskets (also destroyed in the process), grinding the pipe surfaces smooth for re-welding, replacing the flange and gaskets, welding the new flange to the pipes, and replacing the temperature coating and insulation.[2]

ExxonMobil sued U.S. Metals for $6,345,824 as the cost of replacing the flanges and $16,656,000 as damages for the loss of use of the diesel units while investigating, removing, and replacing the defective flanges. U.S. Metals settled with ExxonMobil for $2.2 million and then sought indemnification from its commercial general liability carrier, Liberty Mutual Group, Inc. Liberty Mutual denied coverage.[3]

U.S. Metals subsequently sued Liberty Mutual in federal district court to determine its right to a defense and indemnity under the policy. The district court granted summary judgment on behalf of Liberty Mutual. On appeal, the Fifth Circuit certified four questions to the Texas Supreme Court inquiring about the meaning of the terms "physical injury" and "replacement" in the CGL policy. The Texas Supreme Court consolidated the questions into two issues: "[I]s property physically injured simply by the incorporation of a faulty component with no tangible manifestation of injury? And second: is property restored to use by replacing a faulty component when the property must be altered, damaged, and repaired in the process?"[4]

Beginning with the "property damage"[5] issue, the court noted that different approaches exist but chose to follow the majority view. The court stated, "[w]e agree with most courts to have considered the matter that the best reading of the standard-form CGL policy text is that physical injury requires tangible, manifest harm and does not result merely upon the installation of a defective component in a product or system."[6] Thus, the court concluded that the mere installation of the faulty flanges into the diesel units is not "property damage."

Next, the court addressed the "impaired property" exclusion.[7] While the diesel units were not damaged by the installation of U.S. Metals' faulty flanges, the units were physically injured in the process of replacing the flanges. The court stated, "[b]ecause the flanges were welded to pipes rather than being screwed on, the faulty flanges had to be cut out, pipe edges resurfaced, and new flanges welded in. The original welds, coating, insulation, and gaskets were destroyed in the process and had to be replaced. The fix necessitated injury to tangible property, and the injury was unquestionably physical."[8] The court therefore found, "the repair costs and damages for the downtime were 'property damages' covered by the policy unless [the impaired property] exclusion applies."[9]

U.S. Metals argued that the "impaired property" exclusion did not apply to the downtime damages:

> [I]f the flanges had been screwed onto the pipes, removal and replacement would have been a simple matter, readily restoring the diesel units to use, and

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> making them 'impaired property'. But because the flanges were welded in, U.S. Metals argues, restoring the diesel units to use involved much more than simply removing and replacing the flanges alone, and therefore the diesel units were not 'impaired property' and Exclusion M does not apply.[10]

The Texas Supreme Court rejected this argument:

> The policy definition of "impaired property" does not restrict how the defective product is to be replaced. U.S. Metals' argument requires limiting the definition to property "restored to use by the ... replacement of [the flanges]" without affecting or altering the property in the process. That limitation cannot be fairly inferred from the text itself, nor would it make sense to do so. In U.S. Metals' view, the diesel units could not be restored to use by replacement of the flanges, not only because they had to be cut out and welded back in, but because of the wholly incidental replacement of insulation and gaskets. Coverage does not depend on such minor details of the replacement process but rather on its efficacy in restoring property to use. The diesel units were restored to use by replacing the flanges and were therefore impaired property to which Exclusion M applies. Thus, their loss of use is not covered by the policy.

Thus, based upon the plain language of the exclusion, the court held that Exclusion M precluded coverage for the loss of use damages for the diesel units.[11]

Although the court concluded the "impaired property" exclusion precluded coverage for the big ticket item of the diesel units' loss of use ($16,656,000), the court did find there was coverage for the destroyed insulation and gaskets. The court determined that Exclusion M did not apply to those items because "the insulation and gaskets destroyed in the process were not restored to use; they were replaced. They were therefore not impaired property to which Exclusion M applied, and the cost of replacing them was therefore covered by the policy."[12] Thus, under the court's analysis, the destruction of the insulation and gaskets in order to repair the defective flanges generated new property damage covered by the Liberty Mutual policy.

II. A Change In Direction

The Texas Supreme Court's conclusion that the destruction of property to repair a defective product meets the definition of "property damage" is a novel approach for rip and tear costs under Texas law.

In *Lennar Corp. v. Markel American*,[13] the Texas Supreme Court found coverage for rip and tear costs under a CGL policy under a different analysis. In *Lennar*, a homebuilder made a claim for the cost to repair homes that had been damaged by EIFS siding installed on the homes.[14] Prior to review by the Texas Supreme Court, the court of appeals held that the policy covered the cost of repairing home damage, which primarily involved the repair of damaged studs, but not the cost of locating the home damage by removing EIFS. Focusing on the phrase "because of" in the insuring agreement, the court of appeals ultimately found that because Lennar's evidence did not segregate the two types of damages, Lennar was entitled to recover nothing.[15]

The Texas Supreme Court reversed the court of appeals and found that the cost to go into the structure to locate the property damage was covered. More specifically, the court reasoned that the deteriorated studs were "property damage" to which the insurance applied and that the costs to locate the damaged studs were covered consequential damages of that property damage. The court reasoned that the phrase "because of" in the insuring agreement was susceptible to a broad definition and that "[u]nder no reasonable construction of the phrase can the cost of finding EIFS property damage in order to repair it not be considered to be 'because of' the damage."[16]

The court's analysis in *U.S. Metals* differed from that in *Lennar Homes* because there was no *covered* property damage prior to the rip and tear of the diesel units at issue. As a result, the cost to access and replace the flanges could not be considered covered under the reasoning in *Lennar Homes* because they were not sums the insured was obligated to pay "because of … property damage to which this insurance applies." Instead, the court found entirely new covered physical injury to tangible property caused by the rip and tear damages incurred in replacing the flanges.

III. Future Problems With The *U.S. Metals* Opinion

The court's new approach for treating damage caused by rip and tear as new property damage instead of consequential damage leads to critical uncertainties that courts will have to grapple with in future cases.

One uncertainty is whether rip and tear can be an "occurrence." Under a standard form CGL insuring agreement, property damage must be caused by an occurrence.[17] The policy defines an "occurrence" as an "accident, including continuous or repeated exposure to substantially the same general harmful conditions."[18] The term "accident" is not defined by the policy. However, Blacks

Law Dictionary defines an "accident" as "an unintended and unforeseen injurious occurrence; something that does not occur in the usual course of events or that could not be reasonably anticipated."[19] Similarly, Texas the Supreme Court has previously stated that "[a]n accident is generally understood to be a fortuitous, unexpected, and unintended event . . . . An accident occurs as the culmination of forces working without design, coordination, or plan."[20]

In *U.S. Metals*, damage to the insulation and gaskets was not accidental because it was caused intentionally to access the defective flanges. Thus, the intentional destruction of the insulation and gaskets does not appear to involve an occurrence.

Another uncertainty created by the court's new approach is the determination of which policy is triggered. In *Don's Building Supply, Inc. v. OneBeacon Insurance Co.*,[21] the court determined that property damage due to faulty workmanship does not "occur" at the time the damage manifests (when it is discovered or discoverable) or when the plaintiff is exposed to the agent that will eventually cause the damage (when it is installed, presumably). Instead, *Don's Building* teaches that the property damage occurs when actual physical damage to the property takes place.[22] As a result, the insurance policy that is in effect at the time the property damage occurs is the policy that is triggered.

With respect to property damage caused by rip and tear, this new property damage may not occur until years later. Thus, what happens if these repairs do not get started until a different carrier is on the risk? Is the carrier on the risk at the time of the original property damage responsible, or is the new carrier responsible?

Moreover, Texas courts have long held that "fortuity is an inherent requirement of all risk insurance policies."[23] One can certainly think of scenarios where the new damage caused by rip and tear would not be fortuitous if the insured knew about the need to make the repairs prior to acquiring insurance coverage from a new carrier.

In addition, Exclusion A may apply to property damage caused by rip and tear under the court's new approach. This exclusion precludes coverage for property damage if the property damage is "expected or intended from the standpoint of the insured." In examining whether this exclusion applies, courts focus on whether it is alleged that the insured had the intent to injure, rather than focusing strictly on whether the conduct was voluntary and intentional.[24] With respect to property damage caused by rip and tear, this exclusion may apply if the insured is found to have intended the damage. On the other hand, this exclusion may not apply if someone else performs the rip and tear because the insured presumably did not intend the damage.

Finally, in light of the uncertainties the court's opinion has created, some insurers may draft rip and tear exclusions that limit their exposure for rip and tear costs. The following is an example of a rip and tear exclusion for a concrete insured, which precludes coverage for:

Damages arising out of:

> (1) Any expenses incurred in removing concrete or concrete products from any structure or building due to defective concrete or for improperly mixed, manufactured, poured, formed, cured, or installed concrete;
>
> (2) Any expenses for replacing forms, reinforcements, piping and wiring that are destroyed during the course of removing defective concrete products; or
>
> (3) Any expenses for returning the structure or building to the condition that existed prior to the installation of concrete products.[25]

Under *Lennar*, damages because of rip and tear likely would be covered if there was covered property damage that led to the rip and tear. However, if insurers react to the uncertainties the *U.S. Metals* opinion created by incorporating exclusions similar to the one listed above, the insured may end up with no rip and tear coverage at all.

IV. Conclusion

The *U.S. Metals* decision represents a new and important shift in the treatment of rip and tear costs under Texas law. In light of the substantial uncertainties the court's opinion has caused, *U.S. Metals* likely is just the beginning for determining the scope of coverage available under CGL policies for damages caused by rip and tear in Texas.

1 490 S.W.3d 20, 27 (Tex. 2015), *reh'g denied* (June 17, 2016).

2 *Id.* at 21–22.

3 *Id.* at 22–23.

4 *Id.* at 23–24.

5 A standard form CGL policy contains two definitions of "property damage":

> a. Physical injury to tangible property, including all resulting loss of use of that property. All such loss

of use shall be deemed to occur at the time of the physical injury that caused it.

b. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the "occurrence" that caused it.

Donald S. Malecki, Commercial General Liability Coverage Guide, 4–5 (11th Ed. 2015).

6 490 S.W.3d at 27.

7 Exclusion m. precludes coverage for "'[p]roperty damage' to 'impaired property' or property that has not been physically injured, arising out of . . . [a] defect, deficiency, inadequacy or dangerous condition in 'your product'." 490 S.W.3d at 22.

8 *Id.* at 28.

9 The Liberty Mutual policy defined "impaired property" to mean:

"tangible property, other than 'your product' . . . , that cannot be used or is less useful because:

a. It incorporates 'your product' . . . that is known or thought to be defective, deficient, inadequate or dangerous; or

b. You have failed to fulfill the terms of a contract or agreement;

if such property can be restored to use by the repair, replacement, adjustment or removal of 'your product' . . . or your fulfilling the terms of the contract or agreement."

Id. at 22.

10 *Id*. at 28.

11 *Id*.

12 *Id.*

13 413 S.W.3d 750 (Tex. 2013).

14 *Id.* at 751.

15 *Id.* at 757.

16 *Id*. at 711

17 Malecki, *supra* note 5, at 6–7.

18 Malecki, *supra* note 5, at 7.

19 Blacks Law Dictionary, 6 (2d Pocket Ed. 2001).

20 *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 8 (Tex. 2007) (internal quotations omitted).

21 267 S.W.3d 20, 24–30 (Tex. 2008).

22 *Id.* at 24.

23 *Maryland Cas. Co. v. S. Tex. Med. Clinics, P.A.*, 2008 WL 98375, at *5 (Tex. App.—Corpus Christi, 2008, pet. denied) (citing *Two Pesos v. Gulf Ins. Co*., 901 S.W.2d 495, 501 (Tex. App.—Houston [14th Dist.] 1995, no writ)).

24 *State Farm Fire & Cas. Co. v. S.S. & G.W.*, 858 S.W.2d 374, 378 (Tex. 1993).

25 *See* Form AGL04250611.

By Rachelle H. Glazer and John P. Atkins

RECENT FIFTH CIRCUIT AND TEXAS SUPREME COURT INSURANCE DECISIONS

Texas Supreme Court

Injury to leased-in worker excluded under CGL bodily injury exclusion

Seger v. Yorkshire Ins. Co., Ltd., No. 13-0673, 2016 WL 3382223 (Tex. June 17, 2016)

In a careful and lengthy decision, the Texas Supreme Court reminded everyone that an insured cannot have it both ways when seeking to enforce a voidable insurance contract. The court struggled through several issues before finally deciding that the implicated policy simply did not cover the loss on its terms, despite a jury verdict to the contrary. The court determined that although the Insurance Code provided that the policy could not be enforced against the insured, this rendered the policy voidable—and where an insured holds an insurer to a voidable policy, exclusions under that policy may still apply to bar coverage.

In 1992, Randy Seger, an employee of Employer's Contractor Services, Inc. ("ECS") was killed while operating a drilling rig owned by Diatom Drilling Co. Diatom and ECS were closely related, sharing a general partner.[1]

Mr. Seger's family sued Diatom and its individual partners, and Diatom demanded a defense from its (numerous) CGL insurers. The insurers refused and also rebuffed the Segers' offers to settle within policy limits. After all defendants except Diatom were dropped from the suit, Diatom was so strapped for cash it was unable to pay its attorney and went unrepresented at trial. The Seger family won a $15 million judgment, and Diatom signed over to the Segers all of its claims against its insurers.[2]

The Segers filed a *Stowers* action against insurers Yorkshire and Ocean Marine. The insurers tried to join Diatom and ECS with a third-party claim for declaratory relief and reformation. However, the trial court ruled against the insurers on those claims at summary judgment and severed the third-party claims from the *Stowers* action. The jury found for the Segers on negligence and causation, and based on the underlying judgment against Diatom, the trial court awarded more than $37 million.[3]

On the first appeal the insurers argued that an exclusion for claims for injuries to leased-in workers applied to the *Stowers* claim. The court of appeals did not explicitly rule on the question—it found that the policy did not cover leased-in workers, but remanded the case to the trial court without saying whether the decedent was himself a leased-in worker.[4]

On remand the Segers won again and obtained a revised judgment amount now over $71 million. The insurers again appealed. This time the court of appeals determined that the trial had not been sufficiently adversarial (because Diatom had not retained an attorney and had presented no defense beyond the testimony of one officer), and that therefore, under the *Gandy* doctrine, the underlying judgment was inadmissible to establish damages. The Segers appealed.[5]

The Texas Supreme Court ultimately ruled that the Segers' *Stowers* action failed because injuries to the decedent were not covered under the terms of the policy.[6] The court began by reminding everyone that in a *Stowers* case, as in any coverage case, the insured has the duty to show that the injury falls within the terms of the policy, at which point the burden shifts to the insurer to show that some provision or condition excludes coverage. The policy did not cover "bodily injury to any employee of the Insured arising out of and in the course of his employment by the Insured," and further excluded injuries to "Leased-in Employees/ Workers." However, the policy explicitly covered injuries to independent contractors and other third parties.[7]

The court found that the Segers had met their initial burden to establish potential coverage by presenting evidence at trial that the decedent had not been Diatom's employee, and so he fell within the policy's coverage for third parties injured by Diatom's work. The court then asked whether any exclusion applied. Before it could reach this question, however, it had to address an interesting argument raised

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by the Segers—namely that the insurers could not apply any exclusions because they were prohibited from enforcing the terms of the policy under the Insurance Code, since the insurers were not authorized to do business in Texas.[8]

The court held that the Segers were correct that the insurer could not enforce the policy under the statute. However, the court continued, the Segers could not have it both ways—they could not both demand coverage under the terms of the policy and object to enforcement of the policy's terms (including its exclusions).[9]

The court reached this conclusion by analyzing the relevant provisions of the Insurance Code and finding that "unenforceable" essentially meant "voidable," because the statute, by its terms, permitted an insured, but not an insurer, to enforce policies issued by an unauthorized insurer. The court then cited its own precedent that an insured seeking to enforce a voidable insurance policy may only do so on the terms provided in the policy itself.[10]

Finally, the court reached the exclusion for leased-in workers and held that the jury's determination that the decedent had not been a "leased-in" worker was not supported by sufficient evidence. The court looked first to the jury instruction, which had defined a "leased-in worker" as a person "that perform[s] work for the insured under an agreement with another allowing temporary use of the worker, even though the leased worker would not be an employee of insured."[11]

The court found incontrovertible the evidence that the decedent performed work for Diatom pursuant to an agreement between ECS and Diatom. The agreement had been entered into evidence and was not in dispute. The final element of the definition also was clearly met—both parties agreed that the decedent had not been an employee of Diatom. The court therefore rejected the Segers' argument that the decedent had instead been an independent contractor, because there was nothing in the definition of "leased-in worker" that that made these two categories mutually exclusive.[12]

The undisputed evidence, therefore, "conclusively establishe[d] the opposite" of a fact vital to the district court's verdict. The Texas Supreme Court therefore affirmed the court of appeals decision, albeit on different grounds. From a judgment that had climbed to more than $71 million, the Segers would go home empty-handed.[13]

Other than the lesson to not count one's chickens before they are hatched, this case instructs on some other points as well. First, contracts that are not "enforceable" under the sections of the Insurance Code relating to unauthorized insurers are to be treated as "voidable." Second, that implies that even where an insurer is barred from enforcing an insurance contract, when an insured nonetheless decides to enforce the contract, the agreed terms of the contract apply.

Fifth Circuit

Engineering activities fell within professional services exclusion, but court could not determine duty to indemnify.

Hartford Cas. Ins. Co. v. DP Eng'g, L.L.C., 827 F.3d 423 (5th Cir. 2016)

The Fifth Circuit in this case found that the advice of a contract engineer constituted professional services for the purposes of a professional liability exclusion.

John Scroggins, an engineer with DP Engineering ("DP"), contracted to help out on a project at a nuclear plant in Arkansas. The project required the temporary removal of a massive, 520-ton component from the plant. Scroggins and DP advised the plant on how best to remove the part. During the project, the gantry employed to lift the component from its housing collapsed under the weight of the component, killing one worker and causing enormous property damage.[14]

Litigation ensued. The plant owner, Entergy, sued DP and Scroggins for breach of contract and negligence. Various injured workers and the family of the deceased worker sued DP for personal injury. After receiving notice of the actions, DP's insurers, both Hartford entities, immediately sued for declaratory judgment that they had no duty to defend any of these actions under any of the three policies (two primary policies and one umbrella policy) issued to DP. The insurers contended that the litigation fell within the professional services exclusion.[15]

DP counterclaimed against Hartford for a declaration of the duty to defend, and for breach of contract. Both sides moved for summary judgment, and Hartford prevailed, with the court deciding that Hartford had neither a duty to defend nor a duty to indemnify. DP appealed.[16]

The Fifth Circuit began its review by noting that the professional services exclusions in the three policies excluded claims "arising out of" the insured's "rendering of or failure to render any professional service." The court noted that under Texas law, an injury "arises out of" a professional service that is a but-for cause of the injury, even if there isn't necessarily direct or proximate causation.[17]

All three policies defined "professional services" to include "engineering activities," and an endorsement to the umbrella policy also excluded "Engineering Services." The court considered caselaw establishing that "professional services" generally includes the exercise of specialized knowledge mixed with professional judgment, as opposed to "administrative services," which usually involve execution of a decision made based on the professional judgment of another.[18]

The court then turned to the factual allegations in the underlying lawsuits to determine, in each action, whether the insured's alleged conduct was excluded. In the negligence and breach of

contract case with Entergy, the plaintiff alleged that DP:

> (1) was involved in a decision not to perform a load test on the gantry to ensure it could lift the stator; (2) knew or should have known of certain inaccurate and false statements by the gantry engineer . . . that it was not possible for the gantry to undergo a load test and such a test was unnecessary because the gantry had previously lifted heavier objects; (3) had concerns about the failure to anchor the gantry to the building itself but did not act on those concerns; (4) failed to provide qualified and competent personnel; and (5) did not comply with applicable standards in Entergy's manual requiring a load test.[19]

In the personal injury lawsuits, the injured workers and the decedent's family alleged that the plan for moving the component was faulty. These allegations included claims that DP:

> ignored the appropriate and applicable standards regarding the design evaluation[,] . . . improperly used an assumption of transverse frame loading that was less than two percent of the handled load[, failed to conduct] a required load test[, . . . did not inspect all load bearing welds before and after a load test[, and] . . . was unable to provide to the NRC inspection team any alternate approved standard for the design and testing of the crane.[20]

The court held that although certain of the personal injury complaints stated generally that DP's employees participated in "non-engineering tasks," these bald statements did not change the nature of the underlying allegations, which clearly arose out of the provision of professional services. Ultimately the court determined that none of the complaints by the plant or the personal injury plaintiffs contained allegations relating to any claims based on administrative or nonprofessional services provided by Scroggins, DP, or any DP employees, and the professional services exclusion therefore clearly applied to all claims. Moreover, claims in the personal injury lawsuits for negligent hiring and supervision also fell within the professional services exclusion because they "related to" and were "interdependent with" the negligent provision of services, under Texas precedent.[21]

The court therefore found no duty to defend. But what about the duty to indemnify? Usually, a duty to indemnify can't be resolved on the pleadings alone, but a Texas court may do so if "the same reasons that negate the duty to defend likewise negate any possibility the insurer will ever have a duty to indemnify."[22] This is a difficult bar to clear—the exemplar case involved an insured's attempt to require an auto policy to pay for injuries suffered in a drive-by shooting. The Texas Supreme Court determined in the *Griffin* case that a policy that covered "auto accidents" could not cover an alleged intentional shooting regardless of future factual development.[23]

The Fifth Circuit distinguished *Griffin*, however, because the present case was too factually complex. Given the number of parties and complaints, the court held that at some point the litigation could involve theories of liability not barred by the professional services exclusions. As the court explained, "[t]he allegations in the underlying lawsuits here do not conclusively foreclose that facts adduced at trial may show DP Engineering also provided non-professional services . . . ." Therefore, the court reversed the lower court's determination that there was no duty to indemnify.[24]

This decision approves and somewhat clarifies Texas cases construing professional services exclusions, particularly regarding the distinction between "professional" and "non-professional" conduct. Second, the decision reaffirms *Griffin*, and arguably raises the (already high) bar against summary judgments on the duty to indemnify. The standard for resolving the duty to indemnify on the pleadings is not whether it is *likely* that future developments will invoke coverage, but whether the facts as they are set out in the pleadings *completely foreclose* the possibility that the insurer will end up with such a duty.

Ecstasy is a narcotic, and "due to" requires a showing of "substantial cause."

Crose v. Humana Ins. Co., 823 F.3d 344 (5th Cir. 2016)

This case, involving coverage under a Humana health insurance policy, forced the Fifth Circuit to make an *Erie* guess about the meaning of the term "narcotic" under Texas law.

Eleanor and Ronald Crose attended a concert in the summer of 2013. Ronald took ecstasy while there. Ronald complained to Eleanor of nausea and a headache later that evening. Sometime that night, or possibly the next morning, Ronald suffered a stroke, which his doctors suspected could have been caused or exacerbated by hypertension brought on by the ingestion of the ecstasy.[25]

Ronald submitted the claim to Humana, which denied the claim because of an exclusion that read, in pertinent part:

> Loss due to being intoxicated or under the influence of any narcotic unless administered on the advice of a health care practitioner.[26]

Eleanor sued Humana for breach of contract and for various statutory causes of action under the Texas Insurance Code.

In the district court, Humana successfully moved for summary judgment. Eleanor appealed.[27]

Eleanor argued on appeal that the district court erred by determining that the term "narcotic" was not ambiguous as used in the exclusion, and for not adopting her alternative definition that the term "narcotic" could technically only be applied to certain drugs derived from plants. She supported this argument with evidence that ecstasy was classified by experts in the field as a "hallucinogen" rather than as a "narcotic," as well as with federal and state statutory definitions of the term.[28]

The Fifth Circuit rejected this argument as overly technical. Although no Texas or Fifth Circuit precedent had yet defined the term, necessitating an *Erie* guess, the Fifth Circuit noted that Texas law required that undefined terms in a contract be given their ordinary and generally-accepted meaning, not a technical meaning in a particular scientific or legal field. On this basis the Fifth Circuit adopted the district court's definition:

> [a] drug affecting mood or behaviour [sic] which is sold for non-medical purposes, *esp.* one whose use is prohibited or under strict legal control but which tends nevertheless to be extensively used illegally.[29]

This definition, the Fifth Circuit concluded, plainly encompassed ecstasy.[30]

This holding did not resolve the coverage dispute, however. The court still needed to determine whether any issue of material fact remained that Ronald's stroke was "due to" his consumption of ecstasy. Luckily, Texas courts *had* construed the phrase "due to" before. The Fifth Circuit found that under Texas law, "due to" is a more exacting standard than "arising out of"—the latter term requires only a showing of "but for" causation. "Due to," by contrast, requires a showing of *proximate* causation.[31]

The court continued, noting that although Humana needed to show proximate causation, this did not mean it had to establish sole causation—to establish proximate cause, Humana had to show that there was no question of fact as to whether ecstasy was a "significant" or "substantial" cause of Ronald's stroke. The court held that Humana had met that burden by providing expert evidence of the power of ecstasy to cause a stroke and by submitting Ronald's medical records showing that his doctors had suspected ecstasy had played a role in Ronald's stroke. Moreover, the court found the temporal proximity between the ingestion of the ecstasy and the stroke to be persuasive, especially given the lack of any evidence that Ronald had a history (or family history) of hypertension or other conditions that could give rise to a stroke. This set of facts, the court determined, left little doubt that ecstasy had been a substantial cause of the stroke.[32]

In addition to establishing for the first time a judicial definition of "narcotic" in Texas, the Fifth Circuit here also reminded litigants that reliance on technical definitions is not favored. Ordinary usage is the rule, regardless of whether ordinary usage comports with typical use of a term in expert fields. Additionally, the court reaffirmed that "due to" contract language requires establishment of proximate cause.

Nineteen months is not prompt notice.

Hamilton Properties v. Am. Ins. Co., 643 Fed. Appx. 437 (5th Cir. 2016)

This short but interesting case comes to us *per curiam* from the Fifth Circuit. In July 2009, a hailstorm damaged the Dallas Plaza Hotel in Dallas, Texas. The owner, Hamilton Properties, had property and casualty insurance covering the hotel with American Insurance Company (AIC). At the time of the hailstorm, the hotel was no longer in use as a hotel, but still had a few permanent residents. The damage was significant, with evidence suggesting significant roof leakage and destruction of ceiling tiles.[33]

Hamilton did not immediately make a coverage claim. Instead, it waited until November of 2010 before hiring an inspector to look into the damage. Hamilton's representative then emailed AIC in February of 2011. AIC responded that it was no longer Hamilton's broker of record and refused to report a claim. Hamilton made a formal claim in October of 2011, which AIC denied due to the amount of time that had passed since the damage, the multiple intervening instances of hail damage (which would not have been covered by the policy at issue, since it had expired in September of 2009), and an early inspection report by an AIC engineer from just a few weeks after the July hailstorm that had found no damage to Hamilton's property from water or hail. Additionally, AIC asserted that the roof itself was not adequately designed, which suggested the damage may have resulted from a faulty roof.[34]

Hamilton sued for coverage. In the district court, AIC successfully moved for summary judgment. Hamilton appealed.[35]

The court of appeals began by analyzing Hamilton's contract claim. Observing that the policy required Hamilton to provide "prompt" notice of any claim, the court enunciated the general Texas rule about such provisions: although a prompt notice provision is a condition precedent, an insured's failure to give prompt notice does not excuse the insurer unless it can show prejudice. Although the parties disputed when notice occurred, the court assumed, for the purposes of its review, that notice had occurred with the first email in February of 2011 (the earliest possible date).[36]

The court found that Hamilton's delay was without excuse, in part because the damage was not hidden—indeed, one of the hotel's residents, whom Hamilton had used as a witness, had reported damage to Hamilton quickly after the hailstorm.

The court reaffirmed its prior position that where a substantial delay is without explanation, it is appropriate to conclude that prompt notice was not given as a matter of law.[37]

The insurer still had to show prejudice to escape liability. The court found that AIC was prejudiced by its inability to investigate the damage. Because Hamilton had delayed so long in reporting the claim, the court reasoned, AIC did not have sufficient evidence to properly adjust or defend the claim, because it could no longer determine the state of the roof before or immediately after the July hailstorm, during the period between the hailstorm and the end of the coverage period, or during the period between the July hailstorm and the additional intervening storms.[38]

Even though the court had disposed of all relevant questions, it then took the unusual step of giving an alternative ground for its decision. It held that even if AIC had not been prejudiced by Hamilton's late notice—which the court had just held it had—Hamilton had failed to establish a prima facie claim for coverage under the policy, because it had not provided sufficient evidence to show that the damage occurred during the time the policy was active.[39]

Because the court found no breach of contract by the insurer, it also held Hamilton could not recover under any of the various insurance and consumer protection statutes, all of which first required a demonstrated breach.[40]

This case may provide insurers with useful criteria for establishing prejudice due to failure to give prompt notice, which is usually difficult for an insurer to show. Look for it to be cited, compared, and distinguished in future cases touching on prejudice associated with late notice.

Insurer's overpayment obviated need to later pay prompt payment penalty.

Quibodeaux et al. v. Nautilus Ins. Co., No. 15-40567, 2016 WL 3644641 (5th Cir. July 7, 2016)

This case grew out of the destruction wrought by Hurricane Ike in 2008. The hurricane damaged a warehouse and daycare center owned by Quibodeaux, who filed a claim with his insurer Nautilus. Nautilus hired an independent adjuster and paid Quibodeaux's claims based on the adjuster's findings. Rather than pay the actual cash value of the itemized appraisal as required under the policy, Nautilus instead paid the replacement cost, and so actually paid Quibodeaux approximately $11,000 more than it otherwise would have. Quibodeaux cashed the checks.[41]

After two years of silence, Quibodeaux sued Nautilus in state court for breach of contract and bad faith. Nautilus tried to get Quibodeaux to send an itemized list of damages, but he failed to do so, even after his attorney promised to produce one. Nautilus removed the case to federal court and moved to compel arbitration. Quibodeaux tried to resist the arbitration, and refused to fill out a proof of loss form, but did designate an appraiser. The district court compelled appraisal.[42]

After the appraisal—which did not include any damage to the contents of the warehouse or daycare, just to the exterior—Nautilus paid Quibodeaux the amount of the appraisal less what it had already paid. Quibodeaux again went silent, this time for six months, at which time he resurfaced again and claimed that he had additional claims for damaged contents and lost business income. Quibodeaux moved to set a trial date. The district court denied the motion and demanded dispositive pleadings, after which it granted summary judgment in favor of Nautilus.[43]

Quibodeaux appealed and argued that although an insurer's timely payment of a binding and enforceable appraisal award estops a breach-of-contract claim, he should not be estopped from asserting claims relating to the contents of the buildings, which were not the subject of the appraisal. The Fifth Circuit rejected this argument as irrelevant, and held that Quibodeaux had produced no authenticated evidence whatsoever of his alleged "contents" damages.[44]

Quibodeaux's last argument was for prompt pay penalties under Chapter 542 of the Insurance Code, asserting that he was entitled to delay penalties for the period between the initial payment and payment of the compelled appraisal award, and that he was entitled to late penalties for the delay between his initial claim and Nautilus's first payment. The court dismissed the first argument outright, holding that under Texas law "[a] plaintiff may not seek Chapter 542 damages for any delay in payment between an initial payment and the insurer's timely payment of an appraisal award."[45]

As for the initial payments, Nautilus conceded it had not notified Quibodeaux of acceptance or rejection within the required deadline. However, it argued that when it had overpaid Quibodeaux originally, this had more than compensated him for the penalties that would have accrued during that delay period, plus any attorney fees associated with the penalty claim (which had not been the focus of the litigation). Quibodeaux failed to respond to these arguments. Under the plain error standard, the Fifth Circuit affirmed the district court's grant of summary judgment on this claim as well.[46]

Although the interesting part of this case is the way in which the insurer cleverly managed to avoid a prompt payment penalty, the real lesson it teaches is to be diligent in litigation. The courts will not look favorably on delay, or on a party who raises arguments he has failed to preserve.

1 *Seger v. Yorkshire Ins. Co., Ltd.*, No. 13-0673, 2016 WL 3382223, at *1 (Tex. June 17, 2016).

2 *Id.* at *2.

3 *Id.*

4 *Id.* at *3.

5 *Id.* (citing *Yorkshire Ins. Co., Ltd. v. Seger*, 407 S.W.3d 435, 443 (Tex. App.—Amarillo 2013), aff'd on other grounds sub nom., *Seger v. Yorkshire Ins. Co., Ltd.*, 13-0673, 2016 WL 3382223 (Tex. June 17, 2016)); *see also State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex.1996).

6 *See Seger*, 2016 WL 3382223, at *4–15

7 *Id.* at *4.

8 *Id.* at *8–9.

9 *Id.* at *10–12.

10 *Id.* at *11 (citing *Urrutia v. Decker*, 992 S.W.2d 440, 443 (Tex. 1999)).

11 *Id.* at *13.

12 *Id.* at *14–15.

13 *Id.* at *15.

14 *Hartford Cas. Ins. Co. v. DP Eng'g, L.L.C.*, 827 F.3d 423, 425–26 (5th Cir. 2016).

15 *Id.* at 426.

16 *Id.*

17 *Id.* at 427.

18 *Id.* at 427–28 (citing various cases, including *Atlantic Lloyd's Ins. Co. of Tex. v. Susman Godfrey, L.L.P.*, 982 S.W.2d 472, 476–77 (Tex. App.—Dallas 1998, pet. denied), *Utica Lloyd's of Tex. v. Sitech Eng'g Corp.*, 38 S.W.3d 260, 262–64 (Tex. App.—Texarkana 2001, no pet.), and *Nat'l Cas. Co. v. W. World Ins. Co.*, 669 F.3d 608, 615 (5th Cir. 2012)).

19 *Id.* at 428.

20 *Id.* at 429.

21 *Id.* at 429–30.

22 *Id.* at 430 (citing *Farmers Tex. Cnty. Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 82 (Tex. 1997)).

23 *Id.*

24 *Id.* at 431.

25 *Crose v. Humana Ins. Co.*, 823 F.3d 344, 347 (5th Cir. 2016).

26 *Id.*

27 *Id.*

28 *Id.* at 348.

29 *Id.* at 348–49.

30 *Id.*

31 *Id.* at 349–50.

32 *Id.* at 350–51.

33 *Hamilton Props. v. Am. Ins. Co.*, 643 Fed. Appx. 437, 438 (5th Cir. 2016).

34 *Id.* at 438–39.

35 *Id.*

36 *Id.* at 440 (citing *Blanton v. Vesta Lloyds Ins. Co.*, 185 S.W.3d 607, 611 (Tex. App.—Dallas 2006, no pet.)).

37 *Id.*

38 *Id.* at 440–41.

39 *Id.* at 441–42.

40 *Id.* at 442.

41 *Quibodeaux et al. v. Nautilus Ins. Co.*, No. 15-40567, 2016 WL 3644641, at *1 (5th Cir. July 7, 2016).

42 *Id.* at *1–2.

43 *Id.* at *2.

44 *Id.* at *2–3.

45 *Id.* at *4 (citing *In re Slavonic Mut. Fire Ins. Ass'n*, 308 S.W.3d 556, 563 (Tex. App. 2010)).

46 *Id.*

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