

**INSURANCE ISSUES FOR LAWYERS:
EVERYTHING YOU WANTED TO KNOW
BUT WERE AFRAID TO ASK**

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INSURANCE ISSUES FOR LAWYERS: EVERYTHING YOU WANTED TO KNOW BUT WERE AFRAID TO ASK¹

by David D. Disiere

I. WILL READING THIS GIVE ME A HEADACHE?

Although insurance seems to intimidate most lawyers, the legal issues are not very complicated. The purpose of this article is to provide the general practitioner with a basic understanding of the most common insurance policies that are most important for the successful operation of a law practice in Texas. Reading this article will only give you a headache if you do so while driving, standing on your head, or drinking large quantities of alcohol.

This paper examines insurance issues of importance to any trial or transactional lawyer in Texas. The policies to be discussed include the standard Texas Auto Policy, Commercial General Liability Policy (“CGL”), Directors & Officers Liability (“D&O”), Business Auto, Employment Practices Liability (“EPLI”), Keyperson Life Insurance, and Umbrella coverage. This paper also discusses principles and approaches used in determining the coverage afforded by the CGL or business forms typically used in a commercial package policy, and many of these principles and approaches will also apply to the discussions of the other policies.

Although not within the scope of this paper, businesses also require first-party coverages for losses including medical; fire; inland marine; automobile collision or comprehensive protection; uninsured/underinsured motorist; and workers compensation coverage for injuries to employees. These topics will have to be saved for another day and another paper. In an effort to control the size of this paper, I have limited the discussion which follows to CGL, D&O and EPLI coverages.

II. AUTO INSURANCE: UNINSURED/UNDERINSURED MOTORISTS (“UM/UIM”) COVERAGE

A. WHAT IS PURPOSE OF THIS COVERAGE?

The purpose of UM/UIM coverage is to place the insured in the same position as though the uninsured/underinsured driver had been adequately insured. *Sikes v. Zuloaga*, 830 S.W.2d 752 (Tex.App.—Austin 1992, no writ). The purpose of the Texas Legislature was to protect conscientious motorists from financial loss caused by the negligence of financially irresponsible

¹ I wish to express my gratitude to Jack McKinley, a partner with Ramey & Chandler, for allowing me to use portions of his article, *Insurance: CGL, E&O, Employment Liability, Keyman, Etc.*, as a basis for this paper. I would also like to thank Michael Quinn for his analytical contributions to the D&O sections of my paper.

drivers. *Stracener v. United Services Automobile Ass'n.*, 777 S.W.2d 378 (Tex. 1989). UM/UIM coverage is a part of every Texas automobile policy unless there is a rejection in writing. If an insured does not reject UM/UIM coverage in writing at the time of the issuance of the policy, then UM/UIM coverage exists. *See Howard v. INA County Mutual Ins. Co.*, 933 S.W.2d 212 (Tex.App.—Dallas, 1996, writ denied). The Dallas court stated that the intent of the parties is not relevant and that a policy cannot be reformed to retroactively reject the UM/UIM coverage. *Id.* The Austin Court of Appeals recently held that an insured spouse could not waive UM coverage on an insured's behalf if she was not a named insured on the policy. *Old American County Mut. Fire Ins. Co. v. Sanchez*, 81 S.W.3d 452 (Tex.App.—Austin 2002, no writ).

If there is no written rejection and coverage exists by operation of law, it exists in an amount equivalent to the statutory minimum of liability insurance, or \$20,000. *Allstate Ins. Co., v. Hunt*, 469 S.W.2d 151 (Tex. 1971).

B. WHAT ARE THE IMPORTANT PARTS OF THE INSURING AGREEMENT?

The insuring agreement provides the carrier will pay damages “which a covered person is legally entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injury sustained by a covered person, or property damage, caused by an accident.” Thus, legal liability or negligence must exist on the part of the uninsured motorist in order to trigger this coverage. The insuring agreement goes on to say the owner's or operator's liability for these damages must arise out of the “ownership, maintenance or use” of the uninsured motor vehicle.

1. “Legally entitled to recover”

The Texas Supreme Court has held the insured must establish the liability of an uninsured/underinsured motorist and the extent of the damages before becoming legally entitled to recover benefits under a UM/UIM policy. *See Henson v. Southern Farm Bureau Casualty Ins. Co.*, 17 S.W.3d, 652, 653 (Tex. 2000). The insured seeking the benefits of UM/UIM coverage may (1) sue the insurance company directly without suing the UM/UIM driver, (2) sue the UM/UIM driver with the written consent of the insurance company, making the judgment binding against the insurance company, or (3) sue the UM/UIM driver without the written consent of the insurance company and then re-litigate the issue of liability and damages. *United States Fire Ins. Co., v. Millard*, 847 S.W.2d 668, 674 (Tex. App.—Houston [1stDist.] 1993, original proceeding). This coverage requires the insured to show that the uninsured driver would be liable to him for his damages. In *Valentine v. Safeco Ins. Co.*, 928 S.W.2d 639 (Tex. App.—Houston [1st Dist.] 1996, writ denied), the insured was not allowed to recover from her UM carrier for the negligence of her employer because the employer could not be legally liable (the worker's compensation bar prohibited any legal liability on the part of the employer to the insured). *See also Essman v General Acc. Ins. Co. of America*, 961 S.W.2d 572 (Tex. App.—San Antonio, 1997, no writ) (holding settlement and dismissal of uninsured motorist destroyed insured's predicate of recovery of UM benefits under her policy because insured could not

establish fault on the part of the alleged tortfeasor).

2. Damages must be caused by “accident” and liability must “arise out of use” of the vehicle

In two Houston Court of Appeals cases, this condition has been used to exclude coverage for drive-by shootings as they do not arise out of the operation of the vehicle and are not accidents. *Collier v. Employers National Ins. Co.*, 861 S.W.2d 286 (Tex. App.--Houston [14th Dist.] 1993, writ denied); *Le v. Farmers Texas County Mutual Ins Co.*, 936 S.W.2d 317(Tex App--Houston [1st Dist] 1997, no writ). In *Collier*, the court pointed out it was not the intention of the policy to protect the insured against criminal assaults but to insure against automobile collisions. *Collier*, 861 S.W.2d at 289. The shooting did not arise out of the inherent nature of the vehicle and therefore did not “arise out of the use” of the uninsured auto. Similarly, the *Le* court reasoned the gun was the instrumentality which caused the injuries, not the car. *Le*, 936 S.W.2d at 321. Accordingly, the injuries did not arise out of the use of the vehicle.

By contrast, the Texarkana Court of Appeals has found UM/UIM coverage in two shooting cases. In *Mid Century Ins. Co. v. Lindsey*, 942 S.W.2d 140 (Tex. App.-Texarkana 1997, writ granted), the court found UIM coverage for the Plaintiff, Lindsey, who was seated in the driver’s seat of a parked vehicle. In a truck next to Lindsey’s parked vehicle, a child tried to enter the cab of the truck by climbing through the back window. In doing so, the child accidentally contacted a loaded shotgun, causing it to discharge and strike Lindsey in the head. Lindsey’s UIM carrier denied coverage on the grounds the injury did not “arise out of the use” of the vehicle and because the event was not an “accident.” The court opined an accident need not be a collision; rather the court adopted the common understanding of the term accident and held because no one expected or intended the firing of the shotgun, the incident was an accident within the meaning of the UM/UIM provision. Further, the court found the transportation of a firearm is an ordinary use of a vehicle, especially in Texas, and therefore, the accident arose out of the use of the vehicle. “Use” was further demonstrated by the fact the accident was caused by the child’s attempt to enter the vehicle as injuries sustained by a person trying to enter a vehicle arise out of the “use” of the vehicle.

Similarly, the Texarkana Court of Appeals explained that “use” is a catchall term not limited to “ordinary use,” and any exercise of control over the vehicle constitutes a “use.” *Whitehead v. State Farm Mut Automobile Ins. Co.*, 952 S.W.2d 79 (Tex. App.--Texarkana, 1997, no writ). *Whitehead* involved a passenger in a truck who was injured when the truck in which she was riding hit a bridge stanchion after the driver lost control of the vehicle. He lost control after being shot by the passenger of another vehicle. The insurer claimed the liability did not arise out of the use of the vehicle and was not an accident. The court held that the negligence by the driver and the intent of the shooter constituted a “use” of the vehicle - “the fact that the van was used as a moving gun platform” did not exclude liability under the UM portion of the policy. *Id* at 83. Further, although the shooting was intentional, it constituted an accident as to the victims.

The foregoing cases seem to suggest if there is no evidence the shooting was not expected or

intended, an “accident” may exist. On the other hand, if the incident is criminal in nature, there may not be an “accident” for UM/UIM purposes. In any event, the somewhat varying interpretations of “accident” and “use” require close scrutiny of the facts of each claim in order to determine if UM/UIM coverage is triggered.

3. Are Punitive Damages Covered?

The case of *Milligan v. State Farm Mut. Automobile Ins. Co.*, 940 S.W.2d 228 (Tex. App.--Houston [14th Dist.] 1997, writ denied) addressed the conflicting authority as to whether exemplary damages are recoverable under the UM/UIM provisions of the policy. Until *Milligan*, the Houston 14th District Court of Appeals had taken the position that punitive damages were recoverable in a UM/UIM case. *Home Indemnity Co. v. Tyler*, 522 S.W.2d 594 (Tex. Civ. App.--Houston [14th Dist.] 1975, writ ref'd n.r.e). Following the *Tyler* decision, however, both the Texarkana Court of Appeals and the Houston First District Court of Appeals held punitive damages were not recoverable under the uninsured motorist's coverage. *Vanderlinden v. United Services Auto Assoc. Property & Casualty Ins. Co.*, 885 S.W.2d 239 (Tex. App.--Texarkana 1994, writ denied); *State Farm Mutual Auto Ins. Co. v. Shaffer*, 888 S.W.2d 146 (Tex. App.--Houston [1st Dist] 1994, writ denied). The *Milligan* court found the reasoning in *Vanderlinden* and *Shaffer* “logical and persuasive,” and found, as a matter of law, the uninsured motorist clause does not cover exemplary damages. *Id.* at 232.

4. Written Consent

The policy provides “any judgment for damages arising out of a suit brought without [the carrier's] written consent is not binding on [the carrier].” According to *US. Fire Ins. Co. v. Millard*, 847 S.W.2d 668 (Tex. App.-Houston [1st Dist.] 1993, no writ), this provision is valid and enforceable in Texas. The fact the carrier has notice of the insured's suit against the uninsured motorist makes no difference - the carrier must give written consent in order to be bound. *Id.* at 675. Without the written consent, liability and damages must be re-litigated. *Id.* at 674 (citations omitted).

C. THE IMPORTANCE OF “PHYSICAL CONTACT”

The policy includes within the definition of “uninsured motor vehicle” a hit and run vehicle whose operator or owner can not be identified. This definition incorporates the Insurance Code's requirement there be physical contact where the owner or operator of the reported uninsured motor vehicle is unknown or unidentified. *See* Texas Insurance Code art. 5.06-1 (2)(d) (Vernon's 1998). Thus, there is no coverage if an unidentified vehicle runs the insured off the road but does not actually hit the vehicle in the process. *Goen v. Trinity Universal Ins. Co.*, 715 S.W.2d 124 (Tex. App.--Texarkana 1986, no writ).

Likewise, a drive-by-shooting in which there is no collision does not meet the UM/UIM physical contact requirement. *Le v. Farmers Texas County Mutual Ins. Co.*, 936 S.W.2d 317,322 (Tex. App.—Houston [1st Dist] 1997, writ denied); *Collier v. Employers Nat. Ins. Co.*, 861 S.W.2d 286

(Tex App.-Houston [14th Dist.] 1993, writ denied). An insured may, however, recover when a hit and run auto hits another auto which consequently hits the insured's auto. *Latham v. Mountain States Mut. Cas. Co.*, 482 S.W.2d 655 (Tex. Civ. App.-Houston [1st Dist.] 1972, writ ref d n.r.e.) This is commonly referred to as the "indirect contact rule." The indirect contact rule, however, does not apply when an unidentified vehicle does not actually hit any car. *Guzman v. Allstate Ins. Co.*, 802 S.W.2d 877 (Tex. App.-Eastland 1991, no writ). Likewise, the indirect contact rule does not extend to collisions with objects left in the road. *Republic Ins Co. v. Stoker*, 903 S.W.2d 338 (Tex. 1995); *Texas Farmers Ins. Co. v. Deville*, 998 S.W.2d 331 (Tex.App.—Houston [1st Dist.] 1999, no pet.); *Williams v. Allstate Ins. Co.*, 849 S.W.2d 859 (Tex. App.--Beaumont 1993, no writ).

D. WHAT ARE THE KEY EXCLUSIONS?

1. "Owned But Uninsured"

The policy does not provide UM/UIM coverage for any person for bodily injury sustained while occupying or when struck by any motor vehicle owned by the named insured or any family member which is not insured for coverage under the policy. *Frazer v. Wallis*, 979 S.W.2d 782 (Tex. App.—Houston [14th Dist.] 1998, no writ); *Farmers Texas County Mutual Ins. Co. v. Griffin*, 868 S.W.2d 861 (Tex App.--Dallas 1993, writ denied); *Reyes v. Texas All Risk General Agency*, 855 S.W.2d 191 (Tex.App.--Corpus Christi 1993, no writ). The Dallas Court of Appeals noted: "it is not the function of UIM coverage to operate as liability insurance and protect family members from their own negligence in owning and operating an underinsured automobile." *Griffin*, 868 S.W.2d at 869.

In *Old American County Mutual Fire Ins. Co. v. Sanchez*, the Austin Court of Appeals held that an insured was not "occupying" an owned a vehicle for purposes of the owned vehicle exclusion of the policy because "occupying" did not include touching of the vehicle from below while working on the vehicle. 81 S.W.3d, 452 (Tex.App.—Austin 2001, no writ). At the time of the accident, Sanchez was under the truck working on the gas tank hose and the truck collapsed severing Sanchez' spinal cord. *Id.* Sanchez sought to recover uninsured motorist coverage but the truck was not scheduled as a covered vehicle on his automobile insurance policy. *Id.* at 455. The Austin Court of Appeals held that Sanchez was not "occupying" the vehicle. *Id.*

2. Settlement Without Consent

In order to preserve the carrier's right to subrogation against the at-fault party, the Policy states it will not provide UM/UIM coverage to an insured who settles with that at-fault party without the carrier's consent. The Supreme Court has limited the impact of this rule inasmuch as an insurer has to prove that it was prejudiced by its insured's breach of this provision in order to void UM/UIM coverage. *Hernandez v. Gulf Group Lloyds* 875 S.W.2d 691 (Tex. 1994). After *Hernandez*, the carrier must prove that the uninsured motorist would have been able to pay the carrier's subrogation interest. This standard was recently applied in *Davis v. Allstate Ins. Co.*, 945 S.W.2d 844 (Tex. App.--Houston [1st Dist.] 1997, no writ). In *Davis*, the issue of whether

the tortfeasor was judgment proof presented a question of fact precluding summary judgment on issue of whether insured had materially breached the policy by settling without the insurers consent. Because the carrier had not presented sufficient summary judgment evidence to establish that the subrogation right it lost by the insured's settlement was sufficiently valuable to make the breach material, summary judgment in the carrier's favor was not proper. *Id.* at 846.

Additionally, the consent to settlement requirement only applies to automobile defendants--the carrier's consent to settle is not required for a non-motorist defendant. *See Simpson v. Geico General Ins. Co.*, 907 S.W.2d 942 (Tex.App.—Houston [1st Dist.] 1995, no writ).

E. WHAT IS THE LIMIT OF LIABILITY?

1. Stacking

The Limit of Liability section of the UM/UIM coverage provides there will be no stacking of limits on a policy covering more than one vehicle. One policy limit maximum amount is the most the carrier will pay regardless of the number of covered persons, claims made, policies or vehicles. *Upshaw v. Trinity Companies*, 842 S.W.2d 631 (Tex. 1992).

2. Per Person/Per Occurrence

As with the Liability coverage, the limits are delineated on a per person, per occurrence basis. In *Christian v. Charter Oak Fire Ins Co.*, 847 S.W.2d 458 (Tex. App.--Tyler 1993, writ denied), the wrongful death beneficiaries could not recover additional "per person" limits for their bystander claims where they had settled their wrongful death claim under the UM/UIM coverage. There was one claim for the death and the survivors were not entitled to additional damages for having witnessed the death.

3. No Duplication of Payments

The policy provides any payment under the UM/UIM or PIP coverages to or for a covered person will reduce any amount that person is entitled to recover under the liability coverage. This provision prevents a duplication of payments.

4. Does Settlement For Less Than Liability Limits Trigger UIM Coverage?

In *Olivas v. State Farm Mut. Automobile Ins. Co.*, 850 SW.2d 564 (Tex. App--El Paso 1993, writ denied), the court held an insured's settlement with the at-fault party for less than the full amount of that party's liability coverage does not bar a claim for UIM coverage. The UIM carrier, however, is allowed to offset its coverage by the full amount paid by the liability carrier. *See Leal v. Northwestern National County Mut. Ins. Co.*, 846 S.W.2d 576 (Tex. App.--Austin 1993, no writ).

5. Offset

Another issue in automobile insurance is the question of personal injury protection offsets. The question before many courts is to the extent a plaintiff recovers or receives any money under the uninsured motorist portion of his policy, can the insurer take an offset against any sums previously paid under the PIP portion of the same policy.

The basis for PIP offset can be found in the policy language of the uninsured/ underinsured motorist provision. This provision provides:

In order to avoid insurance benefits payments in excess of actual damages sustained, subject only to the limits set out in the declarations and other applicable provisions of this coverage, we will pay all covered damages not paid or payable under any workers compensation law, disability benefits law, any similar law, auto medical expense coverage or personal injury protection coverage.

Under this provision in the Texas Personal Auto Policy, it appears an insurer has the right to credit the amount of benefits paid under PIP if any UM benefits are otherwise due and owing. This theory, however, was disallowed in a particular context in *Dabney v. Home Ins. Co.*, 643 S.W.2d 386 (Tex. 1982). In *Dabney*, two passengers in the insured vehicle were injured and a third was killed. The insurance company settled with the three claimants under the liability portion of the auto policy for negligence of their driver and also paid them PIP benefits. The claimants then brought an action against the insurer for UM benefits on account of the negligence of the other driver. Of significance, the insured's damages clearly exceeded the benefits available under the policy. Judgment was rendered against the insurance company. While the insurer argued it was entitled to reduce that judgment by the amount of PIP benefits already paid, the court disagreed. *Id* at 389.

The *Dabney* court's analysis of the offset issue consisted of two sentences out of a four-page opinion. It merely cited its earlier decision in *Westchester Fire Insurance Co. v. Tucker* 512 S.W.2d 679 (Tex. 1974), which involved offset of medical payment benefits, and drew a parallel between medical payment benefits and PIP benefits. One must, therefore, return to *Tucker* to fully understand this issue.

Tucker involved a claim where the insured's damages exceeded \$46,000, greater than the combined limits of UM and medical expense coverage. The policy had a reduction clause which said the insurer would not be obligated to pay UM benefits for the part of the insured's damages which represented expenses for medical services paid or payable under the medical expense coverage. *Id.* at 685. The Supreme Court, relying on its earlier decision in *American Liberty Insurance Co. v. Ranzau*, 481 S.W.2d 793 (Tex. 1972), held the reduction clause was "ineffective to the extent it reduces the uninsured motorist's protection below the minimum [statutory] limits." 512 S.W.2d at 686.

In *Ranzau*, the claimant had damages of \$50,000 and had potential UM coverage under two separate policies, each with \$10,000 limits. One carrier paid; the other refused, invoking its “other insurance clause.” The Supreme Court held the “other insurance” clause cannot be used to limit the recovery of actual damages. According to *Tucker*, *Ranzau* held “that the ‘other insurance’ provision... [is] ineffective insofar as it operates [as] to deny or reduce the protection required by our insured motorist statute.” 512 S.W.2d at 683; *see also Ranzau*, 481 S.W.2d at 797; *Accord American Motorist Ins. Co. v. Briggs*, 514 S.W.2d 233, 236 (Tex. 1974).

Under these cases, then, the Supreme Court did not disapprove the use of offset or reduction provisions in *every single circumstance*. It was trying to prevent insurance companies from automatically using those provisions because--sometimes--that results in the insured not being able to recover actual damages. What the Supreme Court found objectionable in *Dabney* was the use of a reduction or offset clause to inhibit recovery of actual damages. This point was reiterated in *Stracener v. United Services Automobile Association*, 777 S.W.2d 378 (Tex. 1989), where the court held that to determine whether uninsured motorist benefits are due, the liability proceeds from the tortfeasor’s carrier are to be subtracted from the actual damages rather than the limits of the uninsured motorist coverage. *Id.* at 380, 383. Thus, it appears from the case law that an offset or reduction should be allowed where a plaintiff’s damages are less than the UM limits.

Several courts of appeal have addressed the PIP offset issue and reached various results. In *Travelers Indemnity Company of Rhode Island v. Lucas*, 678 S.W.2d 732 (Tex. App.--Texarkana 1984, no writ), the insured’s damages exceeded the limits of UM coverage. The court, therefore, held the insurer was not allowed to credit PIP payments against UM benefits. *Id.* at 735-736.

The Houston Fourteenth Court of Appeals reached the right result but did so in the wrong manner in *James v. Nationwide Property and Casualty Ins. Co.*, 786 S.W.2d 91 (Tex. App.--Houston [14th Dist.] 1990, no writ). In this case, Betty James sustained total damages of \$4,000 in an accident with an uninsured motorist. She was paid \$840 in PIP benefits and then made a UIM claim for \$4,000. Nationwide asserted that it was entitled to an offset of \$840 against the UIM claim and the Houston Court of Appeals agreed. Improperly relying on TEX. INS. CODE ANN. art. 5.06-3(h), which dealt with liability coverage rather than UM coverage, the court based its decision on the fact Ms. James’ situation did not involve a reduction of UM benefits below the statutory limits. *Id.* at 94. Some observers criticize *James*’ effect on the ‘PIP offset’ question because the Houston Court of Appeals decided the case under TEX. INS. CODE ANN. art. 5.06-3(h) which clearly allows a liability insurer to take an offset if a PIP claim is made by a passenger in a vehicle. The facts of *James*, however, did not deal with a liability offset, but rather, a UM claim. The Texas Supreme Court has noted UM claims are not the same as liability claims. *See Members Mut. Ins. Co. v. Hermann Hasp.*, 664 S.W.2d 325 (Tex. 1984)(holding “[i]n contrast to liability insurance, uninsured motorists coverage protects insureds against negligent, financially irresponsible motorists”). Consequentially, *James* reached the correct result but was probably decided under the wrong theory.

Recently, in *Mid-Century Ins. v. Kidd*, 974 S.W.2d 848 (Tex. App.—El Paso 1998, pet. granted) the El Paso Court of Appeals denied an insurer’s attempt to offset PIP benefits against UM payments. First, the court distinguished *James* because Article 5.06-3(h), the Insurance Code provision relied upon in *James* to entitle the insured to an offset of PIP payments, only applies to “guests or passengers.” *Id.* at 849. Thus, because *Kidd* was the owner and operator of the vehicle, Article 5.06-3(h) was inapplicable. As discussed above, however, Article 5.06-3(h) is inapplicable in this context because it deals with liability coverage rather than UM coverage. Second, without mentioning or analyzing the offset provision in the policy, the court relied on *Dabney* and held *Mid-Century* was not entitled to an offset for PIP benefits paid to *Kidd*. This case is significant because *Kidd*’s total UM damages, \$13,000, were well below the available policy limits, \$100,000.

In another interesting twist, the San Antonio Court of Appeals denied an insurer’s attempt to offset PIP benefits from a settlement of UM benefits in *Nationwide Mist Ins. Co. v. Gerlich*, 982 S.W.2d 456 (Tex. App.—San Antonio, pet. granted). The court concluded the settlement amount was not a stipulation of the insured’s actual damages and could have represented the damages not covered by the PIP benefits. *Id.* at 457. Thus, there was no evidence the insured was receiving a double recovery. Additionally, the court relied on *Dabney* to support its holding. In doing so, the court rejected the insurer’s argument that *Dabney* was distinguishable because the case relied upon by the court in *Dabney* held the offset provision was only ineffective to the extent it reduced UM benefits below the minimum limits required by law. Specifically, the court stated:

To hold that the opinion in *Dabney* is necessarily limited by the holding in *Westchester Fire* prematurely decides that the Supreme Court was not persuaded by the various reasons given for invalidating similar offsetting provisions in other jurisdictions. Therefore, following the holding in *Dabney*, the trial court properly refused the offset in this case.

Id. at 458-59. As such, the court denied the insurer’s attempt to offset PIP benefits.

In *Kim v. State Farm Mutual Automobile Ins. Co.*, 966 S.W.2d 776 (Tex. App.—Dallas, 1998, no writ.), the Dallas Court of Appeals addressed the PIP offset question. In the case, *Kim* had stipulated her total damages were \$10,000 and State Farm had already paid \$2,500 in PIP coverage. In looking at the policy language, the court held State Farm had only “agreed to pay all covered damages that were not previously paid or otherwise payable from another source including PIP coverage.” *Id.* at *2. Thus, under the terms of the policy the court found *Kim* was only entitled to receive \$7,500 under the UM portion of the policy. In reaching this decision, the Dallas Court rejected *Kim*’s reliance on *Dabney* for the proposition that an insurer cannot legally offset payments made under PIP coverage. The court reasoned *Dabney* was not dispositive on the PIP offset question because *Dabney* did not involve a “specific contract provision that allows offsets to prevent recoveries in excess of actual damages.” *Id.* at *4. *See also Laurence v. State*

Farm Mist. Auto. Ins. Co., 984 S.W.2d 351 (Tex.App.—Austin 1999, no pet) (insurer entitled to offset PIP payments when insured’s actual damages are less than the combined PIP and UM coverages); *State Farm Mut. Auto. Ins. Co. v. Brown*, 984 S.W.2d 695 (Tex. App.—Houston [1st Dist.] 1998, writ denied).

F. ANYTHING ELSE IMPORTANT?

1. UM/UIM Rejection

As noted above, UM/UIM coverage must be a part of every liability policy unless the insured rejects the coverage in writing. Texas Insurance Code art. 5.06-1(1) (Vernon’s 1998). Absent this written rejection, UM/UIM coverage is automatic. One question which arises is whether a rejection of UM/UIM coverage applies retroactively. The public policy favoring UM/UIM coverage was addressed by the Dallas Court of Appeals in *Howard v. INA County Mut. Ins. Co.*, 933 S.W.2d 212 (Tex. App.--Dallas 1996, writ denied).

In this case, Howard suffered personal injuries as a result of an automobile accident with an underinsured motorist in 1993. At the time of the accident, Howard was driving a company vehicle owned by Palestine Contractors, Inc. INA insured Palestine under a commercial automobile policy. In the policy, Palestine’s vice-president signed the UM/UIM coverage selection form but failed to date it or to select any of the three coverage options available. Howard then filed a claim for UIM benefits under the policy but was denied coverage because the vice-president had never checked the appropriate coverage. On September 26, 1994, the vice-president executed a new UM/UIM coverage rejection form indicating Palestine’s rejection of UM/UIM coverage in its entirety. After suit was initiated by Howard, INA moved for summary judgment contending Palestine and INA voluntarily removed the policy retroactively to reflect their intent and agreement to reject the UM/UIM coverage at the time INA originally issued the policy. The trial court granted INA’s motion.

On appeal, the Dallas Court of appeals reversed the trial court. They noted according to article 5.06-1 of the Texas Insurance Code, the insured must reject UM/UIM coverage in writing. Absent a written rejection, the court concluded every automobile liability policy of insurance delivered contains UM/UIM coverage by operation of law. As for the reformation argument, the court noted that because the legislature emphasized the import of protecting insured motorists suffering financial loss caused by the uninsured or underinsured motor vehicles; they would strictly construe the policy language at force at the time of the accident and reject the parties’ true intent or their later reformation. *See also Ortiz v. State Farm Mut. Auto. Ins. Co.*, 955 S.W.2d 353 (Tex. App.--San Antonio 1997, no writ) (holding written rejections of UM, UIM, and PIP coverages were valid without application being attached to or incorporated into policy).

Recently in *Old American County Mutual Fire Ins. Co. v. Sanchez*, the Austin Court of Appeals held that an insured spouse could not waive UM/UIM coverage on an insured’s behalf since she was not named as an insured under the policy. 81 S.W.3d 452 (Tex.App.—Austin 2002, no writ).

2. No Statutory Or Common Law Duty Of Good Faith And Fair Dealing After Judgment

An insured has no bad faith cause of action for an insurer's post judgment conduct. In *Mid-Century Ins. Co. of Texas v. Boyte*, 80 S.W.3d 546, the Texas Supreme Court held that the insurer's good faith duties end when "the only legal relationship between the parties following entry of judgment [is] that of judgment credit and judgment debtor."

3. No Breach Of The Duty Of Good Faith And Fair Dealing Reasonable Settlements

An insurer does not breach the duty of good faith and fair dealing by exhausting most of the policy limits on the insureds willing to settle. *Carter v. State Farm Mut. Auto. Ins. Co.*, 33 S.W.3d 369, 374 (Tex.App.—Ft. Worth, 2000, writ denied). In *Carter*, a passenger and his parents sued the car owner's UM carrier for bad faith for exhausting most of the UM limits on the other insureds, including the family of a deceased passenger. *Id.* at 370. The Fort Worth Court of Appeals held that State Farm acted reasonably and did not breach its contract or the duty of good faith and fair dealing by settling with covered persons, even where the settlement exhausts or diminishes the policy proceeds. *Id.* at 372-373.

III. THE CONTINUING MYSTERY OVER STOWERS DEMANDS

The supreme court in *American Physicians. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994). set forth the requirements of a valid *Stowers* demand. There the supreme court held that a settlement demand will not activate the *Stowers* duty unless three prerequisites are met: (1) the claim against the insured is within the scope of coverage; (2) the amount of the demand is within the policy limits; and (3) the terms of the demand are such that an ordinary prudent insurer would accept it, considering the likelihood and the degree of the insured's potential exposure to an excess judgment. *Garcia*, 876 S.W.2d at 849 *Hanson v. Republic Ins. Co.*, 5 S.W.3d 324 (Tex. App. — Houston [1st Dist.] 1999); *Southern County Mut. Ins. Co. v. Ochoa*, 19 S.W.3d 452 (Tex.App. — Corpus Christi 2000, no pet.)

On May 23, 2002, the Texas Supreme Court in *Rocor International, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 45 Tex. Sup. Ct. J. 659 (May 23, 2002) for the first time recognized statutory liability from an insurer to its insured for failing to settle a third-party claim. This liability was predicated upon violation of the Unfair Claims Settlement Practices Act. In that decision, a majority held that in order to establish liability for the insurer's failure to reasonably attempt settlement of a claim against the insured, the insured must show:

- (1) the policy covers the claim;
- (2) the insured's liability is reasonably clear;
- (3) the claimant has made a proper settlement demand within policy limits; and
- (4) the demand's terms are such that an ordinarily prudent insurer would accept it. *Id.* at 664.

In many of the issues, the requirement for a valid or proper settlement demand are the same. In addressing whether or not the same rules that govern *Stowers* demands were going to govern liability under the Unfair Claims Settlement Practices Act, the supreme court stated:

We see no reason why an insurer's duty to its insured under article 21.21 should not be similarly circumscribed. Accordingly, we hold that an insurer's statutory duty to reasonably attempt settlement of a third-party claim against its insured is not triggered until the claimant has presented the insurer with a proper settlement demand within policy limits that an ordinarily prudent insurer would have accepted. *See id.* A proper settlement demand generally must propose to release the insured fully in exchange for a stated sum, although it may substitute the "policy limits" for that amount. *See id.*, 848-49. At a minimum, the settlement demand must clearly state a sum certain and propose to fully release the insured. *See Id.* at 849. *Id.*

Where the insurer does not have the contractual right to control settlement, then no *Stowers* duty can exist. For example, in many professional liability policies, the insurer has the right to consent to settle. Under these policies, the insurer contractually has relinquished the right to settle the case to the insured. *See, e.g., Brion v Vigilant Ins. Co.*, 651 S.W.2d 183 (Mo. App. 1983). An insurer who settles without the insured's consent under such a policy may be liable for ensuing damages to the insured. *Id.* at 185. Conversely, if the insured refuses to settle the case and an excess judgment results, then the insurer would have no liability under the *Stowers* Doctrine.

A third area that is somewhat less problematic concerns excess or umbrella policies. Typically, these policies will not provide a defense if the defense is being provided by the primary insurer. However, most of these policies obtained through the admitted market are not indemnity policies but "pay on behalf of" policies. As such, once the underlying layer of insurers have tendered their limits to settlement, then the settlement obligation under the excess or umbrella policy would be triggered. If the excess or umbrella carrier fails to exercise ordinary care in the settlement of the case, there would potentially be *Stowers* liability. *See Emscor Mfg., Inc. v. Alliance Ins. Group*, 879 S.W.2d 894 (Tex. App.—Houston [14th Dist] 1994, n.w.h.).

With respect to statutory liability, in the *Rocor* case, National Union was an excess insurer. However, the supreme court found the requisite control of settlement. The court noted that:

[W]hile National Union did not have a contractual duty to defend Rocor, it did have a duty to indemnify Rocor for covered losses. As in *Stowers*, the policy prohibited the insured from settling a suit, except at its own expense, without the insurer's consent. And it is undisputed that National Union assumed exclusive control over settlement negotiations after January 1990. *Rocor* at 666.

Under the terms of the policy, only National Union had the right to take complete and exclusive control of the suit and the insured was prohibited from making a settlement, except at its own expense, or to interfere with any negotiations for settlement without the consent of the company. National Union reserved the right to settle any claim or suit brought against the insured. Therefore, the issue of control is still an element in statutory cases and must be demonstrated in order to establish liability.

A. THE WRITTEN DEMAND

The first issue which must be addressed in any *Stowers* demand is whether or not the demand is required to be in writing. While the Texas Supreme Court has not yet addressed this specific issue, directions from the Supreme Court would seem to indicate that a written demand would be required.

The dissent in *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994) interprets the majority opinion as requiring a “formal settlement demand” in order for the *Stowers* Doctrine to be activated. The dissent states:

The court describes an insurer’s duty to settle as (1) the duty to accept reasonable settlement demands within policy limits, (2) the duty to exercise that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business in responding to settlement demands within policy limits, and (3) a duty of ordinary care that includes reasonable attempts to settle within the insured’s coverage after they receive a formal settlement demand within the policy limits. *Id.* at 865. (Emphasis ours.)

The majority comments on the dissent and states:

[W]e have no quarrel with the notion that a formal demand is not “an absolute prerequisite” . . . for holding an insurer liable for damages caused by its misconduct other than a *Stowers* breach. *Id.* at 849. (Emphasis ours.)

The majority opinion later goes on to state:

Moreover, to the extent that *Stowers* and *Ranger* formalize the negotiation process, we think claimants are perfectly capable of transmitting suitable settlement demands without assistance from the other side. *Id.* at 851, n. 17.

The issue of a written settlement demand was most recently addressed in the *Rocor* case. There the court noted:

As we *have* said, a proper settlement demand must clearly state a sum certain and propose to fully release the insured. *See Garcia*, 876 S.W. W.2d at 848-49. The record in this case reflects no such demand. The plaintiffs’ only written settlement demand was for \$10 million, which was conveyed in a May 4, 1990

letter to Martin & Renneker. Rocor does not based its unfair settlement practices claim on National Union's failure to accept this demand, nor could it, given the disparity between that amount and the \$6.4 million for which the case ultimately settled. *Rocor* at 665.

After this discussion, the court goes on to address whether or not an oral settlement demand would be sufficient to be a "proper settlement demand" under article 21.21. The court went on to state:

Rocor relies primarily upon Soechting's oral offer made to Renneker at the April 11, 1990 meeting. However, the record reveals great confusion about that offer's terms. At the meeting, Soechting requested settlement worth \$4.5 million. At trial, Soechting testified that he intended that figure to settle only the adults' claims, and that he was willing to settle the children's claims for \$1.8 million, for a total combined settlement of \$6.3 million. Because the case ultimately settled for close to that amount nearly one year later, Rocor claims that National Union reasonably delayed settlement and is liable for unfair claim settlement practices. But correspondence from Martin to Rocor contemporaneous with the April negotiations suggests that Renneker understood the \$4.5 million offer was to settle all claims, including the children's. Although Soechting testified that he "believed" he communicated to Renneker that the offer's scope was limited, the record indicates that Renneker did not understand the terms of Soechting's proposal.

In *Garcia*, we stated that the *Stowers* remedy of shifting the risk of an excess judgment onto the insurer is not appropriate unless there is proof that the insurer was presented with a reasonable opportunity to settle within policy limits. *Garcia*, 876 S.W.2d at 849. We implied that a formal settlement demand is not absolutely necessary to hold the insurer liable, *see id.*, although that would certainly be the better course. But at a minimum we believe that the settlement's terms must be clear and undisputed. That is because "settlement negotiations are adversarial and . . . often involve[] hard bargaining by both sides." *Id.* Moreover, the settlement process can be fluid and complex, as the negotiations in this case indicate. Given the tactical considerations inherent in settlement negotiations, an insurer should not be held liable for failing to accept an offer when the offer's terms and scope are unclear or are the subject of dispute. Soechting's oral proposal at the April 11th meeting did not clearly state the proposed settlement's terms, nor did it mention a release. Accordingly there is no evidence that National Union was presented with a proper settlement demand, which is a prerequisite to article 21.21 liability. *Id.* at 665.

The placement by the Texas Supreme Court of the burden of making an offer on the plaintiff also supports the fact that the settlement demand must be in writing. In *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842 (Tex. 1994), the Texas Supreme Court placed the burden of making a *Stowers* demand upon the plaintiff. The court there held:

From the standpoint of judicial economy, we question the wisdom of a rule that would require the insurer to bid against itself in the absence of a commitment by the claimant that the case can be settled within policy limits. 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 (Tex. 1994).

Under the rationale in *Garcia*, there must be a commitment by the claimant that the case can be settled within the policy limits in order to be a valid *Stowers* demand. In other words, the defendant must be able to accept the demand and the case be concluded. If the offer is oral, that situation simply does not exist. If oral offers were allowed, plaintiff would be able to make an oral demand for the policy limits hoping that the insurer would not accept the demand. If the insurer does not accept the demand, then the plaintiff later on can argue that indeed there was a valid *Stowers* demand. If the insurer accepts the demand, then the plaintiff is in a position to argue there is no valid settlement because the terms of Rule 11 have not been complied with. In essence, it allows a plaintiff to attempt to place the insurer in a *Stowers* position without actually committing himself to a settlement. This is not what the supreme court had in mind in *Garcia* and is why a settlement demand must be in writing in order to trigger a *Stowers* obligation.

1. Demand Made When Coverage Existed

In many cases, there will be multiple petitions filed, some of which will invoke coverage and some of which do not. Whether a petition has alleged facts sufficient to invoke coverage is very important with respect to the timing of the *Stowers* demand. *Id.* at 848. In *America Physicians Ins. Exchange v. Garcia*, the supreme court reiterated the usual rule regarding determining the duty to defend. The court stated that the duty to defend is determined solely by the allegations in the pleadings filed against the insured. If the petition does not allege facts within the scope of coverage, an insurer is not legally required to defend a suit against its insured. *Id.* at 847-848. More importantly, however, the court went on to state that there is no duty to settle a claim that is not covered under the terms of the policy. *Id.* at 848. In other words, if there is no duty to defend, then the possibility of indemnity under the terms of the policy is foreclosed and hence, there is no duty to settle. As a result, any settlement demand received while there is no duty to defend would not trigger a *Stowers* duty.

Only settlement demands triggered during the time in which there is a duty to defend would trigger a duty on the part of the insurer to respond. The supreme court in *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842 (Tex. 1994), in footnote 19 stated:

Because the Cardenases' claim technically was not covered under the APIE policy until the day of trial, only the \$1.6 million settlement demand could have potentially triggered a *Stowers* duty.

For example, if the plaintiff sends a written *Stowers* demand for the policy limits at a time in

which there is no duty to defend, a *Stowers* duty has not been triggered. One issue raised by this scenario is whether or not there would be a duty if the insurer were defending pursuant to a reservation-of-rights letters and the issue of coverage was not certain. However, in the *Garcia* case, it appears that a defense was being conducted pursuant to a reservation-of-rights letter and that APIE paid for defense costs during the entire case. Based upon footnote 19 of the decision, the fact that APIE was defending pursuant to a reservation-of-rights letter did not change the fact that no *Stowers* duty was triggered when the pleadings did not assert a claim covered under the APIE policy.

The *Rocor* opinion likewise adopted the same rationale as in *Garcia*. In *Rocor*, the court held:

Accordingly, we hold that to trigger an insurer's statutory duty to reasonably attempt settlement of a third-party claim against its insured, the policy must cover the claim and the insured's liability to the third party must be reasonably clear.

Rocor Intl., Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa., 45 Tex. Sup. Ct. J. 659, 664 (May 23, 2002).

2. Specificity of Demand

One issue that is raised on numerous occasions is how specific must the settlement demand be from the plaintiff. In certain instances, the plaintiff may not be aware of the limits of liability insurance available to defendant. In other cases, the limits may have been eroded by payments of prior claims. In such cases, the plaintiff may make a blanket demand for the remaining limits of insurance available to defendant. In such cases, the plaintiff will be taking a chance that the insurance is at a level that would satisfy his evaluation of the case. The current state of the law appears to be that a plaintiff demand for the policy limits will be sufficient to trigger a *Stowers* demand. In *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842, 848 (Tex. 1994), the supreme court addressed this precise situation. There the court held that:

Generally, a *Stowers* settlement demand must propose to release the insured fully in exchange for a stated sum of money, but may substitute "the policy limits" for a sum certain.

Id. at 848. Therefore, a demand for the "policy limits" would appear to be specific enough to trigger a *Stowers* duty. *Rocor* also follows the *Garcia* holding regarding the specificity of demand. In *Rocor*, the court held:

A proper settlement demand generally must propose to release the insured fully in exchange for a stated sum although it may substitute the "policy limits" for that amount.

Rocor Intl., Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa., 45 Tex. Sup. Ct. J. 659, 664 (May 23, 2002).

3. Demand Is Within Policy Limits

In *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842 (Tex. 1994), the Texas Supreme Court set forth three prerequisites which must be met in order for a *Stowers* duty to be activated. The second element in the list was that the demand is within the policy limits. *Id.* at 849. While this requirement would seem fairly simple, in practice it is not. There are a number of variations of this rule which make the application difficult in certain circumstances.

4. Demand In Excess Of Policy Limits

Courts are in agreement that where there is a demand by the plaintiff which is in excess of the policy limits provided by the insurer, no *Stowers* duty has been triggered. *Westchester Fire Ins. Co. v. American Contractors Ins. Co. Risk Retention Group*, 1 S.W.3d 872 (Tex. App.—Houston [1st Dist.] 1999). The insurer is not in a position to accept the demand and bring about a conclusion to the litigation in this particular instance. As a result, no *Stowers* duty is triggered, and no duty exists on the part of the insurer to respond to the settlement demand. In fact, in footnote 13 of the *Garcia* opinion, the Supreme Court specifically stated:

A liability policy requires an insurance company to indemnify an insured only up to the insured's contractual limits with that company. Thus, insurers have no duty to accept over-the-limit demands.

Garcia, 875 S.W.2d at 849, n. 13.

In *Rocor International Inc. v. National Union Fire Ins. Co of Pittsburgh, Pa.*, the supreme court also has required that a demand be within policy limits in order to trigger statutory liability. In *Rocor*, the supreme court likewise required that the demand be within the policy limits. The third element of a valid demand for statutory liability requires that the claimant has made a proper settlement demand within policy limits. *Rocor Intl., Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 45 Tex. Sup. Ct. J. 659, 664 (May 23, 2002).

5. Willingness Of Insured To Contribute

As a general rule, a demand in excess of the policy limits will not trigger a duty under the *Stowers* doctrine. *Garcia*, 876 S.W.2d at 855. However, this does not mean that a settlement offer in excess of the policy limits could never trigger a *Stowers* duty. In footnote 13 of the *Garcia* opinion, the majority noted:

We do not reach the question of when, if ever, a *Stowers* duty may be triggered if an insured provides notice of his or her willingness to accept a reasonable demand about the policy limits, and to fund the settlement, such that the insurer's share of the settlement would remain within the policy limits.

Id. at 849.

According to Keeton, if the insured is willing to contribute the difference between the insurance policy limit and the total settlement demand, then the *Stowers* duty on the part of the insurer would be triggered. Keeton Insurance Law, § 7.8(d).

This interpretation has been followed by at least one Texas court. The San Antonio Court of Appeals held that a jury's finding that the insurer was negligent in failing to settle constituted an implied finding that a demand for \$1 million in addition to the policy limits was a "demand within policy limits." *State Farm Lloyds Ins. Co. v Maldonado*, 935 S.W.2d 805, 815-16 (Tex. App. -- San Antonio 1996, n.w.h.). In *Maldonado*, the underlying suit involved Maldonado's claims against Robert for defamation arising out of Robert's statement accusing Maldonado of being a thief and prostitute. *Id.* at 808. The trial court rendered judgment for Maldonado for \$2 million plus prejudgment interest. *Id.* Robert and Maldonado sued State Farm for breach of its *Stowers* duty regarding settlement of the defamation suit. *Id.*

During the underlying suit, Maldonado's attorney orally offered to settle the suit for State Farm's policy limits of \$300,000 plus \$1 million from Robert's own pocket, and that the offer would expire in thirty days. *Id.* at 809. On the 29th day, State Farm made a written offer to settle for \$50,000 and informed Robert that Maldonado had made a demand in excess of the policy limits, and advised Robert to seek advice of a personal attorney. *Id.* Eleven days later, Maldonado again extended the demand for \$1.3 million for another 3 days. *Id.* Although State Farm did not accept the settlement offer, Robert entered into an agreement to pay Maldonado \$1 million, and did not assign his causes of action against State Farm. *Id.* After the settlement deadline passed, Maldonado denied State Farm's request for an extension of time to accept the settlement offer. *Id.* Later, State Farm offered its policy limits, but Maldonado declined the offer. *Id.* at 810.

The court concluded that the "bifurcated nature" of the demand brought it within policy limits, triggering the *Stowers* duty. *Id.* at 815. The court explained that the demand was tendered both orally and in writing, although the bifurcation of the demand was not reduced to writing. Indeed, no writing is necessary to trigger the *Stowers* duty. *Id.* The court characterized the demand as "an offer of a policy limits" settlement . . . made to State Farm if Robert would pay \$1 million out of his own pocket. *Id.* The court stated:

We note that the present case presents an unusual factual situation. However, the supreme court, while not reaching the merits of the applicability of *Stowers* in such a circumstance, acknowledged that such a situation was feasible . . . We find little distinction between a demand such as this one made in the present case and a more traditional *Stowers* demand. In both cases, the demand to the insurer is limited to the coverage provided in the policy. As such, a demand such as the one in the present case places no additional burden on the insurer. If the insured is amenable to funding the portion of the demand in excess of policy limits, as he was in the present case, the demand to the insurer falls within those limits. *Id.* at 816 (quoting *Garcia*, 876 S.W.2d at 849 n. 13).

The supreme court disagreed with the application of the law of the facts in that case. The court noted that in *American Physicians*, the supreme court had left open the question of whether a

Stowers duty is triggered “if an insured provides notice of his or her willingness to accept a reasonable demand above the policy limits, and to fund the settlement, such that the insurer’s share of the settlement would remain within the policy limits.” *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 849, n. 13. However, in this case, the court went on to state:

Because State Farm did not know that Robert made an unconditional offer to pay the \$1 million excess, we are not confronted with the situation, and we therefore decline to decide it here. *State Farm Lloyds Ins. Co. v. Maldonado*, 963 S.W.2d 38, 41 n. 6 (Tex. 1998).

6. Stacked Policies

Another area that is problematic to both the plaintiff and the insurer is the situation where there is a primary policy with excess policies stacked on top. First, it should be noted that the supreme court in the *Garcia* opinion specifically refrained from addressing this situation. There the Court stated:

Nor do we address the *Stowers* duty when a settlement requires funding from multiple insurers and no single insurer can fund the settlement within the limits that apply under its particular policy.

American Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 849, n. 13. The supreme court in *Garcia* further stated in footnote 25:

Although we have discussed the process of allocation indemnity or settlement costs among multiple insurers, this opinion does not address what responsibilities a *Stowers* duty imposes when two or more insurance companies, excess insurers, or reinsurers must jointly fund a settlement. *Id.* at 855, n. 25.

7. Concurrent Policies

In some cases, there may be multiple policies available to pay the claim but instead of the policies being stacked, they may apply on a concurrent primary basis. Again, in footnotes 13 and 26 of *American Physicians Ins. Exchange v. Garcia*, the Supreme Court specifically refrained from addressing the issue of funding from multiple insurers to settle a case.

To address this question, one must first reconcile the other insurance clauses of the policies. If the policies have other insurance clauses typical in most general liability policies, they will provide for a contribution by limits or equal shares. While an insurer’s duty to defend is not limited by the existence of other insurance, the insurer’s duty to indemnify is. The obligation of insured to contribute toward a judgment or settlement is restricted by the “Other Insurance” clause. The insurer has no legal obligation to contribute toward a settlement more than its percentage of the settlement as determined by the “Other Insurance” clause. For example, if there were two primary policies which apply to a lawsuit and each have policy limits of \$1 million and a settlement offer was received for \$1.5 million, each would have a contractual

obligation only to contribute \$750,000 to the settlement if the policies provided for contribution by limits of equal shares. The obligation under the policy would be for each carrier only to contribute \$750,000.

(a) Demand Within Primary Limits

The more difficult question presented in this situation is when demands are presented that are within the limits of one or more concurrent policies. Clearly, in this situation, the insurer would have the ability to settle the case. However, under the contractual terms of the policy, it is only obligated to pay its pro rata share of the judgment or settlement. Since there has been no guidance provided by the supreme court in this situation, the more prudent course of conduct for the insurer would be to go ahead and pay the limits to settle a case and seek subrogation against the other insurer who was recalcitrant.

(b) Demand In Excess of Limits

An easier situation is presented where the demand is in excess of any of the concurrent primary policies but within the limits of all the policies. In this case, none of the insurers has the ability to settle the case by paying their limits and, similar to the situation which exists with respect to stacked policies, no *Stowers* duty is triggered. However, if the carrier does believe that the settlement demand is reasonable and that the case should be settled, the more prudent course of action would be for the willing carrier to tender its percentage of the settlement. At least one commentator believes that in this situation the company who refused to contribute its share would be responsible and that the carrier who agreed to contribute its share would have no liability. Robert E. Keeton, LIABILITY INSURANCE AND RESPONSIBILITY FOR SETTLEMENT, 67 HARV. L. REV. 1136, 152 (1954).

B. NON-COVERED CLAIMS

In addressing whether or not a *Stowers* demand is valid, one of the issues which must be addressed at the early stages is whether or not the demand seeks recovery for damages not covered by the policy.

1. Effect Of Non-Coverage

One of the most common mistakes made by insureds and insurers alike concerns the extent of the *Stowers* duty. One of the basic premises that must be grasped in order to understand the *Stowers* doctrine is that the duty to settle only extends to covered damages. The insured did not insure those damages not covered by the policy and, as a result, the insurer has no duty to settle those damages. *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 848 (Tex. 1994).

While the duty to defend a case extends to both covered and non-covered damages, this duty does not apply with respect to the duty to settle or indemnify. *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116 (fifth Cir. 1983). In determining whether an insurer has or has not breached its *Stowers* duty, the focus must be solely on the covered damages. If the covered damages that are

eventually found by the jury fall within the limits of the policy, there has been no breach of the *Stowers* even if the non-covered damages exceed the policy limits. It is up to the insured to contribute its money to a settlement to eliminate the risk of non-covered exposure. To hold otherwise would in effect rewrite the contract of insurance that was entered into between the parties.

2. Willingness Of Insured To Contribute To Non-Covered Losses

This issue was more recently addressed in *St Paul Fire and Marine Ins. Co. v. Convalescent Services, Inc.* 193 F.3d 340 (5th Cir. 1999). In that case, the insured was sued for actual damages which were covered as well as punitive damages which were not covered by the terms of the policy. The settlement demand was made within limits of the policy and was rejected by the insurer. The insurer alleged that St. Paul knew that it was willing to contribute additional amounts to settle the case. However, the Fifth Circuit held that this did not trigger any additional duties on the part of St. Paul. The court held:

In both of those cases [*Garcia* and *Maldonado*], the question the Supreme Court expressly left open was “when, if ever, a *Stowers* duty may be triggered if an insured provides notice of his or her willingness to accept a reasonable demand above the policy limits, and to fund the settlement, such that the insurer’s share of the settlement would remain within the policy limits.” 876 S.W.2d at 849 n. 13. Unlike those cases, in the case at bar, Schultz’s settlement demand was not above CSI’s policy limits. More importantly, in contrast to the case at bar, both *Garcia* and *Maldonado* involved claims – and damages corresponding to those claims – that were covered by the insurance policy. . . .

In short, *Stowers* holds insurers liable for damages on covered claims above policy limits to ensure that insurers accept reasonable settlement offers (especially ones close to policy limits) that an ordinary prudent insured would have accepted. *Stowers* therefore extends the policy limits for covered claims; however, CSI’s interpretation would in effect, extend the actual coverage of the insurance contract. CSI’s argument wholly ignores the most basic proposition that an insurer has no duty to settle a non-covered claim. Given these circumstances, CSI has failed to establish that St. Paul had a duty under *Stowers* to accept the \$250,000 settlement demand. *Id.* at 343.

Statutory liability under the Unfair Claims Settlement Practice Act likewise requires that the claim be covered. The first prong in the four-prong test announced by *Rocor* requires that “the policy covers the claim.” The court goes on to note:

Under the common law, and insurer generally has no obligation to settle a third-party claim against its insured unless the claim is covered under the policy. *See Farmers Tex. County Mut Ins. Co. v. Griffin*, 995 S.W.2d 81, 82 (Tex. 1997). Nor is an insurer obligated to indemnify its insured for a third-party claim on which the insured is not liable. [Citation omitted.] These well-established common-law

precepts, which reflect the parties' expectations in contracting for insurance, inform our determination of the scope of the duty the Legislature imposed. Accordingly, we hold that to trigger an insurer's statutory duty to reasonably attempt settlement of a third-party claim against its insured, the policy must cover the claim. . .

3. Offer To Settle Only Covered Claims

One issue that has arisen in limited circumstances in the past is whether a *Stowers* duty is triggered if the plaintiff makes an offer within the policy limits only to settle covered claims while, at the same time, leaving the insured exposed to non-covered claims. Clearly, under the *Garcia* and the *CSI* cases, the carrier has no duty to settle uncovered claims. However, it is equally clear under *Garcia* and *Bleeker* that any settlement must result in a full and complete release for the insured. These two legal statements are not at all inconsistent. Under the current law, if the insurer fails to accept a *Stowers* demand, its conduct will only be reviewed in the context of covered damages. However, as far as there being a *Stowers* duty triggered to begin with, there must be a full release of all liability of the insured. Otherwise, no *Stowers* duty has been triggered.

The rationale for this rule is fairly obvious. If the insurer was able to settle out the covered damages and still leave the insured exposed, the insured would have lost perhaps its most valuable asset, the insurance policy. The insured would have lost the right to have a defense paid for by the insurance carrier as well as the ability to use the policy proceeds to attempt to negotiate a thorough and complete settlement.

C. RELEASE FROM ALL CLAIMANTS

As noted above, in order for a *Stowers* duty to be triggered, there must be an offer to release all claims. A more difficult situation, however, is presented when there is a demand which does not include all of the claimants.

1. Settlement With Some, But Not All The Claimants

Texas courts have already addressed the situation of under what circumstances an insurer may settle with some but not all the claimants. An insurer who is faced with multiple claimants and a policy with insufficient limits may enter into a settlement with one of the several claimants even though such settlement exhausts or diminishes the proceeds available to satisfy other claims. *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 315 (Tex. 1994). The Texas Supreme Court has addressed how an insurer should respond to a situation where that are multiple claimants claiming under a policy with insufficient limits. *Id.*

The lawsuit in *Soriano* arose out of an automobile accident. Soriano, the insured, collided head-on into a vehicle driven by Medina, one of the claimants. As a result of the accident Medina and his children, as well as Soriano's passenger Lopez, were severely injured. Medina's wife was killed. *Id.* at 313.

Soriano had minimum insurance coverage through his parent's policy with Texas Farmer's Insurance group, which provided for limits of \$10,000 per person and \$20,000 per occurrence. Farmers initially offered \$20,000, the policy limits, to the Medinas. This offer was refused. Thereafter the Medinas and Lopez filed suit against Soriano. Prior to trial Farmers settled with Lopez and offered the remaining \$15,000 of the insurance to the Medinas. The offer was refused and a demand was made for the original policy limits of \$20,000. The case went to trial and a judgment was entered against Soriano in the amount of \$172,187.00. *Id.* at 314. Soriano then assigned his cause of action against Farmers to the Medinas in exchange for a covenant not to execute. In the Medina's suit against Farmers, the jury found that Farmers was negligent in the handling of the settlement negotiations and rendered judgment of actual damages in the amount of \$520,577.24 and exemplary damages of \$5 million. *Id.*

The case was appealed, with the primary issue being the standard that was to be applied in reviewing Farmer's conduct in attempting to settle several claims with insufficient policy limits. *Soriano*, 844 S.W.2d 808 (Tex. App. – San Antonio 1993), *rev'd* 881 S.W.2d 312 (Tex. 1994). The court of appeals adopted the "comparative-seriousness" rule. Under this rule, an insurer can be held liable for settling with one claimant to the detriment of the other even though the first settlement was reasonable and entered into in good faith when viewed apart from exposure in the second case. *Id.* at 840. An insurer must measure the proportional limits of each claim and then settle the cases accordingly. *Id.* If the insurer is wrong in this assessment, then it becomes liable beyond its policy limits. *Id.*

The Supreme Court reversed, holding 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 the several claimants even though such settlement exhausts or diminishes the proceeds available to satisfy other claims. *Soriano*, 881 S.W.2d at 315. The court reasoned that this approach would promote settlement of lawsuits and encourage claimants to make their claims promptly. *Id.*

The Supreme Court then stated that Farmers could not be liable for negligently failing to settle the Medina's claims unless there was evidence that either (1) Farmers negligently rejected a demand from the Medinas within policy limits; or (2) the Lopez settlement was itself unreasonable. *Id.* at 315. The court found that there was no evidence of either. First, the Medinas did not demand the \$20,000 until after the Lopez settlement. Farmers was under no obligation at that time to offer to settle in excess of the remaining \$15,000 policy limits. *Id.* at 316. Second, the court stated that to show that a settlement is "unreasonable," the claimant must show that a reasonably prudent insurer would not have made the settlement when considering solely the merits of the first claim and the potential liability of the insured on that claim. *Id.* The court concluded that there was no evidence that Farmer's decision to settle the claim for \$5,000 was unreasonable. The supreme court's holding in *Soriano* has been followed by several courts of appeals. *See Lang v. State Farm Mutual Automobile Ins. Co.*, 982 S.W.2d 545 (Tex. App.-Texarkana 1999, *pet. denied*); *Mid-Century Ins. Co. of Texas v. Childs*, 2000 WL225546 (Tex. App.-Texarkana 2000).

Keeton proposes several solutions to the multiple claimant scenario. These include proration among the claimants of the insurance coverage as well as allocation by agreement of the claimants. Robert E. Keeton, *INSURANCE LAW*, § 8/4(d) and 7.4(e).

Windt offers a more pragmatic approach, though one not recognized in Texas. According to Windt, the insurer should first invite all of the potential claimants to join and participate in efforts to reach an agreement as to the available funds. If an agreement cannot be reached, then the insurer may simply pay the policy limits to the insured. A. Windt, *INSURANCE CLAIMS AND DISPUTES*, § 5.08. Windt's proposal is somewhat troubling in that it allows the insurer to delegate its responsibility regarding settlement to the insured. Again, in many cases, the insurer may have negotiators who are far more skilled than the insured in negotiating claims.

However, the above discussion only addresses the situation of where the insurer elects to accept settlement demands from some but not all of the claimants. A very real issue is does an insurer have liability if it refuses to accept settlement demands from some, but not all of the claimants.

2. *Stowers* Demand From Some But Not All Of The Claimants

A more difficult issue which has not been directly addressed by the Texas Supreme Court is whether or not a *Stowers* duty is triggered if the insurer receives a settlement demand that would fully release the insurer from some, but not all, of the plaintiffs.

(a) *American Physicians Ins. Exchange v. Garcia*

In *American Physicians Ins. Exchange v. Garcia* 876 S.W.2d 842 (Tex. 1994), the supreme court reiterated the rule that for a *Stowers* demand to be effective, it must propose “to release the insured fully in exchange for a stated sum of money. . . .” *Id.* at 848. The supreme court in the case did not define what the term “fully” meant. The court did not indicate whether or not it required a release by all claimants against the insured.

(b) *Texas Farmers Ins. Co. v. Soriano*

In the same year that the *Garcia* case was decided, the supreme court also decided *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312 (Tex. 1994). In *Soriano*, the supreme court reiterated the requirement that a settlement demand must “propose to release the insured fully in exchange for a stated sum of money” in order to be effective. *Id.* at 312. In *Soriano*, two sets of claimants were making claims against the insured arising out of the same accident. The Lopez claimants were making a claim for the wrongful death of their son. The Medina claimants were making a wrongful death claim for the death of Mrs. Medina and for personal injury claims for Mr. Medina and their two children. Farmers settled with the Lopez claimants for \$5,000 and was later unable to meet the policy limits demand of the Medinas because of the erosion of the limits. The focus of the *Soriano* case was primarily on the issue of whether or not an insurer could settle some but not all the claims without further liability. However, the court did touch on the issue of whether an insurer was required to settle a claim within the policy limits when the settlement would not eliminate all the claimants. The supreme court stated:

When Farmers received the Lopez settlement demand of \$5,000 (\$5,000 to settle a wrongful death claim), Farmers was required under *Stowers* to exercise reasonable care in responding to that demand.

Id. at 315.

From reading this particular statement alone, it would appear that the court was holding that a *Stowers* duty was triggered by the receipt of a settlement demand with the policy limits by one of the claimants. The court was stating that Farmers was required under *Stowers* to exercise reasonable care. If Farmers was required under *Stowers* to exercise reasonable care, then the *Stowers* duty must have been triggered. However, the court later come back and makes a contradictory statement. In the same paragraph, the court states:

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 the several claimants even though such settlement exhausts or diminishes the proceeds available to satisfy other claims.

Id. at 315.

Under this language, it appears that the use of the term “may” indicate that the insurer has the option of entering into a settlement or not.

(c) ***Trinity Universal Ins. Co. v. Bleeker***

This confusion was further compounded by the supreme court’s statements in *Trinity Universal Ins. Co. v. Bleeker*, 966 S.W.2d 489 (Tex. 1998). In that case, fourteen members of the Villarreal and Ochoa families were injured in an automobile accident. Initially, the plaintiffs’ counsel represented five members of the Villarreal family. A settlement demand was made at this time and was not accepted. The attorney came to represent all fourteen claimants and never made another settlement offer. The issue was whether the settlement demand on behalf of five of the fourteen claimants was sufficient to trigger the *Stowers* doctrine. The court noted:

Assuming without deciding that Villegas’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, Villegas did not meet the requirement that he offer to release those claims *fully*.

Id. at 491.

Therefore, in the most recent decision from the supreme court, the supreme court has raised the issue of whether or not an offer to release some of a total pool of potential plaintiffs will trigger a *Stowers* duty.

(d) ***Rocor International, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.***

The supreme court in *Rocor* did not further elaborate as to whether or not a “proper settlement demand” must propose to release all the claimants. The court did restate the proposition announced in *Garcia* that “a proper settlement demand must clearly state a sum certain and propose to fully release the insured.” The court provides no further elaboration regarding whether or not all claimants must be included in the proposed settlement demand.

D. RELEASE OF ALL INSUREDS

A similar issue to that previously presented is the question of whether or not the settlement demand must offer to release all insureds under the policy. If a settlement demand offers to completely release one insured under the policy but fails to address the liability of the other insureds, is there a valid *Stowers* demand?

There are at least two circumstances in which this situation may arise. The first is where there are multiple insureds who are insured under different policies. The result in this case is straightforward. The insurer must treat each insured as if the other did not exist. The *Stowers* obligation will be judged as to each insured under that insured’s policy. See *Caserotti v. State Farm Ins. Co.*, 791 S.W.2d 561 (Tex. App. – Dallas 1990, no writ) (duty of good faith and fair dealing in a multiple insured situation is determined as to each insured under that person’s own policy). The second situation is somewhat more problematic. This is a situation where the insurer may have multiple insureds in a case who are insured under the same policy. In this case, the insurer is presented with a dilemma. If the limits of liability are not sufficient to extinguish the exposure of both insureds, the insurer is faced with a dilemma. Obviously, the insurer should first attempt to settle the combined exposure of both insureds for the limits of the policy. Having failed this, the insurer is faced with the situation of how to approach settlement. No Texas case has given precise guidelines as to how an insurer should approach settlement. However, the Supreme Court in *Texas Farmers Insurance Company v. Soriano*, 844 S.W.2d 808 (Tex. App. – San Antonio 1993), *rev’d* 881 S.W.2d 312 (Tex. 1994) gives guidance. In that case, the Supreme Court held that where an insurer has a single insured faced with multiple claims and inadequate proceeds, the insurer may enter into a reasonable settlement with less than all the claimants. *Soriano*, 881 S.W.2d at 315. The same should be true with respect to multiple insureds with less than adequate limits. If the insurer cannot extinguish the liability of both insureds, then the insurer should not be held liable under the *Stowers* doctrine so long as the settlement that it enters into is reasonable.

According to Windt, if there is more than one insured involved in a claim and the value of the claim exceeds the policy limits, the insurance company cannot prefer one insured over the other. Thus, the insurer could not, without the consent of all the insureds, pay its policy limits to the plaintiff in return for a release of only some of the insureds. A. Windt, *Insurance Claims and Disputes* §5.09. Windt’s approach appears to be inconsistent with the guidance given by the Texas Supreme Court in *Soriano*, and indeed, the Fifth Circuit has declined to expand the

holding of *Soriano* based on nothing more than this “general statement in a handbook. *Matter of Vitek, Inc.*, 51 F.3d 530, 537 (5th Cir. 1995).

In *Vitek* the Fifth Circuit interpreted *Soriano* as recognizing “nothing more than the aggrieved insured’s right to seek damages from the insurance company for making such a settlement, by initiating a suit for breach of good faith.” *Id.* at 537. Thus, the court refused to convert this right to sue into a general prohibition forbidding an insurer from entering into a settlement exclusively to or for the benefit of one of several coinsureds. *Id.*

In *Travelers Indemnity Co. v. Citgo Petroleum Corp.*, 166 F.3d 761 (5th Cir. 1999), Travelers settled on behalf of one of its insureds who had been sued prior to the time the other insured had been named a party to the action. The unnamed insured argued that the insurer must provide equal consideration to it as it does to the party named in the action. After reviewing numerous policy implications, the Fifth Circuit held:

We decline to carve out an exception to *Soriano*’s general rule when an insurer is faced with hypothetical claims against a co-insured party, rather than a hypothetical settlement offer from another claimant against the same insured party. Accordingly, we follow *Arnold* and hold that under Texas law an insurer is not subject to liability for proceeding, on behalf of a sued insured, with a reasonable settlement as defined in *Soriano* at 316, once a settlement demand is made, even if the settlement eliminates (or reduces to a level insufficient for further settlement) coverage for a co-insured as to whom no *Stowers* demand has been made.

Id. at 768.

Again, the issue in *Travelers* was whether or not the insurer had liability for proceeding with the settlement. The precise issue of whether a *Stowers* duty was invoked is different. The *Travelers* court did note:

A *valid* *Stowers* demand in the context of multiple insureds requires that the settlement offer be reasonable, and the insured party reasonably fear liability over the policy limit. In other words, for the issue to come up at all there usually has to be an objective possibility that the liability of at least *one* of the insureds would ultimately seek exceed the policy limits.

Id. at 767. Unfortunately, the court did not address an issue of where there were multiple *Stowers* demands against co-insureds and insufficient limits. In footnote 7 of the opinion, the court noted:

We do not address the duties of an insured [sic] faced with multiple and concurrent outstanding separate *Stowers* demands as to different insureds where the demands in total exceed the policy limits.

Id. at 768. One issue which was left open by the court was the duty of an insurer faced with multiple and concurrent outstanding separate *Stowers* demands as to different insureds where the demands in total exceed the policy limits. *Id.* at 768, n. 7.

E. REASONABLE TIME TO ACCEPT

Another issue bearing upon the validity of a “*Stowers*” demand is whether the insurer had a reasonable opportunity to settle. In other words, was the reasonable time given to the insurer to evaluate the settlement demand and respond. In *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842, 849 (Tex. 1994) the supreme court said:

[T]he *Stowers* remedy of shifting the risk of an excess judgment onto the insurer is inappropriate absent proof that the insurer was presented with a reasonable opportunity to prevent the excess judgment by settling within the applicable policy limits.

In *State Farm Lloyds Ins. Co. v. Maldonado*, the supreme court was confronted with the issue of whether or not an insurer must have a reasonable amount of time to respond to the *Stowers* demand. In that case, the court noted:

There is no evidence that State Farm knew, at a point when it had a reasonable amount of time to respond, that Robert had made an unconditional offer to pay the excess.

Id. at 41. As a result, the court held that unless the insurer has a reasonable time period in which to respond, there is no valid *Stowers* demand.

Finally, the Court of Appeals in *Trinity Univ. Ins. Co. v. Bleeker*, 944 S.W.2d 672 (Tex. App. – Corpus Christi 1997) implicitly recognized the requirement that there be a reasonable opportunity to respond to the settlement offer when they held that the “oral offers were made before the written offer and without imposing any deadline of their own gave Trinity a reasonable time to evaluate them.” *Id.* at 676.

The issue remains “what is a reasonable time.” This period will vary depending upon at what stage of the case the demand is made. If a demand is made at the inception of the case, before any investigation has been conducted, in all probability a deadline of seventy-two hours will be insufficient. However, if discovery has been completed, and the case is set for trial on Monday, a deadline on Friday with a twenty-four hour trigger may be a reasonable time.

F. CONDITIONAL SETTLEMENT

On many occasions, the plaintiff will attempt to condition a *Stowers* offer upon other events occurring. As a general rule, a conditional offer does not trigger a *Stowers* demand. For example, in *Insurance Corp. of Am. V. Webster*, 906 S.W.2d 77 (Houston [1st Dist.] 1995), the plaintiff conditioned the extension of the *Stowers* demand upon there being certain limits of

insurance available to the insured. In fact, these limits were not available to the insured. As a result, the court held:

We conclude that both of the offers are unambiguous. Both of the offers to settle were conditioned on the existence of the same fact -- Webster not having any other insurance that could be used to compensate Zabodyn.... Because other insurance was in existence even before the offers were made, it was impossible of ICA to accept them. *Id.* at 81.

Similarly, many plaintiffs counsel will condition a *Stowers* demand to one insured to the payment of policy limits by another insured by the same carrier or by another defendant. Under *Webster*, these offers are not unconditional and would be highly suspect.

IV. WHAT IS COMMERCIAL GENERAL LIABILITY INSURANCE?

Commercial General Liability insurance -- commonly referred to as "CGL" coverage -- pays money to settle a lawsuit (or pay a judgment) against the insured asserted by a third party because the other person (or entity) suffered bodily injury, personal injury, or property damage due to some act or omission of the insured. CGL coverage also pays for the lawyer (or lawyers) to defend any such suit brought by a third party against the insured.

The CGL policy extends liability coverage to "bodily injury," "property damage," "personal injury," "advertising injury," and medical payments through separate sections. In practice, the CGL policy is often combined into a package with other policies (*e.g.*, commercial property and inland marine, or commercial liability and business auto), tailored to fit the needs of the insured (and insurer) by adding endorsements which extend or restrict the coverage of the basic insuring agreements. Insurers in Texas are now permitted to, and many do, issue their own forms for business liability coverage, if approved by the Texas Department of Insurance (TDI). Those forms are usually close to, or just a variation of, the format and phrasing of the "standard" CGL form issued by the Insurance Services Office. All such business liability forms are generically called "CGL" in this paper, although insurers may have their own names for proprietary forms.

Due to time and space limitations, this paper and the accompanying presentation can provide only an overview of, and some representative citations for, the scope of liability coverage afforded for standard liability coverages. The ones examined in depth are those in a CGL form: "bodily injury," "property damage," "personal injury," and "advertising injury," as these issues are repetitive as an integral feature of other policies as well. The paper includes discussions of some endorsements and policy conditions which affect the scope of coverage.

CGL policies come in two types:

- An "occurrence" CGL policy: this protects the insured from any claims or lawsuits arising out of an "occurrence" which take place during the policy period regardless of when those claims are made against the insured and regardless of when the insured turns that claim into the insurer.

- Claims-made CGL coverage: although this form covers claims caused by an “occurrence” during the policy period, it also limits its coverage to those claims which are actually made against the insured during the policy period (or during a specified period of time after the policy expires). Most professional liability policies (*i.e.*, those insuring lawyers, doctors, architects, etc.) are claims-made liability policies.

A. WHAT IS A POLICY PERIOD?

The policy period is the span of time during which the occurrence must take place which gives rise to the ultimate claim against the insured. Under a claims-made policy, the policy period also defines the period of time during which the insured must give notice of a claim to their insurer.

Determining the relevant policy period and whether the injury or damage for which a claim is made is within the policy period is one of the first steps in evaluating coverage. This determination often involves looking to see if the date of the loss occurred within the policy period stated on the face of the policy. However, in some cases the determination is not obvious from the face of the policy, because it turns upon events that span more than one policy, and upon legal principles established to determine *which events matter* (*e.g.*, acts, injuries) in identifying coverage.

1. Which Insurer Should I Put On Notice?

To determine which carrier or policy provides coverage under the CGL, you must determine the date to which you look, which means you must know what event triggers coverage. There are three prevailing views, although there are also further variations on them. Some courts hold that the coverage trigger is the date on which the damages occurred (the “manifestation” theory), because the policy speaks in the insuring agreement of damages within the policy period. Another line of precedent fixes the date(s) of exposure to harmful conditions from an act or omission as the triggering event for an “occurrence” (the exposure theory), using that date to determine whether a policy applies even if injury only later becomes apparent. Another line of precedent (the “injury-in-fact” theory) focuses upon when injury actually occurred, regardless of the possibly different dates of exposure and manifestation. The injury-in-fact trigger theory often yields the same outcome as the exposure trigger. It differs mostly in cases of long-term exposure to conditions that only cumulatively, and long after first exposure, prove harmful.

Most of the time, a choice among “manifestation,” “exposure,” and an “injury-in-fact” trigger will not affect the coverage outcome, because most claims are for an act that results in immediate and recognized harm, such that the “occurrence” is easily fixed in time. Difficulty most often arises when an act or course of conduct produces latent injury, which only later becomes manifest as actual injury (*i.e.*, structural problems from a contractor’s poor work; environmental contamination; respiratory disease).

Using the manifestation approach, if damages do not manifest to a reasonably attentive person until some time after the act that caused them, the date of the act is not the key to a covered “occurrence” even though the act occurred within the policy period and the recognition of harm did not. The damages must also occur *and be recognized* during the policy period, per the insuring agreement. Failing to realize that policy language and prevailing precedent indicate the possibility of this result is a mistake, even if an insured or plaintiff insists that the manifestation theory is not the proper means of analyzing coverage. The outcome of no coverage for an event within the policy period, just because damages from it are not recognized until later, would often surprise persons not familiar with the policy and precedent taking this view of it. There is good reason for uncertainty about the relevant coverage trigger, because two Texas appellate court decisions appear to be split and the Texas Supreme Court has not ruled on the issue.

2. What Is “Long-Tail Claim” (And Do I Have To Go To The Zoo To See One)?

A “long-tail” claim has nothing to do with wild animals or the zoo. Long-tail claims are those bodily injuries or property damage which do not become apparent until many years after the act or omission which gives rise to the alleged damage. Asbestos provides the best example. Because it takes ten to thirty years for the inhalation of asbestos fibers to noticeably damage the lungs, asbestos has a long “latency period” between exposure and the manifestation of any physical health defects. This delay between the time of the allegedly bad act of exposure and the manifestation of damages is referred to as a “long-tail.” This is significant because it impacts how far back in time an insured may look for insurance coverage to protect itself from the long-tail claims asserted by a third party.

The fact that some “occurrences” produce an injury that does not manifest until a future date is a fairly common concern for the Commercial General Liability Policy approved for use in Texas. For some commercial risks, such as the settling of a foundation or other damage caused by inadequate work, or injury to persons or products due to long-term exposure to hazardous substances, injury may be delayed. When it is, there arises the need to choose among several different rules in use nationally to determine when damages occur.

Although the Texas Supreme Court has not yet made a choice among the different theories for determining the date of injury, the high court has explained the different theories:

Strict Manifestation: Coverage is triggered upon the actual discovery of an injury.

Relaxed Manifestation: Coverage is triggered in the first policy period when a reasonable person could have discovered the injury.

Exposure: Coverage is triggered in any policy period in which an exposure to the cause of injury takes place.

Injury-In-Fact: Coverage is triggered, in personal injury cases, when a body's defenses are overwhelmed.

Multiple or Triple Trigger: Coverage is triggered under all policies in effect during the period of continuing exposure and manifestation.

American Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 853 n.20 (Tex. 1994).

There is a good chance that a manifestation trigger will guide property coverage insurance and the exposure or injury-in-fact trigger (which can amount to a continuous trigger) will govern liability coverage, which would maximize predictability in property coverage while avoiding coverage for a loss-in-progress. It would maximize liability coverage in proportion to the scope of any "progressive" loss, while also taking literally the word "occurs" (the policy does not say damage that was "noticed") in the CGL Insuring Agreement. The Texas Supreme Court, not to mention lower appellate courts, may struggle for consensus when they pick a coverage trigger.

B. WHO IS THE "INSURED?"

It is fundamental to liability coverage that a person seeking it qualify as an "insured."

1. Who Is The Named Insured?

The CGL policy always provides insured status (not coverage, which depends upon the entire policy) for the named insured. The named insured is the entity(s) listed on the declarations page of the CGL policy. The CGL policy also includes certain individuals and entities as insureds depending upon the manner in which the enterprise is organized. Where a CGL policy provides coverage to a sole proprietor, the named insured is often listed in that person's name "d/b/a the insured business." When the named insured is a sole proprietor, the named insured and his or her spouse are insured with respect to the conduct of a business of which the named insured is the sole owner. When the named insured is a sole proprietor and the owner of more than one business, the CGL policy form and the courts are unclear on whether other businesses are also insured by the policy. The insured should therefore list all businesses it wishes to cover.

2. Are My Employees Insureds?

Employees have "insured" status for liability arising out of acts in the scope of their employment by the named insured. The extent of this coverage is determined by the meaning of scope of employment. The workers compensation definition for injury in the course of employment comes from a statute, and is defined as "an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer and that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer." TEX. LABOR CODE ANN. § 401.011 (12) (Vernon 1996). Both the workers compensation definition of course of employment and the CGL meaning of scope of employment affect the coverage grant and determine whether an individual is insured under the

policy. Where there is situational ambiguity, this definition will be read broadly because it determines whether coverage exists for the employee under the CGL policy.

C. WHAT IS AN “OCCURRENCE” AND WHERE CAN I FIND ONE?

Determining what exactly constitutes an “occurrence” is one of the most mystifying aspects of evaluating CGL coverage. Hundreds of Texas cases, dozens of books, and thousands of articles have attempted to accurately explain what constitutes an “occurrence.” Although such legal analysis can become very complicated, it is easier to think of an occurrence as an “accident.” The CGL policy defines “occurrence” as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.”

The insuring agreement for Coverage A of the CGL requires that “bodily injury” or “property damage” be caused by an “occurrence” and that the “bodily injury” or “property damage” occur during the policy period. Most non-environmental litigation over the meaning of “occurrence” does not turn upon injury within the policy period, or even what “exposure to conditions” encompasses, but involves determining what is “an accident.” It is crucial to proper interpretation that the reader know how the policy definition of “occurrence” compares to definitions of that same but *differently defined* term in older policies.

1. If I Did Not Mean To Hurt Anyone, Is It Still An Accident?

An intentional act which directly causes a claimant’s injury is inconsistent with “an accident” and cannot constitute an “occurrence” if “occurrence” is defined without regard to intended or expected injury. The “occurrence” requirement in the CGL policy is defined to require “an accident,” with no mention of intended or expected injury.

The leading Texas precedent on the “occurrence” issue is *Argonaut Southwest Insurance Co. v. Maupin*, 500 S.W.2d 633 (Tex. 1973), and now *Trinity Universal Insurance Co. v. Cowan*, 945 S.W.2d 819 (Tex. 1997). In *Maupin*, an insured removed fill material from land under a mistaken belief of ownership in the real owner’s tenant, so that the resulting damage to the real landowner was clearly unintentional. The Texas Supreme Court rejected coverage due to the lack of an “accident,” basing its decision on the deliberate nature of the trespass, and rejecting as a coverage argument the insured’s ignorance of any circumstances that would make him aware that he was committing a tort (trespass).

Federal courts interpreting Texas law have also held that the “occurrence” requirement similar to the one in the Texas CGL bars coverage for deliberate conduct even though the resulting injury may have been unintended and unexpected. *Metropolitan Property & Casualty Co. v. Murphy*, 896 F. Supp. 645 (E.D. Tex. 1995), addressed invasion of privacy issues and enforced the accident requirement separately from any issue of intended or expected injury.

The Texas Supreme Court’s 1997 decision in *Cowan* states the present standard for an “occurrence,” although not in very plain language. The court will in essence impute to an insured the consequences of his deliberate conduct, and negate an “occurrence,” if (but only if) the

insured would naturally have expected his act to be harmful (using an objective standard). If so, it is reasonable that he be “charged with” the consequences of his act. The court does not explain how such a standard differs from that of the intentional injury exclusion, which it stated it was not interpreting.

2. If I Acted Intentionally, Should I Even Bother To File A Claim?

The insureds should never make a determination by themselves whether or not intentional acts do or do not constitute an occurrence. At a minimum, an insured should consult with their insurance broker or their lawyer to evaluate this issue. Even if an insured has doubts as to coverage, this author believes that insureds should still submit all claims and lawsuits brought by third parties their liability insurer(s) and let the insurer(s) make the coverage determination.

Most insurers in Texas evaluating these issues will frequently look to the *Cowan* decision from the Texas Supreme Court (discussed in the prior paragraphs) to evaluate the coverage question as well as the long line of Texas legal authority on this topic. Despite the decision in *Cowan*, and the continued validity of *Maupin*, identifying a particular act as an “occurrence” or not can still be difficult. The way to do so most reliably is by first identifying *what act* is in issue as a possible “occurrence.” Doing so will usually make it easier to determine whether the act (or omission) in question was intended, or even if the allegedly harmful result was intended.

D. DO I REALLY HAVE TO HURT SOMEONE OR SOMETHING TO GET COVERAGE?

The Coverage A insuring agreement in the CGL policy obligates an insurer to pay (up to the applicable limit of liability) those sums that the insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage,” and defend any “suit” seeking those damages (the damages must also have been caused by an “occurrence,” occurred during the policy period, and are not subject to an exclusion). In the broadest sense, a claim must be made or a lawsuit filed claiming money damages against an insured under the policy before coverage is provided. A suit for equitable relief, such as specific performance or an injunction, is not covered because the suit is not for damages. *See Feed Store, Inc. v. Reliance Ins. Co.*, 774 S.W.2d 73 (Tex. App.—Houston [14th Dist.] 1989, writ denied) (holding that injunctive relief is not damages). If the suit is one for damages, the damages must result from “bodily injury” or “property damage.”

1. What Is “Bodily Injury?”

“Bodily injury” is defined in the standard CGL policy as “bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.” Usually, this requirement is easily met in cases of physical contact, but is not clearly met in cases of just mental anguish or emotional harm.

(a) Does Mental Anguish Count?

It is now clear in Texas that a claim for mental anguish or emotional distress, without some accompanying physical manifestations or physical contact to the body (and thus bodily injury in the ordinary sense of the term), is *not* within the definition of “bodily injury.” *Trinity Universal Insurance Co. v. Cowan*, 945 S.W.2d 819 (Tex. 1997). This issue is important to businesses because the risk of being sued for sexual harassment or employment-related activities is increasingly a factor in selecting liability coverage.

(b) Is “Physical Injury” The Same Thing?

Cowan probably means that offensive physical contact leading to mental anguish, or physical manifestations of mental anguish absent physical contact, are at best borderline cases of “bodily injury.” Several states and federal courts have been restrictive in such situations. Allegations of offensive contact, such as grabbing a person without any implied permission or touching in sexually provocative ways, are an assault, but are also proof that assault need not produce a *physical* injury. Meaningful physical manifestations, although not just offensive physical contact, may support a finding of “bodily” injury. What the average person thinks of as emotional distress will likely not support a finding of “bodily injury.” As long as the insured and the insured’s attorney have a basis for arguing intestinal difficulties, nervous trauma, or protracted headaches were the result of mental anguish, many courts may read *Cowan* as allowing them to find or uphold a finding of “bodily injury.”

2. What Is “Property Damage?”

The standard CGL policy defines “property damage” as “physical injury to tangible property, including all resulting loss of use of that property.” The definition also includes “Loss of use of tangible property that is not physically injured.”

(a) Does Economic Loss Count As Property Damage?

Courts of almost all jurisdictions have held that mere economic loss, under a variety of definitions of “property damage,” is not covered under liability insurance policies. Typically, the cases interpret policy language requiring the property be tangible and that the injury be physical, such as found in the CGL policy in Texas, which essentially tracks the national CGL form. *Giddings v. Industrial Indemnity Co.*, 169 Cal. Rptr. 278, 281 (Cal.App. 1980), is a good example of the majority view, holding that “strictly economic losses like lost profits, loss of good will, loss of the anticipated benefit of a bargain, and loss of an investment, do not constitute damage or injury to tangible property covered by a comprehensive general liability policy.”

(b) What Is “Loss Of Use?”

The CGL policy covers loss of use of tangible property, both with and without physical injury. Economic loss, such as lost revenues from the loss of use of equipment, may be the measure of consequential damages from the loss of use of property. Although economic loss alone is not

“property damage,” it is crucial to assess whether it stands alone or is a measure of damage for loss of use of tangible property, because the latter is specifically covered by the CGL policy.

E. DOES MY CGL COVER ANYTHING ELSE?

Coverage B provides a defense and indemnification for sums the insured becomes legally obligated to pay as damages because of “personal injury” or “advertising injury.” “Personal injury” and “advertising injury” provide coverage for specific torts (“offenses”) rather than for types of damages (*i.e.*, “property damage”). “Personal injury” and “advertising injury” are defined to include offenses that are intentional torts (*e.g.*, malicious prosecution, invasion of privacy). Covering intentional torts would be inconsistent with requiring an “occurrence.” Coverage B therefore has no “occurrence” requirement.

“Personal injury” usually means false arrest, detention or imprisonment; malicious prosecution; or wrongful entry into, or eviction of a person from, a room, dwelling or premises that the person occupies; oral or written publication of material that slanders or libels a person or organization or disparages a person’s or organization’s goods, products or services; or oral or written publication of material that violates a person’s right of privacy.

“Advertising injury” usually means oral or written publication of material that slanders or libels a person or organization or disparages a person’s or organization’s goods, products or services; oral or written publication of material that violates a person’s right of privacy; misappropriation of advertising ideas or style of doing business; or infringement of copyright, title or slogan.

The definitions of “personal injury” and “advertising injury” overlap, both providing coverage for the same types of offenses (*i.e.*, oral or written publication of material that slanders or libels). It is the insuring agreement that determines whether an offense that could fit both definitions is “personal injury” or “advertising injury.”

1. Can The “Personal Injury” Arise Out of Advertising?

Oral or written publication of material that results in slander or libel, or violates a person’s right to privacy, is included in the definition of both “personal injury” and “advertising injury.” However, the Coverage B insuring agreement does not cover as “personal injury” conduct that occurs in advertising, publishing, broadcasting, or telecasting by or for the named insured. If slander, libel, or invasion of privacy results in the course of advertising the insured’s goods, products, or services, it may be covered as “personal injury.”

2. What Is Advertising?

“Personal injury” is covered if it does *not* arise out of advertising, and “advertising injury” is covered only if it *does* arise out of advertising. The term is used to both grant and bar coverage, but is not defined in the policy.

Advertising, when used to exclude offenses from coverage, has been defined to refer to promotions and materials directed to the public at large. *Playboy Enters., Inc. v. St. Paul Fire & Marine Ins. Co.*, 769 F.2d 425, 428 (7th Cir. 1985). The public at large does not mean the customers of an organization, but refers to widespread distribution. *Id.* This definition of advertising when used in the “personal injury” exclusionary provision is reinforced by the terms that follow advertising in the provision: publishing, broadcasting, and telecasting. *Fox Chem. Co. v. Great Am. Ins. Co.*, 264 N.W.2d 385 (Minn. 1978) (*en banc*).

Advertising is used to grant coverage to offenses as “advertising injury” rather than to exclude offenses. For this reason, less is required in order to be advertising for “advertising injury.” One court has gone as far as to hold that contacting one customer and demonstrating a product is advertising for the purpose of “advertising injury.” *John Deere Ins. Co. v. Shamrock Indus., Inc.*, 696 F. Supp. 494 (D. Minn. 1988), *aff’d*, 929 F.2d 413 (8th Cir. 1991).

F. HOW CAN I GET THE INSURER TO PAY FOR MY LAWYER?

Two promises are made by the insurer in the insuring agreements of the CGL policy. The first is to pay for *damages* for which the insured is legally liable. By requiring legal liability for damages, the obligation to indemnify does not encompass injunctive relief, *in rem* liability, and other forms of legal liability. When a claimant obtains a judgment finding the insured liable, the insurer’s duty to pay (loosely used as equivalent to “indemnify”) will be determined based upon that judgment, the policy, and the true or actual (not alleged) facts. Actual facts must govern indemnity or coverage restrictions would be meaningless, as allegations could trigger indemnity regardless of adjudicated reality. Further, the judgment and trial evidence may not even address all facts that govern coverage. *It is crucial to realize that coverage issues are not necessarily tort suit issues.*

The other promise contained in the general grant of coverage is to provide a defense for a suit brought against the insured if the suit is for damages covered under the policy. This duty to defend is determined by comparing the allegations contained in the complaint against the insured with CGL policy issued to the insured. This is often referred to as the complaint allegation rule, or the eight corners rule. *Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co.*, 387 S.W.2d 22 (Tex. 1965). The corners being counted are those belonging to the pleading and the policy (making a total of eight) for which coverage is being considered.

1. Duty To Defend - The Complaint Allegation Rule

The complaint allegation rule requires that the allegations of the complaint be considered together with the policy provisions, considering the allegations as true, regardless of what the parties know or believe the true facts to be, and even despite a legal determination of those facts. The allegations are to be liberally interpreted to afford a defense if there is a potential for indemnification for the allegations under the policy. *Heyden Newport Chem. Corp.*, 387 S.W.2d at 26.

The duty to defend is broader than the duty to indemnify, because the duty to defend is determined by the factual allegations of the pleadings, with no consideration for truth or falsity. See *Cullen/Frost Bank of Dallas v. Commonwealth Lloyds Ins. Co.*, 852 S.W.2d 252, 255 (Tex. App.–Dallas 1993, writ denied, 889 S.W.2d 266 (Tex. 1994) (*per curiam*); *Gulf Chem. & Metallurgical Corp v. Associated Metals & Minerals Corp.*, 1 F.3d 365, 369 (5th Cir. 1993). When courts must determine an insurer's duty to defend, all allegations in the petition must be accepted as true and all doubts resolved in favor of finding a duty to defend. *Argonaut Southwest Ins. Co. v. Maupin*, 500 S.W.2d 633, 635 (Tex. 1973); *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116, 119 (5th Cir. 1983). The insurer must provide a defense if the complaint contains at least one claim that is factually within the policy's coverage; however the carrier can and should inform the policyholder no coverage exists for the claims not covered by the policy. *Lafarge Corp. v. Harford Casualty Ins. Co.*, 61 F. 3d 389, 393 (5th Cir. 1995).

The insurer is entitled to rely on the allegations contained in the plaintiff's petition and only has a duty to defend those cases that are within the policy's coverage. If the petition alleges only *facts* excluded by the policy, the insurer has no duty to defend. *Fidelity & Guar. Ins. Underwriters, Inc. v. McManus*, 633 S.W.2d 787, 788 (Tex. 1982); *National Union Fire Insurance Co. v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139 (Tex. 1997). It is the *factual* allegations of the petition, not the *legal* theories asserted, that trigger the duty to defend. The insurer must present a coverage defense to every separate ground of recovery in a complaint to defeat coverage. If five harmful acts are alleged, and the insurer can present exclusions or requirements which bar coverage to four of the acts, the insurer still has a duty to defend all acts because the fifth is potentially covered. *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116, 119 (5th Cir. 1983); *American Eagle Ins. Co. v. Nettleton*, 932 S.W.2d 169, 173 (Tex. App.–El Paso 1996, writ denied).

Whether a claim is within the policy's coverage may be difficult to determine. There are times when it may be impossible to determine from the pleadings if a claim is potentially covered under the policy. Such can be the case when a duty to defend is denied because a claim is an excluded loss, although the lack of coverage is not evident from the pleadings and the face of the policy. Where the pleadings lack essential facts necessary to make this determination, Texas courts allow extrinsic evidence to be admitted to show a lack of a duty to defend. *State Farm Fire & Cas. Co. v. Wade*, 827 S.W.2d 448, 453 (Tex. App.–Corpus Christi 1992, writ denied). The purpose of considering the extrinsic evidence is to show the excluded nature of the claim, and it may be proper when doing so does not question the truth or falsity of the facts alleged in the pleading. *Id.* at 453.

When determining the duty to defend, if a review of the petition under the complaint allegation rule shows that at least one essential element of all theories of recovery is barred from coverage through an exclusion or coverage requirement, there is no duty to defend. The insurer is not required to prove redundancy in exclusions and coverage requirements to bar coverage, although to the extent the insurer is at all uncertain of a key coverage defense, redundancy in the form of other defenses may be very significant to its decision whether to deny defense or indemnity. The insured *does* have to eliminate every possible basis for denying coverage in order for there to be a duty to defend (assuming a *prima facie* case for denial is made, and leaving aside the burden of

proof and burden of going forward, which may vary by exclusions vs. coverage requirements, summary judgments vs. trials, etc.). For example, although there may be an “occurrence,” the insurer can still deny a defense to the insured if an exclusion applies to all allegations.

It has not been clear what scope will be attributed to the duty to defend when there are legal allegations with no facts pled to indicate the basis of the causes of action. The Texas Supreme Court’s opinion in *National Union Fire Insurance Co. v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139 (Tex. 1997), is an example of the high court insisting upon giving ordinary meaning—even ordinary and logical implication—to factual allegations. In *Merchants*, the court declined to read into the alleged facts—which stated only that plaintiff was injured when a weapon discharged from an adjacent vehicle into his vehicle—any possible scenario by which the shooting could be an accident. The court instead treated it as a “drive-by shooting,” despite the lack of any such characterization of it by plaintiff. In essence, the court needed no alleged facts negating such a far-fetched possibility as an accidental discharge, followed by failing to stop and render aid.

Some courts will struggle with the duty to defend decision when facts pled contradict or are inconsistent with the alleged causes of action. A negligence pleading in a petition that factually describes obviously intentional conduct is a common example. Knowledge on the part of the insurer through investigation that the claim is clearly outside coverage (so that there will be no duty to indemnify) is not a basis for denying a defense. The allegations of the petition will govern the defense duty.

Merchants indicates that factual allegations will not only control, but are a basis for negating (for the duty to defend analysis) an asserted *cause of action* (e.g., negligence) that is inconsistent with the alleged facts. This adds to the burden of pleading a lawsuit within potential coverage, as some courts have interpreted the duty to defend. It is contrary to the commonly held views of many judges and practitioners. According to the rule of *Merchants*, negligence allegations following a factual description of obviously deliberate conduct intended to injure do not create a duty to defend, because the factual allegations govern. Such alleged facts trigger the exclusion for expected or intended injury while failing to satisfy the “occurrence” requirement.

If it is determined there is no duty to defend, it should follow that there is no duty to indemnify either, at least for the allegations of *the particular pleading in question*. The pleadings can always be amended, so it is best when reserving rights or denying coverage that the insurer make it clear that its decision is based upon the allegations (*i.e.*, the *pleading*) before it at that time, and avoid giving the impression that the insurer is making a determination that applies to the *lawsuit* from that point forward. Otherwise, an insured might present a denial letter for “this lawsuit,” argue that his duty to cooperate (including forward suit papers, original or amended) was then eliminated, and seek indemnity for an agreed judgment he later entered into after receiving an *amended* pleading *within* coverage.

Given the broader scope of the duty to defend, insurers often have a duty to defend without an accompanying duty to indemnify. The duty to indemnify is narrower than the duty to defend because it is based upon *actual facts*, which not just the insured but the *insurer* is entitled to have

adjudicated if they are essential to a determination of coverage. *Employers Casualty Co. v. Block*, 744 S.W.2d 940, 943 (Tex. 1988), *modified*, *State Farm Fire & Casualty Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996). If an insurer wrongfully refuses to defend a lawsuit, it does not thereby lose its coverage defenses through collateral estoppel by fact findings in the tort suit trial.

The Texas Supreme Court has held *coverage* cannot be created by estoppel, meaning that a liability not within the *scope* of risks assumed in the insurance policy does not become one the insurer must pay simply because the insurer has committed some wrong (e.g., failure to notify the insurer of coverage defenses when it should). *Texas Farmers Ins. Co. v. McGuire*, 744 S.W.2d 601 (Tex. 1988). The court contrasted this with estoppel that may arise for policy *conditions*, which potentially impose *forfeiture* of coverage that *would* otherwise exist. Even though an insurer may fail to timely assert its coverage defenses, the scope of *coverage* under the policy does not come within an estoppel rule so as to create coverage not promised by the terms of the policy. The general rule is that only the right of forfeiture vanishes through estoppel; it does not affect the scope of the insuring agreement or exclusionary limits upon the *scope* of coverage.

McGuire notes, but makes no decision regarding, an exception recognized by several Texas courts of appeals and courts in other states. That exception allows estoppel when the insurer "assumes or continues the defense of its insured without obtaining a non-waiver agreement or a reservation of rights," if the insurer knew of the policy defenses but simply failed to assert them for some period long enough to cause prejudice to the insured. *Id.* at 603 n.1. Prejudice is not to be presumed from mere delay in identifying coverage defenses. *State Farm Lloyds, Inc. v. Williams*, 791 S.W.2d 542, 553 (Tex. App.—Dallas 1990, writ denied). Usually, whether failure to timely identify coverage defenses while controlling the defense creates estoppel depends upon detrimental reliance.

A free defense is a benefit, and disappointed expectations created by it (i.e., "I thought my insurer would defend me to the supreme court!!") are not the same as detrimental reliance. One obvious issue of detrimental reliance would be the missed chance for an insured to settle cheaply with its own money, if the insurer failed to convey its justified reliance upon policy defenses as an indemnity matter *while* defending. As a practical matter, judges and/or jurors will probably also focus upon who selected and controlled the defense lawyer, the extent of delay in raising coverage defenses, the reason for the delay, and other factors that affect the decision-makers' perception of fairness. Possibly the most important point for insureds to realize when defense is subject to a reservation of rights is that the duty or the fact of defense implies *nothing* about the duty or fact of indemnity.

G. IF I PAID TO BUY COVERAGE, WHY ARE THERE EXCLUSIONS IN MY POLICY?

Exclusions are written into insurance policies to limit the broad coverage granted by the insuring agreements. In the past, parties have argued that the broad coverage of an insuring agreement is inconsistent with specific exclusions, and that this creates ambiguity requiring courts to hold the exclusions inapplicable. This argument has been soundly rejected because insuring agreements

are often qualified by the phrase “to which this insurance applies” to make it even clearer that the broad grant is intended to be subject to limitations. *T.C. Bateson Constr. Co. v. Lumbermens Mut. Casualty Co.*, 784 S.W.2d 692 (Tex. App.—Houston [14th Dist.] 1989, writ denied). The CGL policy contains this phrase in Coverages A and B.

1. Intentional Injury: It Is Still Not Covered!

The CGL policy contains an exclusion for “bodily injury” or “property damage” which is “expected or intended from the standpoint of the insured.” It may include an exception for the use of reasonable force to protect persons or property. This exclusion, unlike the occurrence requirement, focuses on the result of an act (injury) and whether or not that injury was intended. The Texas Supreme Court has held that the intentional injury exclusion in the homeowners policy bars coverage to any damage or injury the insured subjectively intends as a result of its acts or is substantially certain will occur. *State Farm Fire & Casualty Co. v. S.S.*, 858 S.W.2d 374, 378 (Tex. 1993).

The CGL policy bars coverage for harms that are intended by “the insured.” The CGL policy only excludes coverage for “the insured,” that means “the insured seeking coverage.” *Walker v. Lumbermens Mut. Casualty Co.*, 491 S.W.2d 696, 699 (Tex. Civ. App.—Eastland 1973, no writ).

Most CGL policies now contain an exclusion for liability arising out of the employment relationship, thus avoiding overlap with workers compensation coverage. Similarly, many CGL policies contain an endorsement which negates coverage for employment related practices. Thus, coverage for sexual harassment and employment discrimination claims may best be provided by Employment Practices Liability Insurance, which is discussed later in this paper.

2. Accepting Liability In A Contract May Be Good For Business, But It Is Bad for Coverage

CGL policies exclude coverage for “liability in a contract or agreement.” Many businesses -- particularly service companies -- frequently enter into contracts whereby they agree to assume liability for or indemnify other companies or people who have some connection to their business. For example, a subcontractor will frequently agree to indemnify the contractor from a loss caused by the subcontractor’s negligence on the job site being managed by the general contractor. Most CGL policies contain an exclusion for any liability an insured accepts from another person or entity by way of contract. The reason is simple: the insurance company agreed to protect their insured, not other persons or entities.

Most CGL policies contain an exception to this exclusion for certain contracts identified in the policy when the insured’s liability to the other person or entity would exist in the absence of the contract or agreement. In the subcontractor analogy in the preceding paragraph, for example, the subcontractor will probably be liable to the general contractor for its own acts or omissions regardless of memorializing such liability in a contract. Under many CGL policies, such an indemnity agreement will be covered because of this exception to the general exclusion.

Exceptions to this exclusion are stated for contracts that are an “insured contract” *and* which involve liability that would exist in the absence of the contract or agreement.

3. Miller Lite: Great Taste, Less Coverage

Most CGL policies bar coverage for “bodily injury” or “property damage” for which any insured may be held liable by reason of causing or contributing to the intoxication of any person; furnishing alcohol to a minor or someone under the influence of alcohol; or liability by reason of any statute or other law related to the sale, gift, distribution, or use of alcoholic beverages. The exclusion requires the insured to be in the business of manufacturing, distributing, selling, serving, or furnishing alcoholic beverages (*i.e.*, a bar, restaurant, convenience store) for the exclusion to apply.

4. Can I Slip In A Workers' Compensation Claim?

The CGL policy excludes coverage for "any obligation of the insured under a workers' compensation, disability benefits or unemployment compensation law or any similar law."

The CGL policy also contains an exclusion for “bodily injury” to an employee which arises out of and in the course of employment by the insured. This exclusion will apply to “bodily injury” whether or not there is workers compensation coverage. The workers compensation bar in favor of the employer and co-workers, and the low incidence of workers compensation coverage, means that this exclusion applies more often. It prevents coverage of injuries resulting from the negligence of plaintiff and co-workers, and preempts much debate over fraud in claims of injuries to workers in the course of employment.

5. If I Did Not Pollute Anything, Why Are They Giving Me Such A Hard Time?

Most CGL policies bar coverage for “bodily injury” or “property damage” arising out of pollutants. This exclusion has been referred to as the absolute pollution exclusion, but it is less than absolute, and coverage case law varies depending upon whether the offending compound is sometimes or always a pollutant and the method of discharge. Pollution coverage under a CGL policy has been a legal hornet’s nest for the past two decades. There are dozens of Texas cases and hundreds of national cases interpreting the various pollution exclusion clauses which most liability insurers have sold over the last sixty years. The introductory nature of this article makes it impossible to cover these in detail. A corporate counsel dealing with environmental contamination issues, however, should consult legal counsel as soon as possible regarding these potential insurance implications of environmental claims or environmental problems.

6. “It’s a Boat . . . It’s a Plane . . . It’s not Superman -- It’s a Policy Exclusion.”

The CGL policy also contains exclusions for the ownership, maintenance, use (including loading and unloading), and entrustment of specified watercraft and motor vehicles, as well as the use of

an aircraft. There is also an exclusion for transportation of “mobile equipment,” or its use in preparing for a prearranged racing, speed, or demolition contest.

H. NOW THAT I AM DEPRESSED, WHAT DO I DO WITH MY CLAIM?

1. Notice Of Occurrence Or Claim

The standard CGL policy provides that in case of an “occurrence” or offense which may result in a claim, the insured must give notice to the insurance company as soon as practicable. The purpose of such a provision is to enable the insurer to promptly investigate the circumstances of the accident while the matter is fresh in the minds of the witnesses. *Employers Casualty Co. v. Glens Falls Ins. Co.*, 484 S.W.2d 570 (Tex. 1972). Texas law requires that the notice be given within a reasonable time under the circumstances. *Continental Sav. Ass'n. v. United States Fidelity & Guar. Co.*, 762 F.2d 1239 (5th Cir. 1985). Whether or not notice is given within a reasonable time is generally a question of fact. However, when facts are undisputed, the timeliness of notice becomes a question of law for the court. *Carroll v. Employers Casualty Co.*, 475 S.W.2d 390, 393 (Tex. Civ. App.—Beaumont 1972, writ ref'd n.r.e.).

2. Forward Suit Papers

In addition to requiring notice of an “occurrence” or offense, the CGL policy also requires the insured to “Immediately send [the insurer] copies of any demands, notices, summonses or legal papers received in connection with the claim or ‘suit’.” The requirement that notice be given within a reasonable time applies to notice of the lawsuit, as well as notice of an accident. Additionally, the insurer’s notice of an occurrence or claim, even if it is apparent that the occurrence or claim will result in a lawsuit, does not obviate the condition requiring that an insured forward suit papers. *Harwell v. State Farm Mut. Auto. Ins. Co.*, 896 S.W.2d 170, 174 (Tex. 1995). The insurer has no duty to monitor the courthouse for service of process upon the insured. The purpose of this requirement is (1) to enable the insurer to control the litigation and interpose a defense; and (2) to advise the insurer that a lawsuit has been served on the insured and that the insurer is expected to answer the suit on the insured's behalf. *Weaver v. Hartford Accident & Indem. Co.*, 570 S.W.2d 367 (Tex. 1978).

3. Cooperate With The Insurer

The CGL policy also provides that the insured must assist and cooperate with the insurer in doing certain things, but it is not very specific about just what must be done. It seems likely the insured will be found to have a duty to reasonably cooperate in an investigation undertaken by the insurer, even if part of that investigation addresses coverage issues. However, there is yet no Texas precedent addressing any distinction between cooperation for tort suit purposes and for resolution of liability coverage. Courts have made clear the insured’s duty to cooperate fully in the insurer’s investigation of a first party property loss claim, and it seems likely that a similar duty to cooperate will be imposed for a liability claim or lawsuit.

In 1972, the Texas Supreme Court held that an insurer need not suffer harm in order to avoid liability under a liability policy for a breach of a condition precedent by the insured. *Members Mut. Ins. Co. v. Cutaia*, 476 S.W.2d 278 (Tex. 1972). The court further held that it was not the job of courts to imply a requirement of harm or prejudice to the insurer if it was not contained in the policy. The court suggested that such a change was within the province of the legislature or the State Board of Insurance.

Presumably, in response to this holding, the State Board of Insurance (now the Texas Department of Insurance) responded with a requirement that insurers be prejudiced before they can avoid liability under the CGL and automobile policies by relying upon the insured's violation of the conditions requiring notice and forwarding suit papers. The Department of Insurance did not add the prejudice requirement for denial of coverage based upon breach of conditions to the homeowners policy or the business owners policy.

The prejudice requirement in the mandatory CGL endorsement does not apply to all conditions in the CGL form. It applies only to the notice condition and the requirement to forward suit papers. It also does not apply to "personal injury" or "advertising injury" at all. Such limitations may not matter, because the supreme court may judicially insert a prejudice requirement into insurance policies. The court has interpreted the settlement-without-consent prohibition in the Texas Personal Auto's uninsured motorists coverage section as requiring prejudice, holding that loss of a cause of action against a penniless motorist was not prejudice. *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994). *Hernandez* reads the requirement of prejudice into the uninsured motorists coverage based upon basic contract principles, which require all breaches to be material, as well as public policy grounds and overwhelming precedent in sister states. *Id.* at 693 n.4. Such public policy, sister state precedent, and basic contract principles are almost equally applicable to the CGL policy.

V. DIRECTORS AND OFFICERS LIABILITY INSURANCE

The Enron fiasco has brought professional E&O and D&O coverage into the national spotlight. Businesses organized as corporations may need or wish to secure an Errors & Omissions ("E&O") and/or a Directors and Officers Liability policy ("D&O policy"). Because claims arising from the rendering of the insured's professional services are excluded under the CGL, the E&O policy is formulated to provide professionals with this type of coverage within the policy territory. On the other hand, the D&O policy affords indemnification coverage for the liabilities of the insured entity for injuries caused by the individual directors and officers acting in their official capacity. To an extent, D&O policies are insurance for good faith errors made and omissions permitted in business contexts.

A. WHO DOES D&O PROTECT?

1. Corporate Indemnification

Coverage A—Corporate Indemnification—provides coverage to the named insured because of any claim made against the named insured's directors or officers and caused by a negligent act, error,

omission, or breach of duty, of directors or officers while acting within those capacities. This coverage may not apply to a claim made directly against the named insured. It at least provides coverage where the named insured has agreed to indemnify its directors and officers for claims made against them, which is a common corporate practice. *See, generally, Farmers & Merchants Bank v. Home Ins. Co.*, 514 So.2d 825 (Ala. 1987) (bank is only an insured to the extent it may indemnify its directors and officers for covered loss incurred by them—to the extent complaint asserted claims against the bank, it was not covered). Notice that the Corporate Indemnification coverage does *not* insure the corporation for its own misconduct, although its directors and officers are covered.

2. Directors And Officers Liability

Coverage B—Directors and Officers Liability—generally provides coverage *to* directors and officers for claims made against them based on their negligent acts, errors, omissions or breaches of duty while acting in their capacities as directors or officers. Some insurers have liberalized their D&O coverage by extending it to the entity itself as an insured, not just to reimbursement by the entity of directors and officers. A good broker is a crucial source of insurance options for a business.

B. WHAT IS COVERED?

Both Coverages A and B are subject to certain exclusions. The insurance generally does not apply to claims for bodily injury or property damage, claims for defamation, claims for an accounting of profits or losses from a securities transaction, claims for compensation to officers or directors, claims for anything other than money damages, claims for conduct in procuring insurance, claims establishing dishonesty by the officer or director, claims of racial or religious discrimination, and claims arising out of pollution. Like the CGL policy, the D&O policy contains conditions for “no action,” prompt notice of claims, and cooperation. The traditional purpose of D&O coverage is to insure against *financial* loss resulting from wrongful but not self-enriching or fraudulent acts. D&O coverage is usually meant to pick up where CGL coverage leaves off. CGL coverage does *not* apply to financial loss (unless caused by “property damage”), and will not apply to many of the wrongful acts covered under D&O policies.

Coverage under the D&O policy is triggered by corporations formally indemnifying insured directors and officers. If there is no such indemnification, courts may deny corporate insured coverage, because the insured person may also seek recovery. The corporate insured must also make sure that any indemnification agreement is proper under the corporation’s charter, bylaws, and resolutions; in addition it must be within state law. *National Union Fire Ins. Co. v. Emhart Corp.*, 11 F.3d 1524 (10th Cir. 1993).

C. CLAIMS MADE

The D&O policy is typically underwritten as a “claims-made” policy, as opposed to the “occurrence” based or “injury” based policies. This means that any and all covered claims made against the insured during the policy period are covered. Although the conduct giving rise to a

lawsuit may have occurred prior to the inception date of the D&O policy, the claim will be covered if it is presented during the policy term. Even a claims-made policy is subject to reporting requirements, however, and close attention must be paid to these conditions.

D. DOES IT PAY FOR DEFENSE COUNSEL?

Texas Art. 2.02-1 authorizes corporations to pay legal expenses in advance, to reimburse directors and officers for legal expenses paid (before final judgment), and to indemnify the directors and officers for these expenses. Therefore, it would seem expected that D&O insurance would afford coverage for these expenses. However, under most D&O policies, the insurers have neither the right nor the duty to defend, but rather a duty to pay for the defense, with some limited rights of veto, review, and participation. Often, when D&O insurers do not have the right to control a defense, they retain the right to disapprove defense counsel, disapprove excessive fees, and review case developments. It is important to note that unlike many liability policies, where the cost of defense does not reduce the amount of coverage available, defense expenses are subject to policy limits.

For years, D&O insurers paid legal expenses upon settlement, or only paid if the loss was clearly covered and proved against the named directors and officers. However, policyholders began convincing courts that the policies provided coverage for claims the insured became legally obligated to pay, not just for claims they were legally obligated to pay and had, indeed, paid. One court has even held that deferring the payment of legal expenses would be unconscionable. *See Little v. MGIC Indemn. Corp.*, 649 F. Supp. 1460, 1468 (W.D. Pa. 1986), *aff'd*, 836 F.2d 789 (3rd Cir. 1987).

E. WHAT IS EXCLUDED?

Generally, D&O policies exclude coverage for bodily injury, sickness, disease, or death resulting therefrom, mental anguish, emotional distress, loss of consortium, property damage including loss of use, invasion of privacy, wrongful entry, wrongful eviction, false arrest, false imprisonment, malicious prosecution, and defamation of all sorts. Additionally, dishonesty, fraud, criminality, self-dealing anti-trust violations, securities violations, regulatory losses, fiduciary activities, pollution, and lawsuits brought by insureds are among the generally excluded losses under the standard D&O policy.

F. KEY DEFENSES TO LIABILITY

In this day and age, it is probably a good idea to have some familiarity with the key defenses to D&O liability. In this regard, the "Business Judgment Rule," Director Shield Statutes, and the concept of reliance on other. Corporate officials or professionals are most significant.

1. Business Judgment Rule

Generally, under present application of the business judgment rule, if decisions are made as part of a process that is "either rational or employed in a good faith effort to advance corporate

interests,” directors are protected from liability for the losses resulting from those decisions. *In re Caremark Int'l, Inc. Derivative Litig.*, 698 A.2d 959, 967 (Del. Ch. 1996). The Delaware courts’ generally described the rule as “a presumption that in making a business decision the directors . . . acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interests of the company. *See Aronson v. Lewis*, 473 A.2d 805, 812 (Del. 1984). The business judgment rule was established pursuant to the policy concern that courts might interfere with routine and necessary business decisions such as choosing advertising campaigns or selecting materials supplies. *See Harvey L. Pitt, Fiduciary Duties in Control Contests*, 474 PLI/Corp. 329, 339 (1985). Courts are “ill-equipped and infrequently called on to evaluate what are and must be essentially business judgments[.]” *See Auerbach v. Bennett*, 393 N.E.2d 994, 1000 (N.Y. 1979). The rule remains in place to keep courts from second-guessing corporate decision-makers in the exercise of their “business judgments,” even if those judgments are in hindsight ridiculous or harmful to the company. *See Dennis J. Block et al.*, 1 THE BUSINESS JUDGMENT RULE, 7 (5th ed., 1998). The most important application of the business judgment rule is as a defense to a claim for breaching the duty of care.

2. Director Shield Statutes

Due to concerns that good candidates would avoid serving as directors, that corporations would become overly conservative in their business decisions, and that D&O liability insurance would become unaffordable, a number of states enacted director shield statutes. The most common type of director shield statute is often referred to as a charter option statute. Delaware’s statute is a model for many states. It allows a corporation to include provisions in its charter that effectively eliminate liability for a breach of the duty of care. The Texas director shield statute also permits a corporation to eliminate director liability by charter amendment.

By 1988, at least forty states had adopted statutes reducing the personal liability of directors for money damages. One must carefully examine the shield statute of the company’s state of incorporation as well as the corporation’s charter or articles of incorporation to determine the risk of liability for a director. The statutes rarely allow a director to avoid liability for breaches of loyalty or good faith, but this review is critical with claims for breach of the duty of due care.

If a corporation adopts the pro-director provisions, the D&O policy may only be implicated if the director commits an act of bad faith or breaches the duty of loyalty in a non-intentional but more-than-negligent manner. Because bad faith may necessarily imply intentional misconduct, the potential for the policy to be tapped is slim under these circumstances.

3. Reliance On Other Corporate Officials or Professionals

Texas has enacted a statutory provision entitling directors and officers to rely on: (1) officers or employees of the corporation, (2) professionals including legal counsel, public accounts, and other experts, or (3) a committee of the board of directors. TEX. REV. CIV. STAT. ANN. art. 2.41(C) (Vernon 1980). Directors and officers may rely, however, only on individuals they reasonably believe are “reliable and competent,” and they may not rely on others’ information if they have better knowledge in the matter. Moreover, if a director has a particular area of

expertise, this may limit his ability to rely on advice from third parties within his area of expertise. (The more one knows about a subject, the less likely one is to be able to fend off charges of negligence or other misconduct with the claim “I didn’t know about the stuff, so I relied on an expert.” If one is already something of an expert oneself, it is hardly appropriate to rely on advice of others as a way to defeat liability).

If a director defends a lawsuit against him on the basis that he relied on the opinion of another – someone who was an expert and who should have knowledge – it will not automatically be true that his insurance carrier will not have to pay. First, reliance is factual in nature. The director must actually have relied, and the reliance must have been reasonable under the circumstances. Second, the policy may also cover the officer, director, or committee upon which the director relief. Thus, even if the director who relies is exonerated, the person or entity upon which he relief may require indemnity. Finally, there may be issues of joint liability, for example, when accountants or attorneys were consulted or when both management and the professional were negligent. When two or more people are negligent together, they both have to pay and then divide between themselves who has to pay what amount. *See* TEX. CIV. PRAC. & REM. CODE §§ 32.001 *et seq.*, 33.002 *et seq.* (Vernon’s Supp. 2000). Thus, an inside director might be liable for 60 percent of an injury, while the outside lawyer was liable for 40 percent. Then again, the inside director may be liable for 60 percent, while the outside lawyer is liable for 40 percent. There are as many possible combinations here as there are conceivable numbers.

4. Director Versus Officer Liability

Traditionally, courts have analyzed director liability and officer liability together under the same legal principles. Because director shield statutes almost uniformly appear to apply only to directors, the standard for liability for these two groups diverges somewhat. (In Nevada and New Jersey, officers enjoy the same protection; however, these states are the exception).

Texas courts have pointed out that “[n]early everywhere, and certainly in Texas, it is well established that officers of a corporation, by virtue of their authority, privileges and trust, have a strict fiduciary obligation to their corporation.” *General Dynamics v. Torres*, 915 S.W.2d 45, 59 (Tex. App. -- El Paso 1995) (*citing Int’l Bankers Life Ins. Co. v. Hollowat*, 368 S.W.2d 567, 576 (Tex. 1963, writ denied)). Section 8.42 of the Model business Corporation Act “suggests that an officer’s accessibility to corporate information may subject the officer to a higher standard of scrutiny [than applies even to directors]. Under Texas law and the law of most states, however, corporate officers are entitled to the limited benefit of the business judgment rule and are entitled to rely in good faith on professionals, other employees, directors, and even other officers. Additionally, often the highest-ranking officers also serve as directors, making it impracticable to distinguish their acts to allege director liability and officer liability separately. Therefore, as a practical matter, the actions of directors and officers are likely to be analyzed under the same liability standards unless the corporation has adopted director shield statute language.

5. What Does This All Mean To Me?

Just remember, D&O policies are often triggered by claims against officers and directors for breaches of any of three duties: (1) due care in the process of making business decisions, (2) loyalty, and (3) good faith. However, claims for breaches of these duties are by no means the entire scope of possible claims against directors and officers. Other possible claims include negligent misrepresentations, securities fraud, and aiding and abetting breaches of these fiduciary duties. Generally, to be held liable to the corporation, the director or officer must be found at least to have acted with gross negligence, and the business judgment rule will prevent liability based on the mere fact that a business judgment turned out to be completely wrong. By virtue of a corporation's adoption of optional language in its state director shield statute, the corporation may be able to eliminate claims of liability against its directors and officers for breach of the duty of due care.

VI. WHY DOES ANYONE NEED EMPLOYMENT PRACTICES LIABILITY INSURANCE?

Employers have witnessed a substantial increase in employment suits in the past decade. This increase in employment litigation has been encouraged by greater state and federal recognition of employment law causes of action, by expanding legal remedies, and by substantial media attention to these cases. The average jury award in Texas for wrongful termination has ranged from \$300,000 to \$700,000 over the past decade. Even winning a lawsuit can mean losing for the employer who must bear the legal fees involved in defending itself against a disgruntled ex-employee, a rejected job-applicant, or an unhappy current employee. Win or lose, the possibility of facing the costs of employment-related suits without the benefit of insurance protection is becoming an increasingly unattractive business option.

While the importance of obtaining employment-related coverage is becoming increasingly apparent, the choices for obtaining the appropriate type of insurance are less obvious. For example, the standard CGL policy form cannot be relied upon to provide coverage for employment suits because of the wording in the insuring agreements and exclusions. *See, generally, Folsom Investments, Inc. v. American Motorists Ins. Co.*, 26 S.W.3d 556 (Tex.App.-Dallas 2000, no writ). Similarly, the workers' compensation policy does not afford protection from employment suits, because it applies only to claims for workers' compensation benefits, not to civil actions seeking damages. The Employer's Liability ("EL") policy, whether stand-alone or as Part B of the Workers' Compensation/Employers Liability policy ("WC/EL"), is restricted to actual "bodily injuries," and the policy excludes most wrongful employment practices. However, the Employment Practices Liability Insurance ("EPLI" or "EPL") policy does provide broad coverage for wrongful employment practices.

Employment Practices Liability Insurance (EPLI) first became available in 1992, and since that time, the number of carriers offering EPLI coverage has grown to over 100. *See* Richard M. Gibson, *Employment Practices Liability Insurance: A Corporate Counsel's Buying Guide*, No. 6 ACCA Docket 77. There is, however, no standard EPLI policy language. Although the

Insurance Services Office (ISO) published proposed standard wording for the EPLI in 1998, it has not been adopted as an industry standard.

Given the wide variety in EPLI policies, particular attention must be paid to the clauses most commonly found in EPLI policies. Because EPLI is so new, there is no Texas case law directly on point and very little case law from other jurisdictions interpreting the common definitions and terms in EPLI policies. Published cases involving EPL policies are as yet uncommon. However, many clauses in EPLI forms are similar to clauses in other types of liability insurance policies. Therefore, analysis of these policies can be based on the judicial interpretation of comparable policy language in other liability insurance policies. Although the policy form varies from carrier to carrier, the basic coverages and potential coverage issues are similar.

A. WHAT ARE COVERED LOSSES?

EPLI policies tend to cover three basic employment-related actions, including:

- Wrongful termination;
- Discrimination; and
- Sexual harassment.

The policies can vary in how they define these terms:

- For discrimination claims, a typical definition encompasses violation of a person's civil rights with respect to race, color, national origin, religion, gender, marital status, age, sexual orientation or physical or mental condition.
- Sexual harassment is generally defined as unwelcome sexual advances, requests for sexual favors, or other verbal, visual or physical conduct which (a) is linked with a decision affecting an individual's employment, (b) interferes with an individual's job performance, or (c) creates an intimidating, hostile, or offensive work environment for an individual. This definition includes both "*quid pro quo*" cases and "hostile environment" cases.

In addition, EPLI policies may also include coverage for related workplace torts including defamation, infliction of emotional distress, and invasion of privacy.

EPLI policies are generally "claims-made" policies, although there are a few exceptions. The claims-made policy is not triggered until a claim has been made against the insured and, in some instances, reported to the carrier during the policy period. Texas courts have consistently enforced claims-made policies and their "trigger" requirements.

Claims-made policies are fundamentally different from occurrence policies. Claims-made policies do not provide for the long "tail" of coverage that occurrence policies do. This longer

“tail” under the occurrence policy means that overage continues for claims reported after the policy is no longer in effect, as long as the claim occurred during the policy effective dates, and as long as any other reporting requirements are met. The “claims-made” carrier can more accurately predict the potential exposure and risk on a claims-made policy, because the policy, unless modified by endorsement, provides coverage only for claims reported during the policy period or within a very short time thereafter. The ability to more accurately anticipate the potential risk allows the carrier to price the policy accordingly. In turn, the insured is afforded a shorter period of coverage.

B. WHAT CONSTITUTES A CLAIM?

The EPLI policy usually defines what constitutes a claim. It can include a civil complaint, administrative charge, or arbitration request arising out of an alleged covered employment practice. Other policies define it more broadly to include a written demand or notice alleging damages which could take the form of a claimant's demand letter, whether or not authored by an attorney. A few policies even consider oral notice to the insured a “claim.”

The EPLI policy generally requires that a covered claim be a written complaint or notice, and under many policies, must also contain a demand for monetary damages. There are very significant differences between an oral complaint, a written complaint, a notice from an administrative agency, a written complaint demanding damages, and a written complaint demanding monetary damages. These differences can form the basis not only for triggering coverage, but also for triggering time frames during which certain duties and obligations must be performed. An employer-insured must therefore pay very careful attention to the particular wording of the policy, and any relevant notification of pending claims against it.

Although no Texas court has analyzed the clauses defining “claim” in an employment-related context, Louisiana courts may provide some guidance. Interpreting a definition of claim similar to the definition listed above, but not containing the requirement that a demand be made for monetary damages, the Eastern District of Louisiana held that the notification to the insured of a charge of discrimination filed with the EEOC constituted a “claim” under the insurer's Employment Practices Liability Insurance policy. *Specialty Food Systems, Inc. v. Reliance Ins. Co. of Ill.*, 45 F. Supp.2d 541, 543 (E.D. La), aff'd, 200 F.3r 816 (5th Cir. 1999). The insured failed to report the EEOC notice to the carrier, but upon later receiving the resulting lawsuit, the employer reported the claim to the insurer. The court refused to accept the insured employer's position that a “claim must include both notice from an administrative agency and a demand for damages.” *Id.* Because the court found the EEOC notice did constitute a “claim,” the insured's receipt of the notice did trigger the policy's claim reporting time requirements, and the period of time during which the insured was obligated to report the claim had expired by the time the lawsuit was reported. Thus, the insured employer was left in the unfortunate position of having voided coverage that might have otherwise been available to defend against the employee's claim.

C. WHO PAYS FOR THE LAWYER TO DEFEND ME?

A majority of EPLI policies are “defense within limits” policies. Unlike CGL policies, the costs associated with defending the claim erode the indemnity limits of the policy and thus reduce the amount available to indemnify the employer for damages to the employee. Moreover, the policies often contain a deductible, a retention clause, or a co-payment. The deductible is typically applicable to both indemnity and defense costs, and does not normally reduce the total amount of liability limits available.

Because the indemnity limits available to pay claims of most EPLI policies are reduced for each dollar spent in defense, many EPLI carriers give the insured wide latitude in the selection of defense counsel. Unlike general liability policies which contain an unlimited defense, many EPLI carriers seem less concerned about the particular lawyer or law firm an insured may desire to defend the case because the insurer knows the defense costs are capped. The insurer’s ultimate loss is quantified and limited.

D. WHO IS PROTECTED BY EPLI?

The EPLI policies generally cover the employer entity and often its supervisors and management-level employees. Officers and directors are also covered under many policies. The supervisors and managers are those who have authority to act on behalf of the employing company, and are therefore likely to be the target of suits for their actions including hiring, firing, interviewing, reviewing, promoting and demoting employees. Directors and officers are likewise targets for allegations of wrongful company policymaking, and it is not clear whether a policy that does not specifically include these titleholders as insured would afford indemnification for the employer’s obligations arising from an employment dispute. *See The EPL Book: The Practical Guide to Employment Practices Liability Insurance, Second Ed.*, Gary W. Griffin, et al, p. 170 (1999). Therefore, it is therefore important to clarify who is considered insured under the policy before the issue becomes a coverage argument.

How the policy defines “employee” can vary. For instance, the EPLI policy may apply only to the named insured’s supervisory employees. An employer desiring EPLI coverage on “lower level” employees may be required to purchase an additional endorsement to provide coverage for all employees in the company. The EL policy in contrast applies only to the employing entity. While the CGL policy may apply to both the employer and the co-employee, it usually has exclusions that negate coverage for both.

If an employer contains subsidiaries, care must be taken to review policy provisions for coverage of those entities. Many EPLI policies afford coverage for newly acquired entities that represent less than a certain percentage of the company’s assets. This coverage for lower percentage acquisitions is often automatic, but usually requires reporting within stated time frames. For larger acquisitions, coverage may not be automatic, but may be obtainable by endorsement upon request.

Most EPLI policies apply to traditional employees, both full and part-time. However, some EPLI policies exclude coverage for temporary employees and volunteers. A new category of employee -- the leased employee -- creates other considerations. The leasing company employs the "leased" employee and has control over hiring, firing, etc. At the same time, the client company may direct the substantive work details. Whose employee is he or she? Many EPLI policies will not define "employees" to include leased employees. With the current work-force becoming increasingly non-traditional, the exposure for employers for the conduct of in-house independent contractors continues to increase. If an employer desires EPLI coverage on employees who are leased, the policy must be reviewed very carefully to verify the existence of coverage on such employees. If coverage is not provided under the basic EPLI policy from the insurer selected, leased employee coverage may be available under an endorsement.

E. IS ANYTHING EXCLUDED?

Common exclusions under EPLI policies include intentional acts, prior knowledge of incidents that could give rise to a claim before the policy takes effect, bodily injury and personal injury, consequential loss, claims for non-monetary relief, ADA accommodation expenses, front or back pay, and in some cases, punitive damages.

F. SHOULD I BUY EPLI?

Employers who are only insured under CGL and/or Employer's Liability policies will probably discover they do not have defense or indemnity benefits if an employee files suit for an employment tort. EPLI insurance was created to provide such coverage and employers would be wise to seriously evaluate the protection provided by this coverage. EPLI insureds and EPLI insurers, however, have little guidance to help them evaluate the meaning of the terms in these relatively new policies.

As Texas and other jurisdictions throughout the country address EPLI policies and interpret the various clauses which are unique to EPLI policies, the law concerning these policies will become more defined. Until that time, insurers, insureds, their attorneys, and courts will be forced to rely on the law concerning other liability policies and general insurance principles to construe and predict questions surrounding this relatively new creature in the insurance industry.

VII. WHAT IS EXCESS LIABILITY COVERAGE?

Excess insurance policies provide coverage above an underlying primary liability policy or above the amount of the insured's "self-insured-retention." An umbrella policy, however, differs from an excess policy in that it provides excess coverage on a diversity of risks such as would normally be covered by a variety of different policies.

A. HOW DOES IT WORK?

One of the most common forms of excess coverage, the "following form" excess liability policy, contractually agrees to follow the terms, conditions and exclusions of the underlying policy or

policies. Umbrella policies, on the other hand, generally provide both a standard “following form” coverage and primary coverage that is broader or different than the standard primary policy. *See, generally, Marick, Excess Ins.—An Overview of General Principles and Current Issues*, 24 Tort & Ins. Law J., 715, 717-719 (1989).

Communication is critical. When reporting potential losses to liability carriers, it is imperative for any insured to always notify any excess or umbrella insurer of any losses for which there may be coverage. Failure to do so may create coverage problems, including potential waiver of coverage.

B. HOW DOES THE EXCESS CARRIER RELATE TO THE PRIMARY LIABILITY INSURER?

Two years ago, the Texas Supreme Court examined the issue of whether a duty should be placed on the excess carrier to monitor the progress of a suit before the primary limits of the claim are tendered by the primary insurer. *Keck, Mahin & Cate v. National Union Fire Ins. Co. of Pittsburgh*, 20 S.W.3d 692 (Tex. 2000). In this case, the insured had \$1 million of coverage with the primary carrier, and an additional \$9 million in excess coverage. The excess carrier settled the suit for \$7 million and then filed suit against the primary carrier under the equitable subrogation doctrine. The primary carrier argued that the excess carrier was comparatively responsible for the amount of the settlement and asserted that the excess carrier caused its own harm by deciding to negotiate and settle the suit.

In Texas, the rule applicable states, “where the insured maintains both primary and excess policies...the excess liability insurer is not obligated to participate in the defense until the primary policy limits are exhausted.” *See, e.g., Texas Employers Ins. Ass’n. v. Underwriting Members of Lloyds*, 836 F. Supp. 398, 404 (S.D. Tex. 1993). Although the primary carrier argued comparative responsibility should be considered, the Court refused to broaden the duty owed by excess carriers to the primary insurer and the insured. The Court therefore held in *Keck* that no duty should be placed on the excess insurer until the primary policy limits are tendered.

The excess carrier also has a duty to act reasonably when negotiating settlement. The San Antonio Court of Appeals recently considered a case involving an excess carrier who chose to take over settlement negotiations in a DWI case involving fatalities. *Rocor v. National Union Fire Ins. Co.*, 995 S.W.2d 804 (Tex.App.—San Antonio 1999, rev. granted). The case presented few defenses, and exposure was high enough to allow for the reasonable expectation that the loss would exceed the insured’s self-insured deductible and primary limits. After taking over the settlement negotiations, the excess carrier unreasonably delayed the negotiations. The excess carrier was therefore held liable to the insured for extra defense costs incurred by the insured during the time the excess carrier unreasonably delayed the negotiations.

VIII. WHAT IS “KEY PERSON” INSURANCE?²

New businesses need to be assured that they can at least pay their debts if someone crucial to the enterprise dies or becomes disabled. The options include insuring the life of each “key man” whose performance is crucial to the survival of the business and/or the business being able to repay its debt. Who is a “key man?” Any of the persons upon whom the company most depends for its financial success. Obvious examples include officers and shareholders of a corporation, or a comparable person in another form of enterprise. The company’s obligation to purchase stock from owners is a related and common example of something financed by life insurance. Insurance to fund such buy-sell agreements is not quite the same as insuring key persons who make the business run, but the financial product and outcome is the same.

Texas Insurance Code Article 3.49-1 states: Any person of legal age may apply for insurance on his life . . . and in such application designate in writing any . . . corporation . . . as the beneficiary . . . or owner . . . or both . . . and with respect to any such policy . . . any such beneficiary or owner so designated shall at all times thereafter have an insurable interest in the life of such person

TEX. REV. CIV. STAT. ANN. art. 3.49-1 (Vernon 1981).

It is possible (but consult your tax advisor and lawyer) to have an employee apply for life insurance and designate the corporation as the beneficiary. However, ordinarily the employer applies and pays for the insurance. Some precedent indicates a corporation's insurable interest does not survive the relationship that created it. *See Stillwagoner v. Travelers Ins. Co.*, 979 S.W.2d 354, 359 (Tex. App.--Tyler 1998, no pet.); *Tamez v. Certain Underwriters at Lloyd's, London*, 999 S.W.2d 12, 19 (Tex. App.--Houston [14th Dist.] 1998, no pet.). Those decisions did not involve life insurance governed by article 3.49-1, because the persons insured were neither purchasers nor beneficiaries of the life insurance. Stop ‘N Go, the beneficiary in *Tamez*, insured the lives of its convenience store employees in order to assure a source of funds to pay their families when the employees died in robberies. This coverage protected Stop ‘N Go, but was not key person insurance.

Longstanding Texas precedent puts persons with an insurable interest in others' lives in three general categories: "(1) one so closely related by blood or affinity that he wants the other to continue to live, irrespective of monetary considerations, (2) a creditor, and (3) one having a reasonable expectation of pecuniary benefit or advantage from the continued life of another. *Drane v. Jefferson Standard Life Ins. Co.*, 161 S.W.2d 1057 (Tex. Comm. App. 1942). Texas law allows broad use of key person insurance, given that last category of insurable interest. *Tamez* marks the point at which statutory liberality is tested beyond courts' tolerance.

²This insurance is still commonly referred to as “Keyman Insurance,” but political correctness is slowly transforming this coverage moniker into a more gender-sensitive title.

IX. HOW DOES INSURANCE IMPACT E-COMMERCE?

The Internet has rapidly become a “virtual marketplace” where services, products, information, and ideas are broadcast, advertised, sold, disseminated or exchanged. This marketplace has created new risks and liabilities for the new businesses emerging, including claims of intellectual property violations, invasion of privacy, false advertising, and defamation. In addition, traditional notions of jurisdiction and venue are being expanded as web sites advertise and offer business communications through the world-wide-web. These increasing exposures may create difficulties for e-commerce under the more traditional forms of insurance available, and insurers are responding by creating new products to keep pace with the virtual risks.

A. DOES MY CGL COVER E-ANYTHING?

The standard CGL policy, as described in greater detail earlier in this paper, affords liability coverage for bodily injury, property damage, personal injury and advertising injury. The CGL policy provides very limited coverage for loss to intangible property and intellectual property.

Many emerging Internet liabilities concern claims of intentional harmful conduct, such as defamatory publication, or securities manipulations, which do not meet the definition of “occurrence” under the CGL policy. Generally, an accident does not exist where (1) the acts that produced the injury were voluntary and intentional; and (2) the resulting injuries were a natural result of the acts. *See Wessinger v. Fire Ins. Exc.*, 949 S.W.2d 834 (Tex. App.–Dallas, 1997, no writ); *Pierce Mortuary Colleges, Inc., v. Forrest*, 212 B.R. 549 (Bkrctcy, N.D. Tex., 1997).

The CGL policy affords coverage for bodily injury claims, but this does not include claims for pure mental anguish, without a manifestation of physical injury. *Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819 (Tex. 1997). Therefore, claims such as defamation, invasion of privacy, and misrepresentation would likely fail to meet the bodily injury requirement under the terms of the policy.

The CGL policy definition of property damage includes claims for “physical injury to tangible property” or “loss of use” of tangible property that is not physically injured. However, data processing and software producers are likely to find difficulty in pursuing coverage, because these damages are financial loss, and the damage does not arise out of physical injury to or destruction of tangible property. Tangible property is generally property that is capable of being handled or touched. *Lay v. Aetna Ins. Co.*, 599 S.W.2d 684, 686 (Tex. Civ. App.–Austin 1980, writ ref’d n.r.e.). Losses that are strictly economic, such as lost profits, money, or investment, does not constitute damage or injury to personal property.

Claims that are likely to arise in e-commerce litigation will not be claims for computers that burn up and software programs that cause physical injury—instead, these claims are more likely to be claims for lost data. Thomas R. Cornwell, *The High Stakes of High Tech: Property and Casualty Insurance for the High Technology Industry*, BEST’S REVIEW- PROPERTY CASUALTY INSURANCE EDITION, Vol. 94, No. 5, September 1, 1993, at 31.

Lost data, computer tapes and systems, and information stored have been held not to be tangible property. *Rockport Pharmacy, Inc. v. Digital Simplistics, Inc.*, 53 F.3d 195, 198 A. Sup. Ct. 1995; *Retail Systems, Inc. v. C.N.A. Ins. Cos.*, 469 N.W.2d 735 (Minn. 1991); *St. Paul Fire & Marine Ins. Co v. National Computer Systems, Inc*, 440 N.W.2d 626, 631 (Minn. App. 1992). Additionally, claims for loss of investments and anticipated profits have been held not to be losses of tangible property. *Terra International Inc., v. Commonwealth Lloyd's Ins. Co.* 829 S.W.2d 270 (Tex.App.-Dallas 1992, writ denied); *Houston Petroleum Co. v. Highlands Ins. Co.*, 830 S.W. 2d 153, 156 (Tex. App.-Houston [1st Dist.] 1990, writ denied).

The Personal and Advertising Injury Coverage under the CGL is limited to enumerated torts. *Nutmeg Ins. Co. v. Proline Co.*, 836 F. Supp. 385 (N.D.Tex. 1983). In order to fall within the scope of personal injury or advertising injury, the claim must be for a distinct tort set out in the policy definitions. See *Liberty Bank of Montana v. The Travelers Indemnity Co.*, 870 F. 2d 1504 (9th Cir. 1989). Texas courts have held that claims of trademark and trade dress infringement were covered under CGL policies. *Gemmy Industries Corp v. Alliance General Ins. Co.*, 1998 WL 804698 (N.D. Tex 1998), aff'd, 200 F.3d 816 (5th Cir. 1999). Using trade dress to call public attention to its product was held to constitute advertising activity. *Id.* at 3. *Accord, Bay Electric Supply, Inc. v. The Travelers Lloyds Ins. Co.*, 61 F. Supp. 2d 611 (S.D. Tex. 1999).

Copyright infringement is generally covered under CGL policies. However, the claim must still arise in the course of the insured's advertising. In *Sentry Ins. v. R.J. Webber Co., Inc*, 2 F.3d 554 (5th Cir. 1993), the insured was sued for copying, publishing and selling copyrighted works without first obtaining permission, and because these acts were not connected to advertising, there was no coverage under the policy.

B. CAN I BUY ANYTHING TO COVER E-COMMERCE RISKS?

The insurance industry is meeting the challenge to create new policies for e-commerce that fit the particular needs of the business. These new products are specifically tailored to meet the unique needs of the virtual marketplace.

1. Technology Errors and Omissions Coverage

Companies designing or selling computer software or hardware typically require worldwide coverage for compensatory damages and consequential damages resulting from the insured's products or services. Carriers providing technology errors and omissions policies protect companies providing services on the Internet, including marketing or advertising agencies, Internet Consultants, Internet developers, website monitoring organizations, and Internet connectivity and support services. These businesses are securing coverage against third-party claims alleging loss of data, loss of access to email, or loss of e-commerce that arises from the insured's use of the Internet. See Paar, Randy K., *Coverage for Losses Arising out of the Use of the Internet*, S.E. 64 ALI-ABA 1095, 1011, 1113.

2. Media Liability Policies.

Multi-media policies are designed to afford coverage for publishing and broadcasting, and media services, which are excluded under the CGL policy. The areas of third party liability that may arise on the Internet include libel, slander and defamation claims, and infringement of intellectual property rights.

Generally, these policies afford coverage for:

- (1) Liabilities arising from Internet activities including advertising and webcasting, as well as material published, transmitted, disseminated, distributed, serialized, created, originated, exhibited or displayed via the world-wide-web in the course of business;
- (2) Allegations of libel, slander, product disparagement, trade libel; infringement of copyright, title, slogan, trademark, trade name, trade dress of service name; plagiarism, piracy or misappropriation of ideas on implied contract; invasion, infringement or interference with rights of privacy or publicity; and disclosure of private facts and commercial misappropriation of name or likeness;
- (3) Coverage for liability resulting from the actions of a third party;
- (4) Coverage encompassing claims for monetary, non-monetary or injunctive relief and punitive, exemplary and multiple damage awards; and
- (5) Worldwide coverage.

3. Internet Security (“Hacker Insurance”)

Carriers are now affording coverage for lost website and advertising revenue due to unauthorized entry, theft of credit data; viruses; virus clean-up; loss of data confidentiality, loss of data integrity, loss of system availability; or employee error.

X. CONCLUSION

All lawyers must have at least a general understanding of insurance law in order to protect their clients. Insurance is frequently a mere afterthought for both litigation and transactional counsel. Such an approach has potentially devastating consequences. Almost every business transaction and lawsuit should involve insurance counsel to make sure that these risks are accurately valued, assessed, and insured in the future to the extent possible.

Lawyers responsible for ongoing guidance of a business must also maintain a general familiarity with insurance issues. Because policies renew each year, the evaluation of needed coverages is a constantly reoccurring task. When claims are made against a business, or when losses are

suffered, corporate counsel must also guide the business through the insurance process to make sure that corporate assets are not unnecessarily squandered by overlooking available insurance. One need only watch the nightly news or pick up a newspaper to realize how corporate finances can implicate risk of loss on a global scale.

I hope this paper will help simplify that which previously seemed mystifying, confusing, or just plain dull. While numerous insurance coverages are not be addressed, and while many of the legal issues discussed were only covered in a superficial way, I hope this paper heightens the reader's awareness of both the importance of insurance and the general substance of basic insurance law as it impacts today's business world.