

PROFESSIONAL LIABILITY CLAIMS AND COVERAGE ISSUES

**By: Michael McCoy, Partner
Fowler Rodriguez**

I. HISTORIAL REFERENCE

A. The Composition of Professional Liability Policies.

1. To insure professionals for the rendering of professional services, typically as defined in the policy per the specific profession.
2. Generally limited to “Wrongful Acts,” as usually defined in the policy.
3. Claims made.
4. Sometimes claims made and reported.
5. Retroactive dates.
6. Limits reduced by defense costs and expenses.
7. Various professional liability policies included:
 - a. lawyers;
 - b. doctors;
 - c. accountants;
 - d. engineers;
 - e. surveyors;
 - f. real estate brokers and agents;
 - g. insurance brokers and agents;
 - h. directors and officers;
 - i. architects;
 - j. other medical related professionals and entities.



INSURANCE AGREEMENT

The relevant portions of the Policy read as follows:

SECTION I – COVERAGE

1. Insuring Agreement

a. We will pay on behalf of the insured those sums in excess of the deductible that the insured becomes legally obligated to pay as damages because of “loss” to which this insurance applies. We will have the right and the duty to defend the insured against any suit seeking those damages even if the suit is groundless, false or fraudulent. We may, at our discretion, investigate any “wrongful act” and settle any “claim” that may result. But:

1. The amount we will pay for damages is limited as described in SECTION V – LIMITS OF INSURANCE; and

2. Our right and duty to defend end when we have used up the applicable limit of insurance in the payment of judgments or settlements.

No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under Supplementary Payments.

b. This insurance applies to “loss” only if:

1. The loss is caused by a “wrongful act” that takes place in the “coverage territory;
2. The “wrongful act” did not occur before the Retroactive Date shown in the Declarations or after the end of the policy period; and
3. A “claim for damages, with respect to the “loss”, is first made against any insured, in accordance with paragraph c. below, during the “policy period” or any Extended Reporting Period we provide under SECTION VII – EXTENDED REPORTING PERIOD.
4. The loss is caused by a “wrongful act” committed by the insured or a person for whom the insured is held legally liable in the performance of or failure to perform “professional service”.

...

2. Supplementary Payments

We will pay with respect to any “claim” we investigate or settle, or any suit against an insured we defend:

...

- c. All reasonable expenses incurred by the insured at our request to assist us in the investigation or defense of the “claim or suit, including actual loss of earnings up to \$250 a day because of time off from work attending trials, depositions, or other court appearances.



...

SECTION II – WHO IS AN INSURED

Each of the following is an insured to the extent set forth below:

1. The person or entity in the Declarations of this policy designated as the Named Insured;

...

3. Any of the Named Insured's or "predecessor firm's" past or present partners, officers, directors, stockholders or employees, but only while acting within the scope of their duties for the Named Insured or "predecessor firm";

...

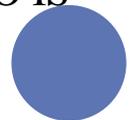
SECTION III – DEFINITIONS

1. "Claim" means:

- a. A written demand for monetary or non-monetary damages, or a demand for arbitration; or

- b. A civil proceeding commenced by the service of a complaint or similar proceeding; or

- c. Any other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with our consent against any insured as defined in SECTION II – WHO IS AN INSURED for a "wrongful act" to which this insurance applies.



2. “Claim expense” means:

a. reasonable and necessary fees (including attorneys and experts fees) and expenses incurred in the defense or appeal of a “claim”,

b. Other expenses resulting from the investigation, adjustment, and defense of a “claim” if incurred by us or by the insured with our consent,

c. Pre- and post-judgment interest paid on the part of judgments we pay within policy limits.

5. “Litigation expense” means that part of “claim expense” incurred during the defense of a “claim” which is in formal litigation. “Litigation expense” does not include salaries or expenses of our employees.

6. “Loss” means any “claim expense”, compensatory damages, settlement amounts, legal fees and costs awarded pursuant to judgments. “Loss” does not include civil or criminal fines or penalties imposed by law, punitive or exemplary damages, taxes or matters that are uninsurable pursuant to applicable law.

10. “Professional services” means insurance services performed for others, including via electronic means or methods: (1) as a property, casualty, surety, life, accident, health or other insurance agent, insurance broker, or insurance consultant, including managing general agent, program administrator, general agent, surplus lines broker, wholesale broker, and (2) premium financing, notary public services, claims handling or adjusting, risk management, and loss control services.

...

12. “Wrongful act” means any actual or alleged negligent act, error or omission to which this insurance applies.



B. Differences with Occurrence Based Policies.

1. Occurrence based claims determined by whether the incident happened/rose during the pendency of the policy, regardless of when reported; if the incident was outside of the policy period, then typically no coverage.
2. Claims made policies require both the claim to have been made and reported; however, if a retroactive date existed, and the incident took place after the retroactive date, but was made during the year of coverage, and was reported as a claim, then assuming the claim comports with the insuring terms and conditions, without the application of other exclusions, there would be coverage.



C.Older case law made clear the differences between occurrence based policies and claims made policies regarding the importance of such notice.

Members Mut. Ins. Co. v. Cutai, 476 S.W.2d 278

This Court again stated in Womack v. Allstate Ins. Co., 156 Tex. 467, 296 S.W.2d 233 (1956) that as a general rule, the failure of the insured to comply with the conditions of the policy requiring notice of accident and notice of claim of suit will relieve the company of liability to an injured third party. Womack held that there had been a waiver by the company in that case. [**6] There is no waiver here. The company here proceeded under a plainly-worded [*280] non-waiver agreement, and the validity or efficacy of the non-waiver agreement is not questioned here.

Our conclusion is, however, that on balance it is better policy for the contracts of insurance to be changed by the public body charged with their supervision, the State Board of Insurance, or by the Legislature, rather than for this Court to insert a provision that violations of conditions precedent will be excused if no harm results from their violation.



Hirsch v. Texas Lawyers' Ins. Exchange, 808 S.W.2d 561

The major distinction between the "occurrence" policy and the "claims made" policy constitutes the difference between the peril insured. In the "occurrence" policy, the peril insured is the "occurrence" itself. Once the "occurrence" takes place, coverage attaches even though the claim may not be made for some time thereafter. While in the "claims made" policy, it is the making of the claim which is the event and peril being insured and, subject to the policy language, regardless of when the occurrence took place. [Emphases added].

Insurance contracts are subject to careful scrutiny to avoid injury to the public. However, we must look to the type of contract bargained for. In *Gulf Insurance Company v. Dolan, Fertig and Curtis*, 433 So.2d 512 (Fla. 1983), the Supreme Court aptly states:

Claims-made policies . . . require that notification to the insurer be within a reasonable time . . . **claims-made policies require that notice be given during the policy period itself.** When an insured becomes aware of any event that could result in liability, then it must [**11] give notice to the insurer, and **that notice must be given "within a reasonable time" or "as soon as practicable" -- at all times, however, during the policy period.** With claims-made policies, the very act of giving an extension of reporting time after the expiration of the policy period . . . negates the inherent difference between the two contract types [referring to occurrence and claims-made policies].

Claims made or discovery policies are reporting policies. If the (claim is reported to the insurer during the policy period, then the carrier is legally obligated to pay; if the claim is not reported during the policy period, no liability attaches. If a court would allow an extension of reporting time after the end of the policy period . . . in effect rewrites the contract between the two parties. [Emphases added].

The policies, in the instant case, are unambiguous in stating that coverage is provided when claims are made and reported during the policy period.

Hernandez v. Gulf Group Lloyds, 875 S.W.2d 691

In the context of an underinsured motorist claim, there may be instances when an insured's settlement without the insurer's consent prevents the insurer from receiving the anticipated benefit from the insurance contract; specifically, the settlement may extinguish a valuable subrogation right. Cf. *Liberty Mut. Ins. Co. v. Cruz*, 1994 Tex. LEXIS 61 (Tex. 1994)(insured's failure to provide notice of suit prejudiced insurer as a matter of law). 3 In other instances, however, the insurer may not be deprived of the contract's expected benefit, because any extinguished subrogation right has no value. In the latter situation--where the insurer is not prejudiced by the settlement--the insured's breach is not material. We conclude, therefore, that an insurer who is not prejudiced by an insured's settlement may not deny coverage under an uninsured/underinsured motorist policy that contains a settlement-without-consent clause. 4

Because the stipulated facts establish as a matter of law that Gulf was not prejudiced by the Hernandezes' settlement with McCullough, Gulf may not escape liability by invoking the settlement-without-consent exclusion.



Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co., 174 F.3d 653

In conjunction with this basic insurance policy, Matador purchased from St. Paul an endorsement that provided a narrow exception to the absolute pollution exclusion. The endorsement stated that St. Paul would not apply the pollution exclusion in the event of a "covered pollution incident." The endorsement defined "covered pollution incident" as:

[*656] the discharge, dispersal, release, or escape of pollutants that:

- . Results from an event;
- . Begins and ends within 72 hours, and does not result [**3] from a well out of control; or results from a well out of control above the surface of the ground or waterbottom;
- . Is known to you or your operating partner within 7 days of its beginning; and
- . Is reported to the company within 30 days of its beginning.

St. Paul argued before the district court that it properly denied coverage to Matador because [**4] Matador failed to report the pollution incident within thirty days as required by the endorsement. The district court agreed and granted St. Paul summary judgment. Matador timely appealed.

The impact that untimely notice has on coverage depends on the type of insurance policy. For example, courts traditionally distinguish between two types of insurance policies: "occurrence" policies and "claims-made" policies. 2 In the case of an "occurrence" policy, any notice requirement is subsidiary to the event that triggers coverage. See *FDIC v. Booth*, 82 F.3d 670, 678 (5th Cir. 1996) ("In occurrence based policies, the notice requirement is generally included [**11] to aid the insurer in administration of its coverage of claims."); see also *Zuckerman v. National Union Fire Ins. Co.*, 100 N.J. 304, 324, 495 A.2d 395, 406 (N.J. 1985) (noting that "the requirement of notice in an occurrence policy is subsidiary to the event that invokes coverage"). Courts have not permitted insurance companies to deny coverage on

the basis of untimely notice under an "occurrence" policy unless the company shows actual prejudice from the delay. See *Hirsch v. Texas Lawyers' Ins. Exch.*, [*659] 808 S.W.2d 561, 562 (Tex. App.--El Paso 1991, writ denied) (noting that the prejudice-notice requirement applies to "occurrence" policies). In the case of a "claims-made" policy, however, notice itself constitutes the event that triggers coverage. See, e.g., *FDIC v. Mijalis*, 15 F.3d 1314, 1330 (5th Cir. 1994) (noting that "notice provisions are integral parts of claims made policies"); *McCullough v. Fidelity & Deposit Co.*, 2 F.3d 110, 112 (5th Cir. 1993) ("Notice, as provided in the policy, is required in a claims made policy to trigger coverage."). Courts strictly interpret notice provisions in a "claims-made" policy. See *Booth*, 82 F.3d at 678.

Courts interpret notice provisions in "claims-made" policies strictly because in these types of policies, unlike in "occurrence" policies, the insured and insurer specifically negotiate the terms of the notice provisions.

Hence, courts will not "rewrite policies to permit notice-prejudice to be applied to claims-made policies. . . . [because to do so] would . . . interfere with the public's right to contract." *Hirsch*, 808 S.W.2d at 565 (internal citations omitted).

Likewise, in this case, under the plain language of the endorsement, timely reporting of the claim constituted one of the events necessary to trigger coverage. We will respect the plain language of the limitation contained in the endorsement. Matador received what it bargained for under the endorsement, with premiums presumably reduced to reflect the limited coverage. Whether St. Paul suffered prejudice as a result of Matador's late notice is irrelevant. The district court properly enforced the insurance policy according to its terms.

Federal Ins. Co. v. COMPUSA, Inc., 319 F.3d 746

Federal issued the Policy to CompUSA, insuring it and its officers and directors against specified legal liabilities, for an initial term of two years, beginning December 16, 1998 and ending December 16, 2000. The Policy covered "claims made" during that two-year policy period, and contained a provision allowing CompUSA to extend the "reporting period" (but not the coverage period) for any claims made within one year following the effective date of termination of the Policy, but only as to claims based on acts committed during the policy term, i.e., prior to the effective date of termination of the Policy.

The Insureds shall, as a condition precedent to exercising their rights under this coverage section, give to [Federal] written notice as soon as practicable of any Claim made against any of them for a Wrongful Act (emphasis added).

We speculate that CompUSA's decision not to furnish notice to Federal when COC's claims were made, and instead to assume sole responsibility for the claims, was influenced, if not directly caused, by the fact that CompUSA, in full awareness of its impending acquisition and the impending early termination of the policy, was negotiating for the six-year reporting-period extension at the same time, and likely viewed the COC claims as a potential fly in the ointment. Some things are too much of a coincident to be a coincident.

6. Distinctions were not really made historically in the claims made area between claims made, and claims made and reported.

D. **Insurance Agency Issues with Respect to Notice of Claims.**

1. Insurance agents are typically dual insurance agents, meaning that such agents can bind both the insured and the insurer with respect to representations, though numerous exceptions exist.

2. Generally, a wholesale insurance agent does not owe duties to the client, excepting certain circumstances; *North American Shipbuilding v. So. Marine & Aviation Underwriting*, 930 S.W.2d 829 (Tex.App.—Houston [1st Dist.] 1999, no writ).

3. *Lexington Ins. Co. v. Buckingham Gate, Ltd.*, 993 S.W.2d 185 (Tex.App.—Corpus Christi 1999, no writ).

4. *Celtic Life Ins. Co. v. Coats*, 885 S.W.2d 96 (Tex. 1994), in which the Texas Supreme Court held in general that an individual who performs at least some of the acts listed in Section 4001.051 of the Texas Insurance Code, is an agent of the insurer; it is important to note that this was a life insurance policy, and only involved an agent of the direct insurer, as opposed to a wholesale broker, or surplus lines broker.

5. Retail agent typically not the agent of surplus lines broker/underwriter unless is admitted carrier, or agent is written into the policy as the agent for claim loss notices.

II. TYPICAL BATTLEGROUND PREVIOUSLY IN COVERAGE ISSUES UNDER PROFESSIONAL LIABILITY POLICIES

A. Misrepresentations in the Application.

1. Controlled by Chapter 705 of the Texas Insurance Code, specifically § 705.004.
2. Essentially a five-prong test for determining if a misrepresentation allows the insurer to invalidate a policy of insurance.
3. *Mayes v. Mass. Mutual Life Ins. Co.*, 608 S.W.2d 612 (Tex. 1980).

***Mayes v. Massachusetts Mut. Life Ins. Co.*, 608 S.W.2d 612**

Under these circumstances we hold that insured's failure to advise the insurer of the changes in his prior answers were misrepresentations. It is now settled law in this state that these five elements must be pled and proved before the insurer may avoid a policy because of the misrepresentation of the insured: (1) the making of the representation; (2) the falsity of the representation; (3) reliance thereon by the insurer; (4) the intent to deceive on the part of the insured in making same; and (5) the materiality of the representation.



4. Steep burden of proof. However, see *Legion Ins. Co. v. Texas Timber Group*, 2000 U.S. Dist. LEXIS 14488 (N.D. Tex. September 29, 2000).

5. Condition precedent and warranties. Traditionally, warranties which cause forfeiture, or policy coverage avoidance, have been disfavored under Texas law; *Gouverne v. Care Risk Retention Group*, 2008 U.S. Dist. LEXIS 38869 (S.D. Tex. May 13, 2008).

6. *Allied Bankers Life Ins. Co. v. De La Cerda*, 584 S.W.2d 529 (Tex.Civ.App.—Amarillo 1979, writ refused n.r.e.).

7. See however, *Riner v. Allstate Life Ins. Co.*, 131 F.3d 530 (5th Cir. 1997).

***Gouverne v. Care Risk Retention Group, Inc.*, 2008 U.S. Dist. LEXIS 38869**

Generally, provisions in insurance contracts that turn on the truth or falsity of answers in an insurance application are treated as representations because warranties which cause forfeiture are disfavored under Texas law. *Allied Bankers Life Ins. Co. v. De La Cerda*, 584 S.W.2d 529, 532 (Tex. Civ. App.--Amarillo 1979, writ ref 'd n.r.e.) .

However, a policy provision that expressly provides that coverage does not exist unless the applicant's statements are true operates as a warranty or condition precedent. *Riner v. Allstate Life Ins. Co.*, 131 F.3d 530, 536-37 (5th Cir. 1997).

B. Reliance on Policy Language.

1. Conditions precedent or warranties, as noted above.
2. **Prior wrongful acts.**
3. **Part of a continuing wrongful act or incident.**

SECTION I - PROFESSIONAL LIABILITY COVERAGE

1. Insuring Agreement

We will pay those sums that the insured becomes legally obligated to pay as “compensatory damages” as a result of a “wrongful act.” This insurance applies to injury only if a “claim” for damages to which no other insurance applies, because of the injury being first made against the insured and reported to us during the “policy period”. This insurance does not apply to injury caused by a “wrongful act” that takes place outside the “coverage territory” **or was committed before the Retroactive Date shown in the Declarations or after the “policy period.”**

- a. **A “claim” by a person or organization seeking damages will be deemed to have been made when notice of such “claim” is received and recorded by the insured or by us, which ever comes first;**

b. All “claims” arising out of the same “wrongful act” will be considered to have been made at the time the first “claim” is made; and

c. We will have the right and duty to select counsel and to defend any “suit” seeking damages. However, we will have no duty to defend the insured against any “suit” seeking damages for injury to which this insurance does not apply. But:

(1) The amount we will pay for damages is limited as described in SECTION IV-LIMITS OF INSURANCE;

(2) We may, at our discretion, investigate any “wrongful act” and settle any “claim” or “suit that may result; and

(3) Our right and duty to defend ends when we have used up the applicable limit of



5. “Compensatory damages” do not include damages imposed upon the insured as punitive or exemplary damages for wanton, willful, outrageous, malicious or reckless conduct for gross negligence.

...

12. “Wrongful act” means any act, error or omission in the furnishing of professional social services. It includes the furnishing of food, beverages, medications or appliances in connection with those services. All “wrongful acts” committed in the furnishing of professional social services to any one person will be considered one “wrongful act.” All interrelated “wrongful acts” of one or more insured will considered on “wrongful act”.

...



WRONGFUL ACTS DEFINITION AMENDMENT

This endorsement modifies insurance provided under the following:

PROFESSIONAL LIABILITY COVERAGE PART

Paragraph 12. of SECTION VI.-DEFINITIONS is deleted and replaced by the following:

12. “Wrongful act” means:

a. any act or omission in the furnishing of healthcare services to a patient or client including the furnishing of food, beverages, medications, medical treatment or appliances in connection with such services and the postmortem handling of human bodies.

b. All “wrongful acts” committed in the furnishing of services to any one patient or client will be considered one “wrongful act”. All interrelated “wrongful acts” of one or more insured will be considered on “wrongful act”.



4. Claim reported after the expiration of either the policy or even the extended reporting date.

II Insurance Policy

The Policy provides in relevant part the following:

SECTION I. COVERAGES

I. Insuring Agreements

A. Professional Liability Insurance

We will pay those sums in excess of the deductible amount specified in Item 4 in the Declarations which the “Insured” becomes legally obligated to pay as “Damages” as a result of any “Claim” first made against the “Insured” during the “Policy Period” and reported in writing to us as soon as practicable, but in no event later than thirty (30) days after the end of the “Policy Period” or any Extended Reporting Period (if applicable), caused by a “Medical Incident”; provided that such “Medical Incident” first takes place in the “Coverage Territory” and on or after the “Retroactive Date” specified in Item 6 in the Declarations.

SECTION II. EXCLUSIONS

A. Exclusions Applicable to BOTH Insuring Agreements A. and B.

We will not defend any “Claim” or pay any “Damages” based upon, arising out of, directly or indirectly relating to or in any way involving:

1. Any “Medical Incident”, “Event” or offense committed prior to the effective date of this Policy if:

(i) Such “Medical Incident”, “Event” or offense was the subject of a notice under any prior insurance policy or any prior or pending litigation; or

(ii) At the effective date of this Policy you knew or could have reasonably foreseen that such “Medical Incident”, “Event” or offense might reasonably be expected to be the basis of a “Claim”.

...



C. **Issues When Consecutive Policies Exist.**

1. Claim arguably is covered under one or both policies.
2. Impact on issues regarding deductibles, aggregates, etc.
3. Analysis if claim was not made and reported under first year policy, yet the “wrongful” act was known or should have been known at the time of application or inception of the second year policy.

REAL ESTATE ERRORS AND OMISSIONS INSURANCE POLICY

In consideration of payment and subject to the terms and conditions of this policy, we agree with you to provide insurance as stated in this policy.

SECTION I. INSURING AGREEMENTS

A. COVERAGE PROVISION

We will pay on your behalf, damages that you become legally obligated to pay because of claims made against you for wrongful acts arising out of the performance of professional services for others.

...

B. CLAIMS MADE PROVISION

This insurance applies to a wrongful act only if all of the following conditions are satisfied:

1. the wrongful act took place on or after the Retroactive Date;
2. prior to the inception date of this policy period no Insured had knowledge of such wrongful act and had no basis to reasonably anticipate a claim that would be made. For purposes of this provision, prior knowledge of a wrongful act includes, but is not limited to, any prior claim or possible claim or circumstance referenced in your application;
3. the claim arising out of the wrongful act is first made against any Insured during the policy period; and
4. the claim is reported in writing to us no later than 60 days after the end of the policy period or,



D. Loss or Incident Known or Should Have Been Known.

1. The “known” loss doctrine.

2. Failure to disclose “incidents” which could give rise to a claim, and whether that is sufficient to void coverage at a later date.

3. “Fortuitous” loss doctrine.

4. “Reasonably should have been known” or “reasonably could have been foreseen” standard.

5. Verbal or written loss or incident; important distinctions in policy forms. insurance in the payment of judgments or settlements.



insurance in the payment of judgments or settlements.

No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under SECTION II-“Claims” Expenses and Defense Costs.

2. Exclusions

This insurance does not apply to:

...

s. Any “claim”, “suit” or “wrongful act” that might result in a “claim” or “suit”, of which any insured had knowledge or could have reasonably foreseen, at the signing date of the application for this insurance.

...



SPECIFIED OPERATIONS ENDORSEMENT

It is agreed the insurance provided by this Policy does not apply to any Claim for liability arising out of any operations of the Insured other than those operations as specified and described below and in the application attached to this Policy:

Home Health – Private Homes

III. NEW BATTLEGROUNDS IN COVERAGE ISSUES UNDER PROFESSIONAL LIABILITY POLICIES

A. Consent to Settle Clause, Cooperation Clause, and Prejudice by Settlements to which Insurer Does Not Agree.

1. The consent clause had been used favorably by insurers to deny professional liability claims where the insured settled without consent of the insurer; *Dairyland Co. Mutual Ins. Co. v. Roman*, 498 S.W.2d 145 (Tex. 1973); *Ford v. State Farm Mutual Automobile Ins. Co.*, 550 S.W.2d 663 (Tex. 1977); *Guaranty Co. Mutual Ins. Co. v. Kline*, 845 S.W.2d 810 (Tex. 1992);

2. Denials previously based on by insurers' reliance on consent to settle clauses, cooperation clauses, or conditions precedent requiring consent by an insurer to a settlement for coverage to exist.

i. Immediately record the specifics of the “claim” and the date received; and

ii. Notify us in writing of the “claim” as soon as practicable.

c. You and any other involved insured must:

i. Immediately send us copies of any demands, notices, summonses, or legal papers received in connection with the “claim” or suit;

...

iii. Cooperate with us in the investigation, settlement, or defense of the “claim” or suit; and

...

d. No insured will, except at that insured’s own cost, voluntarily make a payment, assume any obligation, or incur any expense without our consent.



3. Notice of claim provisions handled similarly; *Members Mutual Ins. Co. v. Cutaia*, supra, in which Texas Supreme Court did not require insurer prejudice as to claim denial where late notice took place.
4. Notice of claim provisions for occurrence based policies changed, requiring prejudice, in Texas State Commission Board Order No. 23080.
5. Texas law regarding consent to settle clauses, and the requirement of prejudice, changed in *Hernandez v. Gulf Group Lloyds Ins.*, supra.
6. Attempts by insurer coverage counsel to distinguish the *Hernandez* decision requiring prejudice on the consent to settle provision if such constituted an actual policy requirement, as opposed to timely notice of a claim, was soundly rejected by Texas Supreme Court in *Lennar Corp. v. Markel American Ins. Co.*, 413 S.W.3d 750 (Tex. 2013) [referred to as *Lennar II*].

***Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d 750**

As noted above, Condition E of Markel's policy forbade Lennar, "except at [its] own cost, [from] voluntarily mak[ing] any payment, assuming] any obligation, or incurring] any expense. . . without [Markel's] consent". Though Markel did not consent to Lennar's settlements with homeowners, it concedes, as *Lennar I* held,²² that this provision does not excuse its liability under the policy unless it was prejudiced by the settlements. *Lennar I* relied on our decision in *Hernandez v. Gulf Group Lloyds*.²³

In this Court, Markel nevertheless asserts that it established prejudice as a matter of law. It argues in its brief:

When an insurer is not asked to adjust a claim, provide a defense, or be involved in negotiating [**15] a settlement, but is simply told it has to pay for a voluntary payment, [*756] the insurer has suffered prejudice as a matter of law. That prejudice is even more stark in this case, in which the insured actively solicited claims which might otherwise never have been brought and made payments which were not covered under the Policy.³² Under Hernandez, an insurer establishes prejudice from a settlement to which it did not agree by showing that the insured's unilateral settlement was a material breach of the policy — that is, that it significantly impaired the insurer's position. Markel's argument boils down to this — had Lennar stonewalled the homeowners, fewer repairs would have been made. On this record, that is a question of fact, not of law, which the jury resolved in Lennar's favor.

But Condition E's consent-to-settlement requirement also finds expression in the policy's Insuring Agreement, and Markel argues that it can insist on compliance with this separate provision without proving prejudice.



B. Claim Notices Today, Prejudice Required Even in Claims Made Policies?

1. PAJ Inc. v. Hanover Ins. Co., 243 S.W.3d 630 (Tex. 2008).

a. PAJ actually involved an occurrence based policy.

b. Notice prejudice rule had been adopted by the Fifth Circuit in Hanson Prod. Co. v. American Ins. Co., 108 F.3d 627 (5th Cir. 1997) and Ridglea Estate Condo. Assoc. v. Lexington Ins. Co., 415 F.3d 474 (5th Cir. 2005).

2. As defined by the Fifth Circuit in the above-referenced cases, appears to have been immaterial under the notice prejudice rule in an occurrence based policy whether such would be considered a material breach of an insurance contract provision,

or a condition precedent under the policy with respect to coverage itself.

3. PAJ established that the insurer would have to prove prejudice, which would establish a material breach of the policy condition or precedent to coverage, either way, and that a notice of claim provision stating, “as soon as practicable,” would generally not give rise to prejudice.



SECTION V-PROFESSIONAL LIABILITY CONDITIONS

...

2. Duties In The Event Of A “Wrongful Act,” “Claim” Or “Suit”

a. You must see to it that we are notified as soon as practicable of a “wrongful act” that may result in a “claim”. To the extent possible, notice must include:

- (1) How, when and where the “wrongful act” took place;
- (2) The names and addresses of any injured persons and witnesses; and



(3) The nature and location of any injury or damage arising out of the “wrongful act.”

Notice to us of a “wrongful act” is notice of “claim”.

b. If a “claim” is received by any insured, you must:

(1) Immediately record the specifics of the “claim” and the date received; and

(2) Notify us in writing as soon as practicable, but within the “policy period” or any applicable Extended Reporting Period.

c. You and any other involved insured must:

(1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with a “claim” or “suit”;

(2) Authorize us to obtain records and other information;

(3) Cooperate with us in the investigation, settlement or defense of the “claim” or “suit”; and



(4) Assist us, upon our request, in the enforcement of any right against any person or organization that may be liable to the insured because of injury or damage to which this insurance may also apply.

d. No insureds will, except at their own cost, voluntarily make a payment, assume any obligation, or incur any expense without our consent.

...

arises from a series of a related Professional Health Care Services, such Professional Liability Incident will be deemed to have happened at the time of the first act, error or omission in respect of which the Insured may be legally obligated to pay Damages.

25. Professional Health Care Services means services in the treatment or care of any person by an Insured in the practice of the Named Insured's profession as stated in the Declarations, including but not limited to:

A. the furnishing of medical, surgical, dental, nursing or other health care services; therapy services; furnishing or dispensing of drugs, blood products, or medical, surgical, dental or psychiatric supplies, equipment or appliances in connection with such services; the providing of counseling or other social services in connection with such care;



II. Insurance Policies

The Policies provide in relevant the part the following:

I. INSURING AGREEMENTS

1. COVERAGE

A. Coverage 1-Professional Liability

Subject to the Each Claim Professional Liability Limit of this Policy as specified in the Declarations, The Underwriters agree to pay those sums in excess of the deductible specified in the Declarations that an Insured becomes legally obligated to pay as Damages as a result of any Claim which is both first made against the Insured during the Policy Period (or any applicable extended reporting period) and reported to The Underwriters as soon as practicable (but not more than 30 days after the expiration of the Policy Period or after the expiration of



any applicable extended reporting period) and which result from a Professional Liability Incident to which this Policy applies. This Policy only applies to Professional Liability Incidents arising from Professional Health Care Services which were rendered on or after the retroactive date specified in the Declarations and prior to the expiration of the Policy Period.

B. Coverage 2-General Liability

Subject to the Each Claim General Liability Limit of this Policy as specified in the Declarations, The Underwriters agree to pay those sums in excess of the deductible specified in the Declarations that an Insured becomes legally obligated to pay as Damages as a result of any Claim which is both first made against the Insured during the Policy Period (or any applicable extended reporting period) and reported to The Underwriters as soon as practicable (but not more than 30 days after the expiration of the Policy Period or after the expiration of any applicable extended reporting period) and which result from a General Liability Incident to which this Policy applies. This Policy only applies to General Liability Incidents which occur on or after the retroactive date specified in the Declarations and prior to the expiration of the Policy Period.



In the event of a claim, you must do the following:

1. You must give prompt written notice to us, but in no event later than 60 days after the end of the policy period or, during an Extended Claims Reporting Period, if applicable, subject to Section VI. Such written notice will include every demand, notice, summons or any other applicable information received by you or your representative.

...

B. Reporting Possible Claims

If during the policy period or any applicable Extended Claims Reporting Period, you first become aware of a possible claim arising from a specific wrongful act in performing professional services for which coverage may be provided, such potential claim must be reported to us as soon as practicable during the policy period but no later than 60 days after the end of the policy period, or if applicable, during any Extended Claims Reporting, subject to Section VI. The notice of the potential claim must include the following:



In addition, the timely notice provision was not an essential part of the bargained-for exchange under PAJ's occurrence-based policy. The Fifth Circuit, applying Texas insurance law, aptly describes the critical distinction between "occurrence" policies and "claims-made" policies as follows:

In the case of an "occurrence" policy, any notice requirement is subsidiary to the event that triggers coverage. Courts have not permitted insurance companies to deny coverage on the basis of untimely notice under an "occurrence" policy unless the company shows actual prejudice from the delay. *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653, 658 (5th Cir. 1999)

We hold that an insured's failure to timely notify its insurer of a claim or suit does not defeat coverage if the insurer was [*637] not prejudiced by the delay.



C. Evolution of Prodigy and Financial Industries/XL Specialty.

1. Prodigy Communications Corp. v. Agric. Excess; Surplus Ins. Co., 288 S.W.3d 374 (Tex. 2009), involved a claims made policy, where the insured was required to give written notice of the claim to the insurer as soon as practicable.

2. There was a temporal provision as well, namely requiring claim notice no later than 90 days.

3. Admission by the insurer that the claim was reported within 90 days, but contention not, “as soon as practicable.”

4. Texas Supreme Court in Prodigy noted the distinction between “as soon as practicable” and “in no event later than 90 days” requirement as to its decision that the claim could not be denied under the facts.



Prodigy Communs. Corp. v. Agric. Excess & Surplus Ins. Co., 288 S.W.3d 374

Today, we decide whether PAJ's notice-prejudice rule applies to a claims-made policy when the notice provision requires that the insured, "as a condition precedent" to its rights under the policy, give notice of a claim to its insurer "as soon as practicable . . . , but in no event later than ninety (90) days after the expiration of the Policy Period or Discovery Period." The parties dispute whether notice of the claim was given "as soon as practicable" [**3] but agree that the insured gave notice within the ninety-day cutoff period. The insurer also admits that it was not prejudiced by the delayed notice.

For the reasons explained below, we conclude that "notice as soon as practicable" was not an essential part of the bargained-for exchange under the claims-made policy at issue here. Following PAJ, we hold that, in the absence of prejudice to the insurer, the insured's alleged failure to comply with the provision does not defeat coverage.

We [**9] must decide whether, under a claims-made policy, an insurer can deny coverage based on its insured's alleged failure to comply with a policy provision requiring that notice of a claim be given "as soon as practicable," when (1) notice of the claim was provided before the reporting deadline specified in the policy; and (2) the insurer was not prejudiced by the delay.

First, unlike the PAJ policy, this one states unambiguously that the insured's duty to give "notice, in writing, as soon as practicable" is a "condition precedent" to coverage. Importantly however, our holding in PAJ did not rest on the distinction between conditions and covenants.

In PAJ, we recognized a "critical distinction" between the role of notice in claims-made policies and the role of notice in occurrence policies and concluded that timely notice was not an essential part of the bargained-for exchange in PAJ's occurrence-based policy. 243 S.W.3d at 636. In reaching this conclusion, we were persuaded by the Fifth Circuit's explanation that "[i]n the case of an "occurrence" policy, any notice requirement [**12] is subsidiary to the event that triggers coverage." Id. (quoting *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653, 658 (5th Cir. 1999)).

In a claims-made policy, the requirement that notice be given to the insurer "as soon as practicable" serves to "maximiz[e] the insurer's opportunity to investigate, set reserves, and control or participate in negotiations with the third party asserting the claim against the insured." By contrast, the requirement that the claim be made during the policy period "is directed to the temporal boundaries of the policy's basic coverage terms [This type [**18] of notice] is not simply part of the insured's duty to cooperate, but defines the limits of the insurer's obligation, and if there is no timely notice, there is no coverage." Similarly, a notice provision requiring that a claim be reported to the insurer during the policy period or within a specific number of days thereafter "define[s] the scope of coverage by providing a certain date after which an insurer knows it is no longer liable under the policy."



The role of notice in claims-made policies has been described as follows:

Claims made or discovery policies are essentially reporting policies. If the [*381] claim is reported to the insurer during the policy period, then the carrier is legally obligated to pay; if the claim is not reported during the policy period, no liability attaches. Claims made policies require notification to the insurer to be within a reasonable time. Critically, however, claims made policies require that that notice be given during the policy period itself.

In a claims-made policy, when an insured gives notice of a claim within the policy period or other specified reporting [**24] period, the insurer must show that the insured's noncompliance with the policy's "as soon as practicable" notice provision prejudiced the insurer before it may deny coverage.

Accordingly, we conclude that Prodigy's obligation to provide AESIC with notice of [**25] a claim "as soon as practicable" was not a material part of the bargained-for exchange under this claims-made policy. See Hernandez, 875 S. W.2d at 693.

In a claims-made policy, when an insured notifies its insurer of a claim within the policy term or other reporting period that the policy specifies, the insured's failure to provide notice "as soon as practicable" will not defeat coverage in the [*383] absence of prejudice to the insurer.



5. **Financial Indus. Corp. v. XL Specialty Ins. Co., 285 S.W.3d 877 (Tex. 2009)** was a claims made policy that contained a condition precedent to coverage that the insured give the insurer written notice of any claim “as soon as practicable.”

6. No temporal deadline.

7. **Was a claims made policy, but not a “claims made and reported policy.”**

8. Texas Supreme Court in XL Specialty required a showing of prejudice by the insurer to allow denial of coverage, regardless of the “claims made” nature of the policy, where notice was indeed given within the policy period.

Fin. Indus. Corp. v. XL Specialty Ins. Co., 285 S.W.3d 877

This case comes before us on a certified question from the United States Court of Appeals for the Fifth Circuit.

XL's claims-made policy differs slightly from the Prodigy policy in that XL's policy requires only that notice of a claim be given "as soon as practicable" and does not contain a clear-cut reporting deadline. See *id.* at 379 n.7 (discussing difference between standard "claims-made" and "claims-made-and-reported" policies).



For the reasons stated above and explained more fully in *Prodigy Communications Corp. v. Agricultural Excess & Surplus Insurance Co.*, 288 S.W.3d 374, we answer the certified question in the affirmative and hold that an insurer must show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured's breach of the policy's prompt-notice provision, but the notice is given within the policy's coverage period.

D. **Claims Made and Reported Policies; Distinction?**

1. Argument can be made that even under PAJ, *Prodigy*, and *XL Specialty*, prejudice is not required for “claims made and reported” policy if there is a temporal requirement with respect to the giving of notice, and it has not been met.



2. However, see concurrence in Lennar II, essentially stating that despite a “bright line” distinction between a condition precedent and insuring agreement language requiring consent to settle, that all insurance policies should be subject to a prejudice requirement as to notice provisions, consent provisions, cooperation clauses, and any other portion of the policy, regardless of the type of policy.



Similarly, as in this case, we have repeatedly inserted into insurance contracts a requirement that insurers must suffer harm or prejudice before they can deny coverage based on certain provisions, even though the policies' unambiguous language would have permitted the insurers to deny coverage without showing prejudice.

The Court essentially holds that it does not matter where in the policy a settlement-without-consent provision is located, and it does not matter whether it is expressed as a condition precedent, a covenant, an exclusion to coverage, or a definition of the scope of coverage.

I would instead expressly hold that, as a matter of public policy, a prompt-notice, prompt-service, or settlement-without-consent provision will negate coverage only if the lack of prompt notice, prompt service, or consent causes harm or prejudice to the insurer.

E. How Far Will the Courts Go?

1. Argument can be made that a prejudice requirement extends to a claims made policy where notice is even given outside of the policy period, at least where the lawsuit has not been settled and/or mediated, reached trial, or had important deadlines terminated, before notice is given; in other words, there will be an argument that prejudice must be shown in this situation, and it does not exist; thus, coverage would exist.



2. See *Eastex Medical Center Regional Healthcare System v. Lexington Ins. Co.*, 575 F.3d 520 (5th Cir. 2009).

a. Lexington had denied the claim because of the insured's alleged failure to comply with the notice provisions; Lexington received no formal "notice" of the claim.

b. However, Lexington was arguably aware of the claim because of a "loss run."

c. The Court found that providing notice of the claim and notice of the lawsuit were separate and distinct obligations of the insured under the policy.

d. The Court found that Prodigy and XL Specialty would not allow the insured to fail to satisfy a notice requirement as to the lawsuit itself.

e. Still, since notice of the underlying claim had been timely given per the temporal boundaries of the policy, then notice of the suit, even if provided outside of the policy period, would be subject to a prejudice showing.



East Texas Medical Center v. Lexington Ins. Co., 575 F.3d 520

At the end of the policy period, the loss run remained the only notice given to Lexington.

In January 2004, very soon after the depositions but about seven months after both the lawsuit was filed and the policy period expired, the Medical Center first gave written notice of the Cornelius lawsuit to Lexington.

It asserted that there was insufficient evidence to support the jury findings on any of the claims. The district court granted the motion, rendering judgment in favor of Lexington and against the Medical Center on all claims.

The Medical Center's interpretation of the use of the word "or" is unreasonable.

We cite *Cutaia* not for its discussion of prejudice, which has been superceded by subsequent developments in Texas insurance law. Rather, the case illustrates that requiring notice of the filing of suit even when an insurer has actual notice of the underlying incident is by no means an unprecedented or inexplicable requirement in an insurance contract.



- f. See *Evanston Ins. Co. v. Keeway America, LLC.*, 210 U.S. Dist. LEXIS 66072 (N.D. Tex., June 29, 2010).
- g. The subject policy was only claims made, and not claims made and reported.
- h. Thus, it was considered permissible for the insured to report claims to Evanston even after the policy period had expired.

The Court indicated that if the subject policy had been a claims made and reported policy, Evanston would not need to show prejudice from the failure of the insured to provide notice within a specified and temporal time period.



F. Consecutive Insurance Policies in the Claims Made and Reported Area.

1. Next coverage battle in the professional liability insurance arena.
2. What if claim is made under one policy, but not reported until the following policy?
 - a. Assuming a temporal notice requirement under the first year policy, arguably no coverage for failure to report at all during the policy period.
 - b. However, second year policy would involve a claim being reported that actually took place before the inception of the policy coverage, and was known by the insured before the inception of the policy coverage.
3. Quandary as to coverage.
4. More confusing: what if consecutive policy years involve different insurers?
 - a. First year insurer will argue claim was not timely reported within the policy period, or within the temporal deadline, so no coverage.
 - b. However, second year insurer will argue that it was not a claim “made” under its policy, but was “known” to the insured at the time of policy inception, so no coverage.

IV. CONCLUSION

A. Foreseeable Next Battleground in Coverage Issues Under Professional Liability Policies.

1. Probable tightening of coverage defenses with respect to claims made, and claims made and reported policies.
2. Probable extension of prejudice requirement to conditions precedent, part of the insuring agreement, a definition that restricts coverage, an exclusion, or an endorsement that restricts coverage.
3. Expected additional “push back” from policyholder counsel over insured’s ability to choose counsel where any remotely potential coverage issues are raised in reservation of rights, despite current case law.
4. Possible tightening of policy language, including definitions and endorsements, to allow certain coverage defenses to continue to be raised.

.



B. Emerging Trends.

1. Despite “soft” market, possible increase in deductibles and self-insured retention programs.
2. Despite “soft” market, additional scrutiny as to underwriting.
3. Continued expansion into “new programs” as to “new professions.”

C. Finality.

1. May continue to be lacking, causing potential struggle between underwriters, agents and brokers, claims departments, and policyholders

