

**INSURANCE COVERAGE ISSUES IMPACTING
PERSONAL INJURY LITIGATION**

by

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This paper expresses the opinions of the authors and does not necessarily reflect the views of
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INSURANCE COVERAGE ISSUES IMPACTING PERSONAL INJURY LITIGATION

I. INTRODUCTION

Traditionally, trial lawyers involved in the prosecution and defense of personal injury and death cases have an immediate goal in mind – to obtain a judgment in favor of their respective client. The partners and associates involved in the personal injury defense practice in our firm focus on this goal and pursue it doggedly through discovery battles and dispositive motions, as do their opposing counsel. Historically, it has been the exception, rather than the rule, when insurance coverage for the alleged wrong is considered as a substantive issue in personal injury litigation. More recently, both sides of the bar have become more aware of coverage issues impacting the prosecution and defense of personal injury actions and the effect that insurance coverage may have on the strategic decisions made by counsel on both sides. The purpose of this paper is to provide an overview of these coverage issues.

As with most presentations to gatherings of both sides of the bar, the risks inherent in this paper are that some of the topics may be of keen interest to some attendees and of no interest to others. The attempt of the authors is to give a broad perspective which will provide a roadmap to those who wish to steer clear of impediments to coverage and/or defense or wish to get directly to the heart of a coverage issue for strategic purposes. To that end, this paper provides an overview of the following issues related to coverage in the context of personal injury claims:

- the *Stowers* doctrine
- the insurer's ability to recoup defense and indemnity costs for uncovered claims
- defense counsel's role when the insurer has issued a qualification of coverage
- coverage for personal injury claims arising from toxic torts, mold, and pollution exposure
- various trigger of coverage theories
- issues related to what constitutes an "occurrence" within the meaning of CGL policies

II. THE STATUS OF THE *STOWERS* DOCTRINE IN TEXAS TODAY

Historically, Texas law imposed only one tort duty upon liability insurers in the context of third-party insurance claims. The *Stowers* doctrine imposes a

negligence standard upon insurers when considering settlement demands from third-party claimants upon the insured. *Stowers* demands have been used frequently by plaintiff's counsel over the past two decades to drive a wedge between the insurer, the insured, and defense counsel. Counsel must therefore be familiar with the evolution and current application of the *Stowers* doctrine.

A. The Creation of the *Stowers* Doctrine

In *G.A. Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved), the commission of appeals was faced with an issue of first impression in Texas: whether the insurer owes a duty to its insured to limit the insured's exposure to judgments in excess of policy limits and settle a third party claim if the demand is reasonable and within policy limits.

The *Stowers* case involved a relatively simple auto accident in which an employee of the Stowers Furniture Company, driving a company van, collided with a vehicle on the shoulder of the road. The injured plaintiff filed suit against the company, alleging damages of \$20,000. Stowers' insurer, American Indemnity Company, provided a defense and retained counsel for Stowers, pursuant to the terms of its insurance contract. The limits of the auto policy were \$5,000. During the litigation, the plaintiff offered to settle the case for \$4,000, but the carrier never offered more than \$2,500. Following a jury trial, judgment was entered for \$12,000 plus costs. After an unsuccessful appeal of the underlying case, Stowers satisfied the entire judgment and then brought suit against its insurer.

In the subsequent jury trial, the insurer was found negligent for not settling the case. The commission reviewed the underlying insurance policy involved and noted that the contract gave the insurer the right to control all aspects of the litigation, including settlement negotiations. Consequently, the court held that when an insurer dictates the course of the litigation in which its insured is involved, all actions taken by the insurer on behalf of the insured must be reasonable. The court therefore created a common law duty for all insurers to act "with that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business." *Id.* at 547.

The commission held that, from the standpoint of the insured, if an ordinarily prudent person would have settled the case prior to trial, then by failing to settle the insurer did not act in a prudent manner and is responsible for all damages incurred by its insured as a result of the insurer's failure to settle.

B. The Evolution of the *Stowers* Doctrine

In the early eighties, Texas courts repeatedly applied the *Stowers* doctrine as limited solely to the insurer's obligation to enter into reasonable settlement negotiations and accept reasonable settlement offers in order to protect its insured from an excess judgment. See *Allstate Ins. Co. v. Kelly*, 680 S.W.2d 595, 598 (Tex.App.—Tyler 1984, writ ref'd n.r.e.); *Rosell v. Farmers Texas County Mut. Ins. Co.*, 642 S.W.2d 278, 279-80 (Tex.App.—Texarkana 1982, no writ). In 1987, however, the Texas Supreme Court seemingly supplemented the *Stowers* doctrine by expanding the duty of the insurer to encompass *all* phases of the litigation. In *Ranger County Mut. Ins. Co. v. Guin*, 723 S.W.2d 656 (Tex. 1987), the court noted that the *Stowers* doctrine was based upon an agency relationship between the insurer and the insured, and therefore the insurer's duty to its insured should cover all activities carried on by the underwriters pursuant to the insurance contract. The court thereby impliedly imposed a duty of good faith and fair dealing upon the carrier not only with respect to settlement of claims, but also with respect to the investigation, trial preparation, and the actual trial phases of the case. *Id.* at 659-60.

Taking *Stowers* where no court had gone before, the *Guin* court also impliedly condoned a jury issue which seemed to place the burden on the insurer to make a settlement offer and begin settlement negotiations, even if no demand within limits had been made. The Texas Supreme Court, in *State Farm Mut. Auto. Ins. v. Traver*, 980 S.W.2d 625 (Tex. 1998), now appears to have backed off from its position in *Guin*, stating that its broad language pertaining to an insurer's responsibilities for defense counsel was *dicta*.

In the late 1980's and early 1990's, however, *Stowers* was a common component in any case in which damages could approach policy limits. Many lawyers automatically issued pro forma *Stowers* demand letters offering to settle within policy limits as a means of generating even more pressure upon the insured, insurer, and defense counsel, and as an attempt to drive a wedge between these parties.

C. A Return to Normalcy in the 1990's

Following the public's "approval" of tort reform legislation and the election of a new Texas Supreme Court, the expansion of remedies under the *Stowers* doctrine ceased. While many may think the remedy originally created in 1929 no longer exists, in recent years the Texas Supreme Court has reaffirmed the basic principles of *Stowers* and strictly interpreted the procedures necessary to prove such a case.

American Physicians Ins. Exchange v. Garcia, 876 S.W.2d 842 (Tex. 1994), is the landmark decision with respect to the procedural requirements of and elements necessary to prove a *Stowers* case. The court clarified and expressly stated the three elements of the test for successfully proving a *Stowers* claim:

Generally, a *Stowers* settlement demand must propose to release the insured fully in exchange for a stated sum but may substitute 'the policy limits' for a sum certain. The *Stowers* duty is not activated by a settlement demand unless three prerequisites are met: (1) the claim against the insured is within the scope of the insurance coverage; (2) the demand is within the policy limits; and (3) the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment.

Id. at 848-49. The court declined to extend claims for Article 21.21 violations (and thus the availability of treble damages) to the insured in the context of third-party claims.

The court then retreated from the *dicta* of *Guin*, which seemed to indicate the insurer had a duty to commence settlement negotiations. The court noted that although the insurer had always been involved in the case and was paying defense counsel's fees, the insurer had no obligation to begin settlement negotiations, particularly when no negligent act of the insured within the policy terms and conditions was alleged until the day of trial. "Considering the negotiating incentives for each party, we conclude that the public interest favoring early dispute resolution supports our decision not to shift the burden of making settlement offers under *Stowers* onto insurers." *Id.* at 851.

The court observed that since the various policies which the insured possessed could not be stacked, the plaintiffs' settlement demand of \$1.6 million was not within the limits of the policy and hence the second prong of the *Stowers* test was not met. The court therefore reversed and rendered in favor of the insurer, noting that the insurer could not be liable for breaching the *Stowers* duty when no demand was made within applicable policy limits.

D. The *Stowers* Doctrine and Bad Faith

In *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312 (Tex. 1994), the court considered the applicability of *Stowers* when multiple claimants seek recovery against

one policy. Initially, the court reaffirmed the three prong test enunciated in *Garcia* and reiterated that a *Stowers* claim is not a bad faith claim. The court noted that the insurer had an obligation to act reasonably and protect the insured from all claimants. The court went on to hold:

We conclude that when faced with a settlement demand arising out of multiple claims, and inadequate proceeds, an insurer may enter into a reasonable settlement with one of several claimants even though such settlement exhausts or diminishes the proceeds available to satisfy other claims.

Id. at 315. Unfortunately, the court did not provide any guidance regarding what an insurer should do when faced with multiple *Stowers* demands.

Subsequently, in *Maryland Insurance Company v. Head Indus. Coatings and Services, Inc.*, 938 S.W.2d 27 (Tex. 1996), the Texas Supreme Court again confirmed that an insurer had no common law duty of good faith and fair dealing when handling third-party claims against an insured. The court, relying upon *Soriano*, reasoned that “an insured is fully protected against his insurer’s refusal to defend or mishandling of a third-party claim by his contractual and *Stowers* rights. *Id.* at 28-29. Therefore, the court declined at that time to impose an additional tort duty upon insurers in a third-party context. Most Texas courts have consistently held that *Stowers* is the only extracontractual tort claim available to an insured against its insurer in the context of third-party claims. See, e.g., *Trinity Universal Ins. Co. v. Bleeker*, 944 S.W.2d 672 (Tex.App.—Corpus Christi 1997), *aff’d in part, rev’d in part on other grounds*, 966 S.W.2d 489 (Tex. 1998); *Dear v. Scottsdale Ins. Co.*, 947 S.W.2d 908, 914 (Tex.App.—Dallas 1997, writ denied).

In *Trinity Universal Insurance Company v. Bleeker*, 966 S.W.2d 489, the Texas Supreme Court reversed and rendered a take-nothing judgment in a *Stowers* case based upon the failure of the settlement demand to effectively propose a full release of the insured. Bleeker, the insured under a \$40,000 liability policy, had negligently caused an automobile accident in which fourteen members of the Villarreal and Ochoa families were seriously injured. The attorney for five of the injured demanded that the insurer pay the \$40,000 limit into the registry of the court for distribution to his five clients and the other nine claimants. The demand letter did not explicitly offer to release any potential claims against Bleeker and did not mention the hospital

liens. Trinity refused to pay the policy limits into the registry of the court without a full release for Bleeker. The underlying lawsuit against Bleeker proceeded to a trial court judgment of \$11.5 million.

In the subsequent *Stowers* litigation, the trial court awarded damages against Trinity under the Deceptive Trade Practices Act, the Insurance Code, the duty of good faith and fair dealing, and the *Stowers* doctrine. The court of appeals reversed and rendered judgment for Trinity on all claims except the \$13 million *Stowers* award and the DTPA claim.

The Supreme Court held that the plaintiffs take nothing against Trinity on the *Stowers* and DTPA claims. Relying upon *Soriano* and *Garcia*, the court noted as a preliminary matter that “a settlement demand must propose to release the insured fully in exchange for a stated sum of money.” Assuming without deciding that the plaintiff’s counsel’s letter was in fact a settlement offer, and further assuming that a *Stowers* demand may be made on behalf of only some of the total pool of potential plaintiffs, the court noted that the plaintiffs had not offered to release those claims fully. The court held that Trinity never had a *Stowers* duty to settle because the plaintiffs’ counsel never offered a full release even of his five clients’ claims. When a hospital lien exists, a release is not valid unless the hospital charges were paid in full or the hospital is a party to the release. *Id.* at 671-72.

On May 23, 2002, the Texas Supreme Court issued an opinion in *Rocor International, Inc. v. National Union Fire Insurance Co. of Pittsburgh, PA*, 75 S.W.3d 253 (Tex. 2002). The court held that an insured may assert a claim under Article 21.21 of the Texas Insurance Code for unfair settlement practices involving a third-party claim. To establish liability for the insurer’s failure to reasonably attempt settlement of a third-party claim against the insured, the insured must show that (1) the policy covers the claim; (2) the insured’s liability is “reasonably clear”; (3) the claimant has made a proper settlement demand within the policy limits; and (4) the demand’s terms are such that an ordinarily prudent insurer would accept it.

Rocor was a trucking company sued when one of its drivers, while intoxicated, swerved off of a road and killed two police officers. Rocor had a \$1 million self-insured retention, plus a \$1 million primary liability policy issued by Guaranty National and an \$8 million umbrella policy issued by National Union. Both the primary and excess liability policies placed the duty to defend on Rocor, and Rocor’s defense counsel opined that Rocor was exposed to significant liability. Although extensive settlement negotiations occurred, the only written

settlement demand occurred early in the case, when a \$10 million settlement demand was made. National Union, however, refused to make an offer, took charge of the settlement negotiations, and directed that all future settlement discussions be made with it. Subsequently, some of the claims were settled for \$1.8 million eighteen months after the accident. Fourteen months after that, the remainder of the claims settled for \$4.6 million. Rocor, arguing that all of the claims could have been settled for \$4.5 million, sued National Union for recovery of attorney's fees and costs that it incurred based upon National Union's alleged failure to promptly effectuate settlement.

The jury found that National Union's negligence proximately caused Rocor's damages and that National Union knowingly engaged in unfair or deceptive acts or practices in the business of insurance. The trial court granted a judgment notwithstanding the verdict, and the Court of Appeals was divided. National Union did not dispute coverage under the policy or that Rocor's liability was reasonably clear, but instead claimed that a proper settlement demand had not been made. Thus, the Texas Supreme Court reversed with instructions to render judgment for the insurer, as it agreed that a proper settlement demand had not been made.

In *Rocor*, the policy holder's claim against National Union to recover its defense costs was not based on a breach of the insurance contract, as the insurers had no duty to defend the insured. Thus, the claim was for tort damages for the alleged delay in settling the case once National Union assumed control of the settlement negotiations. The court held that the insurer was not exempt from liability for unfair claim settlement practices set forth in Article 21.21 of the Texas Insurance Code merely because it had no contractual duty to defend.

The significant aspect of the opinion, however, is that the court held that there was no principled basis upon which to draw a distinction between first-party and third-party claims when the insured has been directly injured as a result of its insurer's unfair insurance practices. Seemingly rejecting its earlier opinions without overruling them, the court approved of a statutory cause of action for unfair settlement practices within the context of third-party claims. Outlining the requirements of such a cause of action and recognizing that the Texas Insurance Code does not define when liability is "reasonably clear" for purposes of triggering the insurer's duty to settle, the court adopted the framework provided by *Stowers*. Thus, it appears that the elements of a *Stowers* claim and the elements of a claim under article 21.21 for unfair settlement practices are identical.

The *Rocor* court also confirmed its earlier holding in *Allstate Ins. Co. v. Watson*, 876 S.W.2d 145 (Tex. 1994), that a third-party claimant has no cause of action against a defendant's insurer for not settling a liability claim against its insured. Further, the *Rocor* court discussed its holding in *Vail v. Texas Farm Bureau Mutual Ins. Co.*, 754 S.W.2d 129 (Tex. 1988). In *Vail*, the court recognized that an insured could sue its insurer under Article 21.21 for not attempting in good faith to settle a claim promptly, fairly, and equitably after liability has become reasonably clear. Previously, the *Garcia* court had distinguished *Vail* on the grounds that it involved a first-party property claim. The *Rocor* court appeared to back away from this distinction, stating that the statements in *Garcia* about *Vail* did not indicate that the court intended to limit an insured's statutory claims against its own insurer to first-party claims. Unfortunately, rather than illuminating this somewhat convoluted area of Texas insurance law, the *Rocor* opinion fails to shed much light on the issue at all, as the *Rocor* court did not overrule the holdings of *Head* or *Garcia*. This confusion was rather succinctly described by Justice Nathan Hecht in his opinion concurring in the judgment only:

Plainly, *Garcia* limited *Vail's* applicability to first-party claims. This limitation is consistent with *Vail's* alternative holding that article 21.21 makes actionable a breach of the common-law duty of good faith and fair dealing. That duty covers only first-party claims.

The Court now dismisses these passages as no "indicat[ion] that we intended to limit an insured's statutory claims against its own insurer for unfair claim settlement practices to first-party insurance claims," but if they do not both plainly say that an insurer has no statutory duty to settle third-party claims against its insured, then what do they say? No answer. It would be better to simply overrule *Garcia* as wrong than to pretend as if its words mean nothing. The Court cannot hold the Legislature strictly to the language of statutes and parties to the language of contracts and then fudge on the language of its own opinions. I doubt the Court would indulge a court of appeals' opinion that said, well, yes, the Supreme Court did say such and so, but we don't think that was its intent. Yet the Court can hardly expect the lower courts to follow its opinions if it is so dismissive of them itself.

(footnotes omitted).

Until *Rocor*, the Texas Supreme Court had limited the application of Article 21.21 to first-party policies. Thus, the court appears to be recognizing a new cause of action for insureds. Of course, the real impact of the *Rocor* decision is that insureds may now sue their insurers for unfair settlement practices involving third-party claims and obtain treble damages permitted by Article 21.21.

E. Components of a Valid *Stowers* Demand

There are several lessons to be learned from the many recent cases applying the *Stowers* doctrine.

- When evaluating or formulating a *Stowers* demand, the first issue to address is whether the demand is formal. The *Rocor* court reiterated that a formal demand is not necessary but would certainly be the better course. At a minimum, the settlement's terms must be clear and undisputed.
- No court has ever stated that a verbal *Stowers* demand is invalid, but it is obviously prudent to make sure that all demands which contemplate a *Stowers* claim following the resolution of the plaintiff's case should be reduced to writing to ensure that all of the necessary elements can be proven in a simple, concise manner. Otherwise, counsel is left with attempting to prove that all the elements of a *Stowers* case have been met through the testimony of opposing counsel or a claims handler.
- In addition, if such demands are made verbally at a mediation, the mediator would likely be prohibited from testifying at any subsequent trial and a swearing match could ensue between counsel on key points such as whether an offer was unconditional, released all claims, or otherwise complied with the *Stowers* requirements.
- The *Stowers* demand therefore should be written, must offer to settle all claims unconditionally within policy limits or for a sum certain within remaining limits, and must note that acceptance of the offered amount or remaining limits will result in a full and final release of all claims against the insured, at least as to the offering plaintiff(s).
- Finally, in light of the Texas Supreme Court's language in *State Farm Lloyds Ins. Co. v. Maldonado*, 963 S.W.2d 38 (Tex. 1998), the insurer should be given a reasonable time within which to respond to the demand. While the courts have not specifically stated what is "reasonable", logic dictates that the greater the amount of time the

better the argument that sufficient time was given. Generally speaking, thirty days in which to respond to a *Stowers* demand letter would seem to be sufficient and would likely negate any argument by the insurer that a reasonable amount of time was not given to respond to the demand.

F. The *Stowers* Duty in the Context of Covered and Uncovered Claims Against the Insured

The United States Court of Appeals for the Fifth Circuit attempted to predict how the Texas Supreme Court would rule in regard to an insurer's duty to negotiate the settlement of a case involving both covered and uncovered and uninsured claims against the insured. In *St. Paul Fire and Marine Insurance v. Convalescent Services, Inc.*, 193 F.3d 340 (5th Cir. 1999), the insurance policy at issue specifically excluded coverage for punitive damages. The insured was sued for actual and punitive damages. Prior to trial plaintiff made a settlement demand for \$250,000, well within the limits of the St. Paul policy. St. Paul rejected the demand and made a counteroffer of \$35,000. The case was tried and the jury returned a verdict of \$380,000 in actual damages and \$850,000 in punitive damages. St. Paul paid the actual damage award against the insured but refused to pay the punitive damages award because of the exclusionary language in the policy. The insured ultimately assigned it rights to plaintiff's estate and filed suit against St. Paul, alleging that the insurer had negligently handled the investigation of the case and the negotiation of the settlement. St. Paul removed the case to federal court and filed a complaint seeking declaratory judgment that it had not violated its duties owed to the insured. The insured amended its pleadings to allege that St. Paul violated its *Stowers* obligation to the insured.

The insured conceded that St. Paul's policy did not cover punitive damages, however, the insured maintained that St. Paul's *Stowers* duty was triggered because the insurer had constructive knowledge that the insured would be willing to pay its share of uncovered damages to settle the case. Apparently, the insured felt that St. Paul should have been aware of the insured's willingness to contribute to the settlement because of the insured's contribution toward the settlement of a previous, unrelated suit that involved exposure to punitive damages.

In its opinion, the Fifth Circuit drew upon the Texas Supreme Court's analysis in *Garcia* and *Maldonado* and found that an insurer has no duty to take into consideration an insured's potential exposure to punitive damages during settlement negotiations concerning covered claims. Further, the Fifth Circuit held that St. Paul's alleged knowledge of the insured's willingness to

pay for settlement of the uncovered claims did not trigger the duty to settle under *Stowers*.

The question remains as to whether a plaintiff asserting completely independent causes of action for covered and uncovered claims or damages, or in mixed theories of recovery such as contort, could place an insurer in a *Stowers* situation by offering to completely release and discharge the insured for all covered claims and damages, reserving the plaintiff's uncovered causes of action against the insured. Arguably, the requirements of *Stowers* and *Garcia* would be met by making a reasonable demand to settle covered claims and providing a release for such claims. Certainly, there are many policy considerations which would be served by such a rule, such as the encouragement of settlements and streamlining the issue for litigation. On the other hand, many cases prior to *Convalescent Services* have used language indicating that the insured must be released fully. In light of the holding in *Convalescent Services*, this appears to be an untested and unsettled area of Texas insurance law.

III. INSURER'S ABILITY TO RECOUP DEFENSE AND INDEMNITY COSTS

In *Matagorda County, Texas v. Texas Assoc. of Counties County Gov. Risk Management Pool*, 975 S.W.2d 782 (Tex.App.—Corpus Christi 1998), *aff'd*, 52 S.W.3d 128 (Tex. 2000), the liability insurer for Matagorda County initiated a declaratory judgment action regarding its defense and coverage responsibilities for an underlying federal lawsuit brought against the county by prisoners complaining of jail conditions. In the underlying tort suit, the liability insurer provided the county a defense pursuant to a reservation of rights. While the declaratory judgment action was pending, the liability insurer advised the county that it had received, and intended to accept, a settlement offer of \$300,000. The insurer then advised the county that it intended to seek to recover the full settlement amount and underlying defense costs from the county in the event the insurer prevailed in its declaratory judgment action. After the settlement was funded, the insurer amended its declaratory judgment action to request reimbursement of the defense and settlement costs.

The trial court granted a partial summary judgment in favor of the insurer on the coverage point and entered a final judgment in favor of the insurer for the entire settlement costs as well as the attorneys' fees incurred in defending the underlying suit. Matagorda County argued on appeal that the insurer had no right of reimbursement for either the defense costs or the settlement costs since there was no mention of such a

right within the insurance policy. Noting the dearth of Texas authority on the issue, the appellate court stated:

[T]hose state and federal courts that have examined the issue have generally denied the right of an insurer to seek reimbursement of defense costs for uncovered claims unless the insurer's reservation of rights letter specifically notified the insured that reimbursement of defense costs would later be sought and thus created a quasi-contractual duty to reimburse.

Thus, the appellate court held that under Texas law, "[a]bsent specific notice to the insured that he may later be charged for these costs, the insurer has no right to reimbursement." *Id.* at 784-785. Since the reservation of rights letter directed to Matagorda County did not contain any suggestion that the insurer would attempt to recover for the costs of defense if coverage were determined not to exist, the insurer was not entitled to reimbursement of defense costs from the county. With respect to settlement cost, the court of appeals adhered to the general rule that a liability insurer is not entitled to reimbursement for the amount of a settlement paid to a claimant when the insured did not authorize the payment or agree to reimburse the insurer if the insurer prevailed on the coverage issue:

[A]bsent a specific agreement by the insured to be bound by the settlement and to allow reimbursement to the insurer if the coverage is later determined against the insured, the insurer has no right of subrogation against its own insured to recover the amount of the settlement.

Id. at 787. The Texas Supreme Court affirmed, noting that whether or not an insurer may seek reimbursement from its insured for settlement funds paid under a reservation of rights upon an adjudication of noncoverage was an issue of first impression for the court. The court commenced with an examination of the insurance policy and held that a unilateral reservation of rights letter could not create rights not contained in the insurance policy. 52 S.W.3d at 131. Although the policy at issue allowed the insurer to settle a case against its insured without the insured's consent, it was silent on the issue of recouping these settlement costs. Noting that it would have been simple for the insurer to add language regarding recoupment, the court held that the insurer could only seek to recoup the settlement costs if the insured agreed at the time of settlement.

The court showed great concern for the insured and the precarious position it would be placed in if an insurer was allowed to seek recoupment of settlement costs without the insured's agreement or without specific policy terms permitting recoupment. The insured would be forced to choose between rejecting a settlement within policy limits or accepting a possible financial obligation to pay an amount that may be beyond its means, at a time when the insured is at its most vulnerable. Of course, in circumstances where coverage is unclear, the court's holding places the insurer in a similar precarious position of either risking exposure to a *Stowers* claim or paying a settlement for which its policy may not provide coverage.

It is unlikely that a policy holder will "agree" with an insurer's reservation of rights, and thus it appears that an insurer's right to reimbursement for indemnity of uncovered claims is, at best, uncertain, unless insurers endeavor to include policy language expressly allowing recoupment of settlement costs.

With respect to defense costs, the insurer's ability to recoup these costs by unilaterally reserving the right does affect settlement negotiations, both with the third-party claimant and the insured. With respect to negotiations with third-party claimants, who often maintain that the "costs of defense" should be considered in assessing the value of a claim, an insurer who believes it can ultimately recoup these costs may be less affected by such an argument. On the other hand, the ability to recoup defense costs is dependent upon a subsequent declaratory judgment action on coverage issues, and due to the uncertainty as to the result of such a lawsuit, wise insurers and their insureds will proactively deal with the issue of defense costs, perhaps negotiating an agreement to share costs up front in light of each party's uncertain liability for the costs.

In December 2002, the First Court of Appeals reversed and remanded a summary judgment which applied the *Matagorda* opinion to an insurer's right to recoup defense costs from the proceeds of a judgment. In *St. Paul Fire & Marine Insurance Company v. Beirne, Maynard & Parsons, L.L.P.*, 2002 WL 31771102 (Tex.App. -Hous. [1st. Dist.] 2002) (not designated for publication), St. Paul attempted to recoup defense fees and costs that it expended in defending the law firm of Beirne, Maynard & Parsons from legal malpractice claims of one of the firm's clients.

In response to the malpractice claims, the firm filed a counterclaim against the client for unpaid attorneys' fees. Beirne, Maynard & Parsons ultimately prevailed at trial, defeating the malpractice claims and obtaining a judgment for unpaid attorneys' fees as well as attorneys'

fees expended in the defense and appeal of the malpractice claims. St. Paul made a demand, and ultimately filed suit, against the firm for reimbursement of defense fees and costs from the proceeds of the judgment. In response, Beirne, Maynard & Parsons maintained that St. Paul failed to provide the firm with timely and specific notice of the insurer's intent to seek reimbursement of fees and costs, and under *Matagorda*, St. Paul had waived its right of reimbursement.

The First Court of Appeals distinguished the *Matagorda* opinion based upon the grounds that the insurer in the *Matagorda* case ultimately denied coverage after settling the underlying claims and then subsequently sought reimbursement of defense fees and costs from the insured's own pocket. In the instant case, however, St. Paul never denied coverage to its insured and subsequently sought reimbursement from the judgment on the insured's counterclaim.

IV. INSURANCE DEFENSE COUNSEL'S DUTY UNDER A RESERVATION OF RIGHTS

A. Defense Counsel's Client is the Insured, Not the Insurer

The relationship between an insurer and defense counsel is a fundamental element of any case which is handled by an attorney retained by an insurance company to defend the interests of the insured. This relationship is somewhat counterintuitive and is fraught with inherent tension to the extent that defense counsel owe loyalties to the insured but are compensated by the insurer. In situations where there are no qualifications of coverage by the insured, the peculiar nature of this relationship usually does not create any difficulties for defense counsel, as the interests of the insured and the insurer generally would be aligned. When the insurance company appoints and compensates defense counsel on behalf of the insured while asserting a reservation of rights concerning the ultimate coverage of the claims against the insured, the lines of distinction become less clearly defined. In the current environment, it is not uncommon for claimant's counsel to capitalize on the tension created between an insured, its insurer, and defense counsel when prosecuting and settling personal injury claims (i.e., in the context of *Stowers*).

Generally, an insurer's reservation of rights should:

- Identify the insurer;
- Inform the insured of the conflict of interest;
- Inform the insured that the insurer will provide a defense under the reservation of rights; and

- Inform the insured that it may secure independent counsel.

Rhodes v. Chicago Ins., a Division of Interstate Nat'l, 719 F.2d 116 (5th Cir. 1983). Moreover, under Texas law an insured subject to a reservation of rights may reject defense counsel selected by the insurer, and the insurer remains liable for the reasonable fees and costs of independent counsel selected by the insured.

In Texas, judicial consideration of the conflict of interests faced by defense counsel begins with the Texas Supreme Court's decision in *Employers Casualty Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973). In *Tilley*, the court held that although defense counsel was compensated by the insurance company, counsel owed a duty of unqualified loyalty to the insured as if the counsel had been retained by the insured in the first instance. Further, the court found that the moment any conflict arises between the interests of the insurance company and the insured, defense counsel must immediately inform the insured of the conflict. The *Tilley* decision clearly prohibits defense counsel from simultaneously serving as coverage counsel for the insurer but fails to provide practical assistance in less obvious cases.

The court in *Tilley* opined that defense counsel must advise *both* the insured and the insurer of any coverage problems or conflicts. On the other hand, the disciplinary rules of professional conduct in many states, which set forth ethical considerations for lawyers, almost always *prevent* defense counsel from revealing confidential information to the disadvantage of the client without the client's consent. Furthermore, the disciplinary rules typically prohibit a lawyer from representing opposing parties to the same litigation. The most obvious pitfall for defense counsel in this precarious position is providing comments to the insurer on issues which may have a tangential impact on coverage, such as the date of the loss, the date of manifestation of the injury, the nature or cause of the loss, and/or damages. Moreover, the handling of a case can, in itself, create a conflict between the insured and the insurer if some theories of liability asserted by the claimant arguably fall within coverage while others are excluded. Finally, the existence of a cooperation clause in most insurance policies, which requires the insured to cooperate with the insurer in the investigation and defense of claims, further muddies the waters.

In most instances, where an insurer has issued a reservation of rights or has qualified coverage, the insurer will have its own coverage counsel to review the developments in the case and determine if they impact coverage. If defense counsel's reports are insufficient

or if defense counsel is required to provide further analysis, it is the role of the insurer or its own counsel to make such requests.

If an irreconcilable conflict arises during the pendency of a case, defense counsel may be forced to withdraw from the representation of the insured, which in and of itself raises the additional thorny issue of defense counsel's communication to the insurer of the reasons necessitating withdrawal. If the basis for withdrawal is a coverage conflict that has been discovered during the case, then many states' disciplinary rules could arguably prohibit defense counsel from informing the insurer of this conflict.

Although Texas jurisprudence has many unresolved issues concerning defense counsel's responsibilities under a reserving rights letter, other jurisdictions in the United States have identified clear guidelines applicable to defense counsel appointed by insurers under a reservation of rights to represent an insured. For example, in *San Diego Federal Credit Union v. Cumis Ins. Society, Inc.*, 162 Cal.App. 3d 358, 208 Cal. Rptr. 494, 498 (Cal. Ct. App. 1984), the California Court of Appeals held that:

- attorneys retained by an insurance company to defend an insured under a reservation of rights must fully explain to the insured and the insurer the implications of the defense counsel's appointment;
- if the insured does not consent to the appointment of defense counsel by the insurer under a reservation of rights, the insured can hire independent counsel and the insurer will be responsible for the reasonable costs incurred by the independent counsel in defending the insured; and
- the insurer cannot compel the insured to surrender control of the litigation.

The California legislature codified the *Cumis* decision in California Civil Code § 2860; thus, the *Cumis* opinion has been superceded. The California statute provides additional specific guidance regarding when a conflict arises, the extent of the insurer's obligation to pay fees of the independent counsel, and the extent of the independent counsel's obligation to the insurer. Although insurers and policyholders may differ on the effectiveness of the *Cumis* legislation, both sides must admit that it provides more structure and predictability to an otherwise "grey" area of practice. As evidenced by

Tilley and its progeny, there is a strong need in Texas for legislation similar to the California codification of the *Cumis* decision.

B. Insurer's Liability for Acts of Defense Counsel

In *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625 (Tex. 1998), the Texas Supreme Court held that an insurer is not vicariously liable for the malpractice of an independent counsel selected by the insurer to defend the insured. The court held that independent counsel appointed by an insurer owes unqualified loyalty to the insured and must at all times protect the interests of the insured if those interests would be compromised by the insurer's instructions.

The court's analysis focused on whether the insurer has the right to control the attorney. The court found that "[a] defense attorney, as an independent contractor, has discretion regarding the day-to-day details of conducting the defense, and is not subject to the [insurer's] control regarding those details." The end result of the *Traver* opinion is that an insurer remains liable for appointed defense counsel's unreasonable failure to settle a matter, but the liability does not extend to defense counsel's negligent investigation, defense, or trial of a lawsuit.

The *Traver* decision cites cases from other jurisdictions, such as Pennsylvania, California, Florida, New York, and North Carolina, which emphasize that defense counsel appointed by an insurer should be free from interference by the insurer. *Ingersoll-Rand Equip. Corp. v. Transportation Insurance Co.*, 963 F. Supp. 452, 454-55 (M.D. Pa. 1997); *Merritt v. Reserve Insurance Co.*, 34 Cal.App.3d 858 (Cal. Ct. App. 1973); *Aetna Cas. & Sur. Co. v. Protective Nat'l Insurance Co.*, 631 So.2d 305, 306-7 (Fla. Ct. App. 1993); *Feliberty v. Damon*, 72 N.Y.2d 112, 527 N.E.2d 261, 265 (N.Y. 1988); and *Brown v. Lumbermen's Mutual Cas. Co.*, 90 N.C.App. 464, 473, 369 S.E.2d 367, 372 (N.C. Ct. App. 1988). Strangely enough, the *Traver* decision has not been widely discussed or analyzed by Texas courts.

V. CONSIDERATIONS REGARDING COVERAGE OF PERSONAL INJURIES ARISING FROM POLLUTION INCIDENTS

A. Total or Absolute Pollution Exclusions Broadly Construed

Under current Texas law, insurers are generally in a strong position to exclude coverage for personal injuries arising from pollution incidents under the standard total or absolute pollution exclusion endorsement. Most CGL policies issued after 1986 contain absolute pollution exclusions which state that the insurance "does not apply

to . . . any "bodily injury" or "property damage" arising out of the actual or threatened discharge, dispersal, release or escape of pollutants." Pollutants are defined as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste materials."

The leading Texas opinion on the application of a standard pollution exclusion is *National Union Fire Insurance Co. v. CBI Industries, Inc.*, 907 S.W.2d 517 (Tex. 1995), where the court considered an absolute pollution exclusion and held the provision to be clear and susceptible of only one possible interpretation. *Id.* at 522. The court stated that "[t]his pollution exclusion is just what it purports to be -- absolute[.]" *Id.* Specifically, the court held that the pollution exclusion clause unequivocally denied coverage for damage resulting from pollutants, whatever the cause. The state and federal courts in Texas have followed the Texas Supreme Court's opinion in *National Union*. For instance, the Fifth Circuit, applying Texas law and guided by the *National Union* opinion, has held that a relatively small release of toxic gases during a refinery construction operation fit within a similar pollution exclusion in *Certain Underwriters at Lloyd's v. C.A. Turner Const.*, 112 F.3d 184 (5th Cir. 1997). The Fifth Circuit held that the language contained in the pollution exclusion clause was not ambiguous, as a plain reading of the clause dictated the conclusion that *all damage* caused by pollution, contamination, or seepage is excluded from coverage. *Id.*

B. Endorsements May Change Coverage of Pollution Claims from Occurrence-Based to Claims-Made

Bolstering the strong position enjoyed by insurers in the context of pollution claims, it appears that insurers may change the nature of the coverage afforded by their policies from occurrence-based to claims-made simply by appending a pollution buyback endorsement to the policy. Significant differences exist between claims-made policies and occurrence-based policies which can have a substantial impact on coverage of toxic torts and other pollution-based claims. A claims-made policy is one where the claim must be made against the insured within the requisite time period of coverage afforded by the policy; the date of the actual event causing the claim is irrelevant. On the other hand, an occurrence-based policy is one where the event giving rise to the claim must occur within the policy period regardless of when the damages actually arise. Obviously, in order to obtain coverage, it is crucial that an insured have a good understanding of the differences between these two

types of policies and be aware of the requirements for placing an insurer on notice of a claim or occurrence, as demonstrated by the recent opinion in *Matador Petroleum Corporation v. St. Paul Surplus Lines Insurance Company*, 174 F.3d 653 (5th Cir.1999).

In *Matador*, the United States Court of Appeals for the Fifth Circuit strictly construed a notice provision against a named insured, resulting in the exclusion of coverage for a pollution incident. The case involved an occurrence-based policy which contained a pollution endorsement which had stringent notice provisions that the insured had failed to meet. The *Matador* court recognized that the notice of incident requirement in the Pollution Liability/BuyBack Endorsement was characteristic of a claims-made type of coverage rather than occurrence-based coverage. *Id.* at 659-60. Still, the court construed the endorsement in favor of the insurer and concluded the insurer was correct in denying coverage. In its opinion, the court relied upon a long line of Texas cases which hold that notice clauses in claims-made policies must be strictly enforced. In these cases, the courts noted that the insured and the insurer specifically negotiate the terms of notice provisions contained in claims-made policies. In the case of *Matador*, the court emphasized that the insured and the insurer were both sophisticated commercial parties with comparable bargaining power. As such, the court held that the insured should be held to the benefit of the bargain struck - a specific claim provision in return for reduced premiums commensurate with the reduced coverage afforded. *Id.*

The *Matador* opinion was recently applied and extended in the context of additional insured claims by Judge Atlas in *Commercial Underwriters Insurance Co. v. Mobil Oil Corp. and Mobil Chemical Co., Inc.*; C.A. No. H-99-4155 (February 15, 2001). The case arose out of a release of hydrogen sulfide which occurred at a chemicals refinery. Several employees of a contractor who were working on the premises were allegedly exposed to hydrogen sulfide and brought personal injury lawsuits. Pursuant to the contract between the premises owner, Mobil, and the contractor, the contractor agreed to make Mobil an additional insured on its liability policy. Therefore, when Mobil was named in the personal injury lawsuit, it requested additional insured status under the contractor's policy. The insurer responded by offering an unqualified defense.

A week before mediation and over a year after it first received notice of the claims, the insurer denied coverage, maintaining that the claims fell outside the thirty-day notice provision contained in the Pollution Endorsement attached to the policy. The insurer then

filed a declaratory judgment action seeking a declaration that the personal injury claims were not covered. The court granted the insurer's motion for summary judgment on the issue, and the Fifth Circuit affirmed.

The court concluded that the notice clause contained in the Pollution Liability Endorsement was a condition precedent to Mobil as an additional insured and therefore barred coverage, as notice of the claims was not given within the 30-day window. It was undisputed that Mobil, as an additional insured, did not have knowledge of the notice clause wording and furthermore could not have obtained a copy of the policy wording because the policy had not been transmitted to the named insured until some three months after the accident. Finally, it was undisputed that Mobil had received a certificate of insurance naming it as an additional insured. The certificate indicated that the policy was occurrence-based and failed to mention the pollution endorsement or the stringent notice clause contained therein.

The courts' opinions in *Matador* and *Commercial Underwriters* indicate that although a policy is occurrence-based, an endorsement which alters the nature of the coverage to claims-made is permissible and will be enforced against named and additional insureds alike, regardless of whether they have actual knowledge of it. Therefore, the better practice obviously is to (1) request a copy of the policy as an additional insured, and (2) always put the insurer on notice of a pollution incident within 30 days, even if no claims have yet arisen from the incident or there does not appear to be any personal injuries.

C. Coverage Issues Involving Toxic Mold Claims

There has been an explosion of mold litigation throughout the United States, and particularly in Texas, in the last five years. Although a significant amount of the claims involve homeowner's policies and property damage, which exceed the scope of this conference, there has also been an increase in mold claims involving personal injury against CGL policies. These claims can arise in the context of commercial or residential construction and are generally aimed at the architects and/or contractors involved in such construction projects, although some cases have dealt with claims of building occupants against the property owner. Because the breadth of this topic is very large, this overview will deal with the significant coverage issues impacting toxic mold claims involving CGL policies.

CGL policies often use a standard form wording that has been drafted by the Insurance Services Office ("ISO"); however, some issuing companies revise the wording or append amendatory language which can

significantly alter the coverage of the policy. For that reason, each policy should be reviewed in its entirety to determine whether the analysis and issues set forth herein are applicable. Most CGL policies state "[w]e will pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which this insurance applies." Most policies go on to provide that coverage applies to "bodily injury" only if:

1. It is caused by an "occurrence" as defined in the policy;
2. The occurrence takes place in the "coverage territory"; and
3. The bodily injury occurs during the policy period.

As set forth in Section VII of this paper, the term "occurrence" has been given a varied interpretation by Texas courts and federal courts interpreting Texas law. Because the vast majority of bodily injury mold claims involve construction or design issues, a coverage analysis must consider court opinions which involve construction defect issues. "Occurrence" has been generally defined, in the construction claim context, as damage to property other than the actual work performed by the company performing the construction. See Section VII of this paper for a complete analysis. This rather restrictive definition is based upon the rationale that a claimant/property owner has a breach of contract claim against a contractor that did not discharge its duties under a construction contract and that CGL policies were not intended to provide coverage for breach of contract issues. See *Federated Mutual Insurance Company v. Grapevine Excavation, Inc.*, 197 F.3d 730 (5th Cir.(Tex.) 1999); *Gar-Tex Construction Company v. Employers Casualty Company*, 771 S.W. 2d 639, 641 (Tex.App.--Dallas 1989, writ denied).

An important distinction in reviewing occurrence opinions is that the majority of those cases involved claims of property damage resulting from faulty construction. In prosecuting or defending a case for personal injuries resulting from toxic mold exposure, which in turn was caused by faulty workmanship, this distinction could be significant. Personal injury resulting from toxic mold exposure was clearly not intended by the party involved in construction and may be sufficiently attenuated to be considered an occurrence.

Although policies issued after 1993 may contain amended pollution exclusions, the amendments should not have a significant impact on bodily injury claims involving toxic mold. In respect to mold contamination and the

release of mycotoxins by certain molds, it appears that an argument could be made to bring mycotoxins within the definition of "pollutant". Another issue regarding toxic mold claims and the standard pollution exclusion is whether or not airborne toxic mold can be considered a "release" of pollutants. For instance, in *Lexington Ins. Co. v. Unity/Waterford-Fair Oaks, Ltd.*, 2002 WL 356756 (N.D. Tex. 2002), the insurer sought a declaratory judgment that it was not liable to its insured for damages that the insured incurred from mold damage to first and second floor apartment units and other damage to second floor units caused by a severe rainstorm and flooding at an apartment complex. The issue turned on the interpretation and application of the policy's Pollution and Contamination Exclusion, which was a fairly standard pollution exclusion except that fungi was specifically included in the list of contaminants or pollutants.

The insured contended that the exclusion was inapplicable because the mold in the apartments "was not released, discharged or dispersed nor did it escape." The insured cited expert testimony that mold and mold spores exist at de minimis levels in all apartment environments. Thus, the insured asserted that the mold that caused the extensive damage to the apartments "was simply already present and thrived because of the moisture." The court disagreed, noting that "the process of mold proliferation involves existing mold bodies giving off reproductive spores that are dispersed via the air into the surrounding environment." The insurer's mold expert described mold reproduction as "the airborne transmission of spores". Thus, the court held that there was a "release" of pollutants within the meaning of the absolute pollution exclusion, although it is significant to note that the exclusion specifically included fungi as a pollutant.

VI. TRIGGER OF COVERAGE

In determining the date of the occurrence for personal injury claims, particularly those involving continuous or repeated exposure to harmful substances, the so-called trigger of coverage is critical. Trigger of coverage is significant when several different policy periods may be triggered and the policies are issued by different insurers. For example, a potential claimant may be exposed to a harmful substance over the course of many years involving different insurers' policies, and the resulting illness may arise during yet another policy period. The Texas Supreme Court has declined to adopt a hard and fast rule, but several appellate courts as well as the Fifth Circuit Court of Appeals have considered the issue.

The term "occurrence" is generally defined in CGL policies as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." In determining whether a particular policy's coverage is triggered, the policy's definition of the term "occurrence" is crucial. Several different theories have been developed for determining the trigger of coverage. A recent decision from the First Court of Appeals in Houston applied the exposure rule regarding personal injury and property damage claims based upon continued or repeated exposure to harmful conditions. *Pilgrim Enterprises, Inc. v. Maryland Cas. Co.*, 24 S.W.3d 488, 497 (Tex.App.—Houston [1st Dist.] 2000, no writ).

Pilgrim involved multiple claimants and claims involving personal injury and property damage. The insurer argued that its duty to defend the insured was triggered only if the alleged bodily injury was manifest during the policy period. Because the underlying pleadings failed to allege that any physical injury was manifest during any relevant policy period, the insurer claimed it had no duty to defend. The court noted in its opinion that the case law governing when harm occurs under CGL policies "is far from settled." *Id.* at 495.

In *Pilgrim*, the policy did not define an occurrence as a single event happening *within* a policy period, but as "an accident, including continuous or repeated exposure to conditions, which *results* in bodily injury or property damage." Instead, the policy's time restriction was contained in the definition of "bodily injury", which required the *harm* to occur during the policy period. These definitions were significant to the court in its decision, and the court held that the policies therefore contemplated that harm caused by continuous exposure during a policy period would be covered by that policy.

The *Pilgrim* court relied heavily in its decision upon *Guaranty Nat'l Ins. Co. v. Azrock Indus., Inc.*, 211 F.3d 239, 251-52 (5th Cir. 2000). In that case, also involving both personal injury and property damage claims, the Fifth Circuit Court of Appeals surveyed Texas insurance law regarding the meaning of "occurrence." The court concluded that its "best *Erie* guess as to what Texas would choose as the event that triggers the insurer's duty to defend in asbestos personal injury cases under a uniform CGL policy is the exposure theory"; in other words, coverage is triggered in any policy period in which exposure to the cause of the harm occurred. The court defined the injury as "the subclinical tissue damage that occurs on inhalation of asbestos fibers." *Id.* at 244.

There is little case law citing to or analyzing the *Pilgrim* or *Azrock* cases. Thus, until the Texas Supreme Court has spoken on the issue, the issue of what trigger

of coverage theory to apply to bodily injury claims based upon continuous or repeated exposure to harmful substances is undecided. Still, the *Pilgrim* and *Azrock* cases are thoughtful and well-reasoned opinions and provide some valuable guidance in this little-charted area.

VII. COVERAGE ISSUES REGARDING WHAT CONSTITUTES AN "OCCURRENCE"

A. Intentional Conduct May Constitute an Occurrence

It has been a long-standing and widely accepted tenet of insurance law that intentional conduct cannot form the basis of an occurrence under a liability policy. This rule was somewhat altered on May 30, 2002, when the Texas Supreme Court issued its opinion in *King v. Dallas Fire Insurance Co.*, 85 S.W. 3d 185 (Tex. 2002). The case arose when the insured's employee got into a fight with the claimant who then alleged that the insured/employer had negligently hired, trained, and supervised the assailant/employee. The insurer refused to defend its insured in the lawsuit, claiming there was no occurrence within the meaning of the policy because of the intentional nature of the employee's aggressive conduct. The trial court and court of appeals agreed, imputing the intentional conduct of the employee to the insured. The lower courts held that there was no occurrence and therefore no duty to defend because the injury was caused by the intentional conduct of the insured's employee.

The Texas Supreme Court reversed and held that the separation-of-insureds clause in the policy requires that the duty to defend be interpreted separately between the employee and the insured. Thus, since there were allegations in the petition of negligent hiring, training and supervision, application of the eight corners rule required the insurer to defend the insured against the personal injury suit. The Texas Supreme Court specifically addressed the Fifth Circuit Court of Appeals' prior holdings and decided that they were misinterpreting Texas law on this issue. All recent federal court decisions interpreting Texas law held that when an employee's actions intentionally caused injury, there would be no occurrence on the basis that the claims against the employer, even though couched in terms of negligence, were related and interdependent upon the intentional actions of the employee. The Texas Supreme Court disagreed and stated:

we conclude the Fifth Circuit's rule improperly imputes the actor's intent to the insured. That is to say, whether one who contributes to an injury is negligent is an inquiry independent

from whether another who directly causes the injury acted intentionally. Essentially, the actor's intent is not imputed to the insured in determining whether there was an occurrence.

See page 4 of slip opinion (footnotes omitted).

On August 16, 2001, the United States Court of Appeals for the Fifth Circuit issued its opinion in *Harken Exploration Company v. Sphere Drake*, 261 F.3d 466 (5th Cir. 2001) (although the *Harken* opinion focuses on an insurer's duty to defend, the *Harken* court's analysis of whether an act is an occurrence is material). This most recent Fifth Circuit authority on "occurrence" analysis under Texas law recognizes that "[t]he Texas Supreme Court has not articulated a hard and fast rule for when an accident occurs." The Fifth Circuit acknowledged that under *Mid Century Ins. Co. of Texas v. Lindsey*, 997 S.W.2d 153, 155 (Tex. 1999), "the mere fact that an actor intended to engage in the conduct that gave rise to the injury does not mean that the injury was not accidental". The *Harken* court recognized that an accident has two elements; (1) an action; and (2) the action's effect that results in damage. In determining whether an act is an accident, the Court must consider intent and foreseeability. The *Harken* opinion acknowledges that an accident occurs when an action is intentionally taken but performed negligently and the effect is not what would have been expected had the action been performed non-negligently. *Id.* at 472 (citing *Federal Mutual Ins. Co. v. Grapevine Excavation Inc.*, 197 F.3d 720, 723-24 (5th Cir. 1999) and *Massachusetts Bonding & Ins. Co. v. Orkin Exterminating Co.*, 416 S.W.2d 396, 400 (Tex. 1967)).

The underlying facts involved Harken's operation of an onshore oil facility on the claimant's land pursuant to an oil and gas lease with the claimant. The claimant alleged that, through its work as an oil and gas operator, Harken negligently and carelessly released oil, saltwater, and other pollutants onto claimant's property. The court, in determining whether Harken's acts were occurrences, found that the damage to the claimant's property was not the natural and probable consequence of operating an oil facility in a non-negligent manner. In determining whether a deliberate and negligent act is an occurrence, the courts must be guided by whether the resulting damage would have been the intended or expected result had the act not been performed negligently.

In *American States Ins. Co. v. Bailey*, 133 F.3d 363 (5th Cir. (Tex.) 1998), liability insurers brought a declaratory judgment action to determine if they had a duty to defend or indemnify an insured church and four

of its associate ministers on claims arising from alleged sexual misconduct of the church's pastor-in-charge. The Fifth Circuit affirmed the trial court's judgment in favor of the insurers, holding that the claims of sexual misconduct did not constitute an occurrence. The court held that under Texas law, where a third-party's liability is related to and interdependent on other tortious activities, the ultimate issue is whether the underlying tortious activities are encompassed within the definition of "occurrence." An insurer has no duty to defend or to indemnify its insured against claims that could not be brought absent the underlying and excluded intentional, tortious activities. This approach was recently rejected by the Texas Supreme Court in *King v. Dallas Fire Ins. Co.*

In *Folsom Investments, Inc. v. American Motorists Ins. Co.*, 20 S.W.3d 556 (Tex.App.--Dallas 2000, n.w.h.), another case involving claims of sexual abuse and/or sexual harassment, the court noted that the Texas Supreme Court has adopted the general rule that "where acts are voluntary and intentional and the injury is the natural result of the act, the result was not caused by accident even though that result may have been unexpected, unforeseen, and unintended." Thus, to decide whether an act or event satisfies the definition of "accident", a two-step analysis must be performed:

- determine the specific acts alleged to be the cause of the plaintiff's damages and then whether the acts were voluntary and intentional. If the acts that produced the alleged injuries were committed involuntarily and unintentionally, the inquiry stops there because the results of the acts would be accidental.
- if the acts were committed voluntarily and intentionally, then decide whether the injuries were a natural result of the acts. When a result is not the natural and probable consequence of an act or course of action, it is produced by accidental means. The natural result of an act is the result that ordinarily follows, may be reasonably anticipated, and ought to be expected.

Id. at 559. The court went on to apply the "interdependent" rule articulated by the Fifth Circuit and held that there was no coverage for the insured/employer. Although the *King* opinion did not expressly overrule *Folsom*, it must be overruled by

implication, as the Texas Supreme Court has squarely rejected the interdependent rule.

B. "Arising Out Of"

Under current Texas law, it is unnecessary for the named insured to be found negligent in order for an additional insured to obtain coverage under the named insured's policy. *Mid-Continent Casualty Co. v. Swift Energy Co.*, 206 F.3d 487 (5th Cir. (Tex.) 2000). To satisfy the requirement that the underlying settlement resolved liability "... arising from the operations of the Named Insured . . .", it is sufficient that the plaintiffs were injured while present at the additional insured's facility in connection with the performance of the subcontractors' obligations under their respective subcontracts with the named insured.

In the facts of this case, Swift, the additional insured, leased and operated an oil drilling site and hired a contractor to drill the well. The contractor requested that Air Equipment provide a casing crew to install casing at the site. Swift and Air Equipment entered into a master service agreement which required Air Equipment to provide additional insured status to Swift. Mid-Continent issued the CGL policy to Air Equipment. The plaintiff, an employee of Air Equipment, was injured on the drilling site when gas released from the well ignited and exploded. The plaintiff sued Swift and the contractor alleging that their negligence caused his injuries. Mid-Continent brought suit seeking a declaratory judgment that it was not required to indemnify or defend Swift in the personal injury suit.

The district court found that Swift did not qualify as an "additional insured" under the policy, holding that Swift's liability did not "arise out of [Air Equipment's] ongoing operations for [Swift]," as the policy's language required. The Fifth Circuit surveyed Texas law on the issue and made an *Erie* determination as to what the Texas Supreme Court would hold. The court determined that the Texas Supreme Court would follow the decisions in *McCarthy Bros. Co. v. Continental Lloyds Ins. Co.*, 7 S.W.3d 725 (Tex.App.--Austin, 1999, no pet. h.) and *Admiral Ins. Co. v. Trident NGL, Inc.*, 988 S.W.2d 451 (Tex.App.--Houston [1st Dist.], 1999, pet. denied), stating:

They are consistent with the majority view in other jurisdictions. They are far more thoroughly reasoned. They comport with the Texas Supreme Court's recent decision in *Mid-Century Ins. Co. v. Lindsey*, 997 S.W.2d 153, 156 (Tex.1999). And they are far more consistent with the general principles of Texas

insurance law. Mid-Continent could have expressly stated in the Policy that liability not resulting from Air Equipment's sole negligence was not covered by the additional insured endorsement. It did not do so. To read such an additional limitation into the Policy's language clearly seems contrary to the Texas rule that exclusionary language is narrowly interpreted, and to the rule that ambiguous policy language is interpreted to find coverage.

Id. at 499 (citations omitted). The court reasoned that the term "arising out of" was intended to cover all claims with a cause-in-fact relationship to the named insured's operations. The accident occurred while the employee was on Swift's premises as part of a service crew provided by the named insured. The claim was therefore sufficiently connected to the named insured's operations to be covered under the additional insured endorsement. This is currently the majority view regarding the appropriate interpretation of "arising out of" language.

C. Courts Divided on Whether Damages Caused by Faulty Workmanship Constitute Occurrences

Courts interpreting and applying Texas law are divided on whether or not a claim arising from an insured's faulty workmanship constitutes an occurrence. The controversy usually centers on the distinction between intentional and unintentional conduct; thus, reference to Section VI. A. above, is helpful. Although the following cases involve claims of property damage stemming from the insured's alleged faulty workmanship, the reasoning may be extended to personal injury claims if the injury resulted from the insured's "work" as that term is defined in the policy.

In *Mid-Century Insurance Co. v. Lindsey*, 997 S.W.2d 153 (Tex. 1999), the Texas Supreme Court analyzed the definition of "occurrence" in the context of whether the insured's act was unexpected, unforeseen, or unintended by the insured. The court stated "an effect that 'cannot be reasonably anticipated from the use of [the means that produced it], an effect which the actor did not intend to produce and which he cannot be charged with the design of producing, is produced by accidental means'" and thus constitutes an occurrence. *Id.* at 155.

The *Mid-Century* opinion, although it did not involve faulty workmanship, has been used as a basis for rejecting coverage for damages resulting from insureds' faulty workmanship, based upon the fact that the insured necessarily intended to design or construct a structure;

therefore, any claims arising from such conduct would not constitute an occurrence. See *Malone v. Scottsdale Insurance Co.*, 147 F. Supp. 2d 623 (S.D. Tex. 2001); *Hartrick v. Great American Lloyds Ins. Co.*, 62 S.W.3d 270 (Tex.App.—Houston [1st Dist.] 2000, n.w.h). This reasoning can obviously be carried to an extreme, as most negligent acts arguably start with some intentional conduct, which should not support a denial of coverage based upon the courts' interpretation of an "occurrence" definition.

The Fifth Circuit has found that damages arising from faulty workmanship constitute an occurrence under a liability policy. *Grapevine*, 197 F.3d at 725. In fact, the court in *Grapevine* stated that when an insured's defective performance or faulty workmanship have damaged property of a third party, as opposed to the insured's work product, such damage is presumed to have been unexpected and constitutes an accident or an occurrence. *Id.* On the other hand, *Devoe v. Great American Insurance*, 50 S.W.3d 567 (Tex.App.—Austin 2001, no pet.), involved faulty workmanship that resulted in damages that were restricted to the subject matter of the work, a house, although the factual basis for the Devoes' claims are unclear. The court, in ruling that there was no occurrence under the terms of the policy, clearly distinguished the Devoes' claims for faulty workmanship from other cases where an insured's faulty workmanship caused damage to property other than the subject matter of the work, e.g. property of third parties. *Id.* at 571 (citing *Stumph v. Dallas Fire Ins. Co.*, 34 S.W.3d 722, 729 (Tex.App.—Austin 2000, no pet.)).

In *Malone v. Scottsdale Ins. Co.*, 147 F. Supp. 2d 623 (S.D. Tex. 2001), the underlying facts involved an insured contractor's construction of improvements to an office and warehouse pursuant to a contract with Teste. Teste complained that the "contractor failed miserably in its attempts to construct commercial improvements" and listed forty defects in the contractor's work. *Id.* at 625. Teste's complaints did not encompass damage to Teste's own property, which was not the subject matter of the contractor's work. *Id.* at 628. In fact, the court in *Malone* stated that the insured offered absolutely no authority or argument in the declaratory judgment action to rebut Scottsdale's contention that Teste's complaint did not trigger an "occurrence" under the policy. The court determined that the completed operations coverage was not triggered because the insured had not completed its work. *Id.* at 629.

Hartrick v. Great American Lloyds Ins. Company involved the claims of homeowners against a homebuilder for various breaches of implied warranties. In the underlying trial the jury found that the insured

homebuilder was not liable for negligence. In fact, the court restricted its analysis to whether the insured's "voluntary and intentional conduct . . . was its failure to comply with the implied promises imposed on [the insured] as a matter of law as a homebuilder, by not preparing the soil properly and not constructing the foundation properly." 62 S.W.3d at 277. Clearly, the *Hartrick* opinion is restricted to damage to property that was the subject matter of the insured's work, e.g. a defective foundation arising out of the insured's faulty soil preparation and foundation construction. The court held that the jury's finding that the insured failed to comply with requirements under Texas law established that the insured was "charged with the design of producing plaintiff's damages" and, therefore, the insured's conduct did not amount to an occurrence. *Id.* at 278.

VIII. OTHER POTENTIAL COVERAGE PITFALLS FOR PERSONAL INJURY CLAIMS

A. Products/Completed Operations Coverage

Another type of coverage frequently offered under CGL policies which may provide coverage for personal injury claims is the products/completed operations coverage, which is defined in pertinent part:

- (a) Products-Completed Operations Hazard
Definition includes all **bodily injury** and property damage occurring away from premises you own or rent and arising out of your product or your work except:
 - (i) Products that are still in your physical possession; or
 - (ii) Work that has not yet been completed or abandoned.
- (b) Your work will be deemed completed at the earliest of the following times:
 - (i) When all of the work called for in your contract has been completed.
 - (ii) When all of the work to be done at the site has been completed if your contract calls for work at more than one site.
 - (iii) When that part of the work done at a job site has been put to its intended use by any person or organization other than another contractor or

subcontractor working on the same project.

Work that may need service, maintenance, correction, repair or replacement, but which is otherwise complete, will be treated as completed.

The foregoing language is based upon the standard insurance industry form wording drafted for the insurance industry by the Insurance Services Office ("ISO") and revised in 1986. See White, Paul S., *People Who Live in Glass Houses: The Recurring Issue of Construction Defect Claims and Insurance Coverage*, Defense Research Institute, pp.12, 21 (1997). The standard insurance industry form wording, although merely containing a definition of "products/completed operations hazard", arguably contains products/completed operations hazard coverage. The argument is that unless the policy at issue specifically excluded such language, the coverage is included. Although the ISO forms issued before 1986 did not provide coverage for completed operations hazards, in 1986 the standard policy wording issued by the ISO was revised to include the products/completed operations hazard definition. *Id.* at 21.

In the article *Insurance Coverage Opinions*, authors Michael Sean Quinn and Kimberly Steele explain how the policies issued on the 1986 form include products/completed operations coverage:

The way the newer policies are taking care of this problem is to introduce the twin notions of a products hazard and a completed operations hazard. These hazards refer, roughly speaking, to the long tail of products liability and construction liability. What the policies do is to group all of those exposures together within the twin hazards. This is done by means of a definition. If a policy is going to exclude liability for these exposures, the policy will be endorsed to eliminate anything falling within their definitions. If the policy is not so endorsed, then the definitions become extraneous.

Quinn, Michael Sean and Steele, Kimberly, *Insurance Coverage Opinions*, 36 S. Tex. L. Rev. 479 (April 1995). Unfortunately, few judicial opinions address whether products/completed operations hazard coverage is included in standard commercial general liability policies issued after 1986. In *Houston Building*

Service, Inc. v. American General Fire and Casualty Company, 799 S.W.2d 308, 309-10 (Tex.App.--Houston [1st] 1990, writ denied), the court opined that the products/completed operations hazard definition in a commercial general liability coverage policy defined the coverage that existed in that policy. The court found that the products/completed operations hazard coverage provided an exception to the business risk exclusion precluding coverage for property damage that is "your work" as defined in the policy. See also *Paradigm Ins. Co. v. Texas Richmond Corp.*, 942 S.W.2d 645, 651-2 (Tex.App.--Houston [14th Dist.] 1997, no writ) (recognizing that "it is clear that the coverage for hazards arising out of Products-Completed Operation is merely a part of the coverage provided under the Commercial General Liability Coverage.").

Insurers have argued, however, that the standard CGL coverage does not automatically include products/completed operations coverage unless the policy is specifically endorsed. The basis for the argument is that a definition alone cannot be construed as affording coverage. The products/completed operations definition is included in the policy because, according to insurers, the term is used in several exclusions, including the "your work" business risk exclusion.

Although there is little authority on this issue, practitioners should be aware that there exists room for arguing that any personal injury caused by work falling within the definition of a "completed operations hazard" may be excluded unless the policy at issue is specifically endorsed to provide such coverage.

A final coverage issue to be aware of when prosecuting and defending personal injury claims is the professional services exclusion, which typically appears as an endorsement. The exclusion states:

This insurance does not apply to bodily injury, property damage, personal injury, or advertising injury arising out of the rendering of or failure to render any professional services by you or any engineer, architect or surveyor who is either employed by you or performing work on your behalf in such capacity.

Professional services include:

- (1) The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; and

- (2) Supervisory, inspection, architectural or engineering activities.

This exclusion has not been frequently addressed by Texas courts. It is easy to imagine, however, an argument that such an exclusion could preclude coverage for personal injuries arising from toxic mold exposure, for example, as such claims frequently involve faulty workmanship (such as negligently performing architectural or engineering services in the construction of a house or building which allows for the growth of toxic mold) which may be encompassed by the exclusion's definition of "professional services."

B. Additional Insured Provisions, Self Insured Retentions and the Duty to Defend

Contractors are often contractually required to have their liability insurers provide additional insured coverage to premises owners/business entities for whom the contractors work. Additional insured provisions are frequently found in contracts and master service agreements in the energy, construction and marine industries. Often these additional insured provisions will contain clauses which require the contractor's insurance to be primary to any insurance or self insurance programs maintained by the premises owner/business entity and that the contractor be responsible for the payment of any deductibles or self insured retentions in the contractor's liability policy.

In the current hard insurance market, where premiums have increased significantly over the last two years, a number of companies are increasing their deductibles and/or self insuring larger primary amounts in an effort to reduce insurance premiums. In situations where the insured maintains a significant self insured retention or a retrospective premium program, a fronting insurer is sometimes used to provide a policy of insurance that will satisfy the contractual requirements of clients or administrative agencies. The arrangements for fronting insurers vary depending on the terms of the insurance program, however, they often share the following characteristics:

- A policy is issued on behalf of the named insured on the fronting insurer's forms and letterhead;
- Certificates of insurance issued by agents/brokers usually do not indicate if the policy is traditional insurance or a fronting policy;
- The named insured is often required to reimburse the fronting insurer the full

amount of the deductible or self insured retention;

- Although the named insurer is funding the payment of defense costs and payment of settlements and/or judgments that are covered by the fronting policy, an additional insured often has a direct contractual relationship with the fronting insurer that issues the policy in question.

The use of fronting insurers to provide additional insured status can cause complications in the relationships between the named insured, the additional insured and the fronting insurer. In May 2003, the First Court of Appeals dealt with the issue of the duty to defend an additional insured under a fronting policy. In *Phillips Petroleum Company v. St. Paul Fire & Marine Insurance Company and St. Paul Insurance Company*, No. 01-01-00462-CV, H.B. Zachry was a contractor that was contractually obligated to have its liability insurance policies name Phillips as an additional insured. Pursuant to a master service agreement (MSA) between H.B. Zachry and Phillips, H.B. Zachry was obligated to maintain a liability policy with limits of \$1.0 million per occurrence. H.B. Zachry satisfied this contractual obligation by obtaining a \$1.0 million fronting policy from St. Paul, under which H.B. Zachry maintained a \$1.0 million deductible which St. Paul could pay, subject to reimbursement by the named insured.

Phillips made a demand for defense and coverage under this liability policy when faced with claims arising out of the June 1999 explosion at the Phillips Houston facility. H.B. Zachry's liability insurer, St. Paul, provided Phillips with a defense to these lawsuits pursuant to a reservation of rights issued by St. Paul. Phillips subsequently sued St. Paul for breach of contract and sought a declaratory judgment that St. Paul owed Phillips an unlimited defense in the underlying lawsuits and coverage up to the limits of the policy. Phillips contended that St. Paul's defense obligation was not extinguished until the insurer had exhausted its policy limits through the payments of judgments, settlements or medical expenses in relation to the underlying claims against Phillips, as is often the case with "traditional" liability policies which pay defense fees and costs as "supplementary payments" that do not erode the policy limits. Phillips maintained that the MSA with H.B. Zachry intended to have this sort of traditional insurance program available to Phillips as an additional insured.

The First Court of Appeals found that St. Paul's obligation to defend Phillips was terminated when St. Paul had paid defense fees and costs in the amount of

the \$1.0 million policy limits, e.g. the limits of the policy were reduced by the payment of defense fees and costs. Phillips maintained that although St. Paul may have a limited defense obligation toward the named insured, under the terms of the MSA, the insurer's defense obligation to Phillips, as an additional insured, was not limited. The Court determined that the MSA did not "...expressly specify the type of commercial general liability coverage that Zachry was required to purchase..." and that the MSA did not contain any requirements that Zachry's insurance was to provide a duty to defend that was to remain intact until the insurer paid out \$1.0 million in settlements or judgments.

In response to the current insurance market, brokers, risk managers and insureds are employing increasingly creative insurance programs to reduce costs. The use of self insured retentions, retrospective premium arrangements, captive insurers and fronting insurers are examples of such programs. With the introduction of risk management arrangements which appear to be traditional insurance but, in fact, require the insured to fund payments of defense obligations, settlements and judgments, it is apparent that the fronting insurer and the named insured may face factual situations which create tension between these parties. This tension can be increased when demands for additional insured coverage arise from third parties that have commercial relationships with the named insured as well as contractual privity with the insurer.

C. Policy Exclusions and Multiple Insureds and Severability Clauses

Many liability insurance policies issued in the commercial environment provide coverage to more than one named insured. Often these multiple named insureds are related business entities or affiliated companies. Liability policies frequently contain severability or "separation of insureds" clauses which state that insurance applies to each named insured as if it were the only named insured under the policy and that coverage applies separately to each insured against whom claims are made. A severability clause can allow a policy to provide coverage to one named insured while another named insured may not be covered because of an exclusion in the policy. See *State Farm Fire & Cas. Ins. Co. v. Keegan*, 209 F.3d 767, 769 (5th Cir. 2000) (construing Texas law and citing *Walker v. Lumbermen's Mut. Cas. Co.*, 491 S.W.2d 696 (Tex. Civ. App. – Eastland 1973, no writ)).

Recently, the First Court of Appeals, in *Bituminous Cas. Corp. v. Maxey, et al.*, No. 01-01-01111-CV (May 22, 2003), dealt with the applicability of a coverage

exclusion to multiple named insureds under a policy which contained a severability clause. This case involved a vehicular collision between the plaintiff's car and a tractor/trailer which was owned and maintained by L & R Timber, Inc. ("L & R") but operated by Triple L Express, Inc. ("Triple L"). Bituminous had issued a liability policy to L & R and Triple L, which contained an "auto exclusion" which provided that the insurance did not apply to "[b]odily injury"...arising out of the ownership, maintenance, use...of any...auto... owned, operated by ... any insured." The definition of "auto" included a "land motor vehicle, trailer or semitrailer".

Bituminous sought a declaratory judgment that it had no duty to defend or indemnify L & R or Triple L based upon the application of the auto exclusion clause. Plaintiffs ultimately settled with Triple L, and a judgment was entered against L & R for the full amount of the Bituminous policy. Triple L maintained that the severability clause required the liability policy to be read as if L & R were the only named insured, and therefore the damages attributable to Triple L would not be excluded under the auto exclusion clause. Based upon this interpretation, Triple L maintained that Bituminous was obligated to defend Triple L and pay for the damages caused by Triple L's conduct.

The court determined that because the auto exclusion clause applied to "any insured", that both named insureds would be excluded from coverage, regardless of the application of the severability clause. The court indicated that, had the auto exclusion clause been worded to apply to "the insured" then the severability clause may have restricted the exclusion to the only insured against whom a claim was made under the policy.

Many general liability policies contain standard exclusionary language for automobiles, watercraft and claims of the insured's employees, in addition to other exclusions. The wording and application of a severability clause can have a profound impact on the coverage of multiple named insureds as well as additional insureds.

IX. CONCLUSION

Coverage issues involving liability policies can serve as pitfalls to the unwitting counsel for insureds and claimants alike. Regardless of the manner in which coverage issues are handled, the time to deal with them is in the early stages of the prosecution or defense of a case. Clearly, it is preferable to learn about significant issues early in your case, rather than being educated about the consequence of such an issue by opposing counsel.