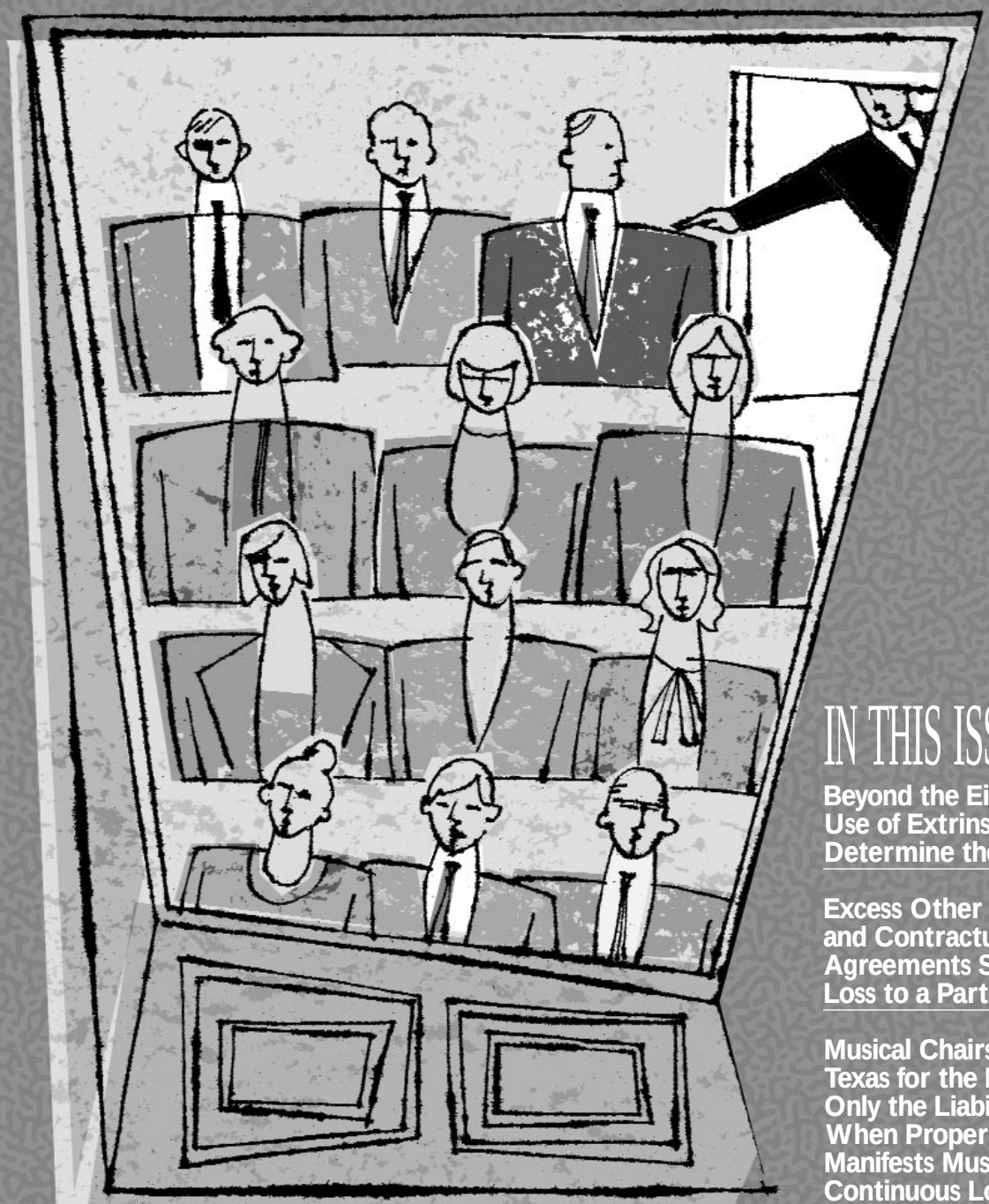
Journal of Texas Insurance Law

December 2004 Volume 5, Number 3



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

Journal of Texas Insurance Law

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PUBLICATION DESIGN
BOB PERETTI
Peretti Design
713-502-6153

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

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

Cite as:
5:3 J. TEX. INS. L. ____ (Dec. 2004)

Journal of
Texas Insurance Law
DECEMBER 2004, VOLUME 5, NUMBER 3

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The Insurance Law Section of the State Bar is pleased to announce the creation of the

BEN LOVE MEMORIAL INSURANCE LAW SECTION SCHOLARSHIP

The Ben Love Memorial Insurance Law Section Scholarship is being established to honor and memorialize our friend, colleague, and former counsel member of the Insurance Law Section of the State Bar of Texas. Ben died of cancer earlier this year. In his memory we are establishing an annual scholarship at Southern Methodist University Law School which will be presented to a deserving second or third year law student who has completed the insurance law course at the law school. The procedure and criteria for determining the scholarship recipient is as follows:

1. The candidate must have completed and passed the insurance law course by the end of the first semester of the applicant's third year of law school.

2. The professor of the insurance law course will nominate three deserving candidates from the course based upon the candidates' participation in the course, class grade, and interest in pursuing an insurance-related practice.

3. The three candidates will be considered by a committee of three counsel members of the State Bar of Texas Insurance Law Section appointed annually by the Chair of the Section. The committee will consider the candidate's need, course grade, and general standing in the law school in making its final recommendation.

4. The committee's recommendation will then be presented to the Section's Council for vote and approval.

If you or your law firm are interested in making a contribution to this Memorial Scholarship in honor of Ben Love, please contact:

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Comments FROM THE CHAIRMAN

BY PATRICK J. WIELINSKI
Cokinos, Bosien & Young

As the incoming chair of the Insurance Law Section, I have the enviable position of stepping into a healthy situation that extends not only to this Journal, but to all aspects of the section. The health and vibrancy of the section is due in no small part to the leadership of Jim Cornell, last year's chair. Jim brought a passion and an eye for detail that was unsurpassed, of which the officers, the Council, and most importantly, our members, have been the beneficiaries. I hope to carry on and follow in Jim's footsteps, as well as those of the prior chairs of what is still a very young organization in its development stage.

A major reason for the section's advancement beyond its chronological years is its Executive Director, Donna Passons. We are very fortunate to be entering our third year with Donna under contract in that position. Donna brings a wealth of experience and talent to the table, freeing up the officers and council to focus on substantive issues, rather than being mired down in day-to-day operations.

Primary mission of this section is to serve as a resource for education and exchange of ideas relating to insurance law issues. This journal has been, and remains, the centerpiece of that mission. Since its inception, Chris Martin has performed yeoman's duty as editor. This issue is another example of his fine work – cutting edge legal scholarship in a variety of articles by a group of accomplished and talented authors.

As to the coming year, priority will be given to the section's CLE efforts, again, in keeping with its mission to educate. Last year, we cosponsored CLE programs with the University of Texas and the State Bar. We also sponsored our own CLE program (with the assistance of Texas Institute of Continuing Legal Education, Donna Passons' organization). That seminar was well-received and the section now has several options as sponsorship and participation this coming year. We are evaluating those options in order to pursue those that will provide the maximum benefit to our members. In addition, we will be focusing on the section website, www.txins.org, in order to enhance its content and usefulness for each and every one of our 1500+ members, in the many facets of insurance law that they practice.

Thank you for the privilege of chairing this section for the coming year and the opportunity to further the mission of our members.

Patrick J. Wielinski

BY JEFF GLASS AND DAVID L. PLAUT

HANNA & PLAUT, LLP, AUSTIN, TEXAS

Beyond the Eight Corners: Use of Extrinsic Evidence to Determine the Duty to Defend

Standard liability policies, including commercial general liability, automobile, and homeowners policies, require the carrier to defend the insured in suits that allege facts within the policy's coverage provisions. The Texas Supreme Court has never addressed the question of whether evidence extrinsic to the underlying allegations against the insured can be considered in determining this duty to defend, but several Texas decisions have considered such evidence in declaratory judgment actions on coverage.[3] A recent Fifth Circuit decision, *Northfield Insurance Co. v. Loving Home Care, Inc.*,[4] predicts the Texas Supreme Court would reject any use of extrinsic evidence to determine the duty to defend and would adhere strictly to the so-called "eight corners" rule, which requires that the court consider only the facts alleged in the underlying suit against the insured and the provisions of the relevant insurance policy. In the alternative, however, the *Northfield* court recognized the Texas decisions that have considered certain types of extrinsic evidence in certain circumstances, and declined to consider extrinsic evidence that did not satisfy the conditions imposed by the prior cases. This latter approach comports more closely with decided Texas cases, including recent decisions from the U.S. Eastern District, *Westport Insurance. Corp. v. Atchley, Russell Waldrop and Hlavinka*,[5] and the Fort Worth Court of Appeals, *Fielder Road Baptist Church v. Guideone Elite Insurance Co.*[6]

Because of its impact on insurance coverage litigation, this issue seems destined to be decided by the Texas Supreme Court, particularly in light of the predictions being made about what the Court will do. Prior to *Northfield*, *Westport*, and *Fielder Road*, a distinguished commentator on Texas insurance law urged the adoption of a rule that would permit the use of extrinsic evidence whenever the policyholder's defense in underlying liability litigation would not be "prejudiced." *See* E. Pryor, "Mapping the Changing Boundaries of the Duty to Defend in Texas," 31 Tex. Tech L. Rev. 869, 890-897 (2000).[7] Professor Pryor suggested the following rule: (1) with respect to extrinsic evidence that addresses facts relating solely to the insured's liability in the underlying case, the eight corners rule would always govern the duty to defend; (2) as to coverage-only extrinsic evidence, the carrier would be permitted to deny a duty to defend at the outset based on such evidence and the court would also be permitted to consider such evidence in a coverage action; and (3) with respect to "overlapping" extrinsic evidence, that is, evidence related to coverage facts as well as to the validity of the underlying claim, the eight-corners rule would govern the carrier's decision whether or not to defend at the outset, but in a declaratory judgment action on coverage, the court could consider the evidence if (and only if) "the insurer can establish that it will not pose any substantial risk of disadvantaging the insured in the underlying case." *Id.*

After reviewing the development of the eight corners rule and the recent decisions addressing the use of extrinsic evidence, including *Northfield*, *Westport*, and *Fielder Road*, we conclude that Texas law supports, and the Supreme Court should adopt, a narrow exception to the "eight corners" rule incorporating the first two prongs of the rule suggested by Professor Pryor. Such an exception will serve the interests of judicial economy, fairness and justice implicated by the eight corners rule, as well as those market interests discussed by Professor Pryor. *See* E. Pryor, 31 Tex. Tech L. Rev. at 890-897. However, we conclude that the Texas Supreme Court is unlikely to adopt a rule that permits consideration of extrinsic evidence relating to "overlapping" facts. Limiting the exception to coverage-only facts has all the advantages of simplicity

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and avoids the complexities inherent in proving, during coverage litigation, that certain facts will cause prejudice to the insured in the underlying litigation.

A. THE EIGHT CORNERS DOCTRINE AND ITS RATIONALE

The virtually universal rule, known in Texas as the "eight corners" or "complaint allegation" rule, provides that "[a]n insurer's duty to defend is determined solely by allegations in the pleadings and the language of the insurance policy." *King v. Dallas Fire Ins. Co.*, 85 S.W.3d 185, 187 (Tex.2002). *See generally* Annotation, *Allegations in Third Person's Action Against Insured as Determining Liability Insurer's Duty to Defend*, 50 A.L.R.2d 458 (1956). The rule derives from standard liability policy language creating the duty to defend, which provides, in at least one version, that the carrier will "have the right and duty to defend" any suit seeking covered damages "even if the allegations of the suit are groundless, false or fraudulent." *See, e.g., Maryland Cas. Co. v. Moritz*, 138 S.W.2d 1095, 1097 (Tex. Civ. App.–Austin 1940, writ refused) (where the policy binds the carrier to defend suits, even if groundless, false or fraudulent, the insurer's duty to defend depends upon the allegations of the plaintiff's petition).

The Supreme Court originally adopted the "eight-corners" rule in the course of rejecting a claim by the carrier that the insured's underlying liability to the injured party had to be determined by a trial on the merits before the carrier's duty to defend could be determined. *Heyden Newport Chem Co. v. Southern Gen. Ins. Co.*, 387 S.W.2d 22, 24 (Tex. 1965). The Court disagreed with that proposition and held:

> We think that in determining the duty of a liability insurance company to defend a lawsuit the allegations of the complainant should be considered in the light of the policy provisions without reference to the truth or falsity of such allegations and without reference to what the parties know or believe the true facts to be, or without reference to a legal determination thereof.

Id. Thus, in adopting the "eight corners" approach, the Court rejected the proposition that the insured's liability to the injured party determines the duty to defend.[8] The court did not reject the argument – and has never rejected the argument – that courts may look beyond the pleadings in limited circumstances to consider evidence that relates solely to coverage and does not touch upon the insured's underlying liability.

The court further refined the doctrine by observing that courts should interpret the underlying pleadings liberally and "[w]here the complaint does not state facts sufficient to clearly bring the case within or without the coverage," to resolve doubts in favor of coverage. *Heyden Newport*, 387 S.W.2d at 26. More recently, the Court noted that this "liberal interpretation" approach has its limits. It does not allow a court to "read facts into pleadings" or "imagine factual scenarios which might trigger coverage." *National Union Fire Ins. Co. of Pittsburgh, PA v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141 (Tex. 1997). That is, the pleadings must contain at least enough facts to "create that degree of doubt which compels resolution of the issue for the insured" before the issue of "liberal interpretation" even arises. *Id*. In Texas, moreover, the carrier has no duty to investigate whether there was a reasonable basis for denying coverage because, under the eight corners rule, the carrier "is entitled to rely solely on the factual allegations contained in the petition in conjunction with the terms of the policy to determine whether it has a duty to defend." *Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 829 (Tex. 1997).

As a hedge against the requirement that pleadings be interpreted "liberally," the "eight corners" rule requires that courts look only to the facts alleged in the underlying petition, not to legal theories isolated from or in conflict with alleged facts. *Merchants Fast Motor Lines, Inc.*, 939 S.W.2d at 142. Thus, if the pleading alleges only intentional conduct, excluded by the policy, a legal allegation seeking relief under a negligence or gross negligence theory will not overcome the factual allegations that preclude coverage. *Farmers Texas County Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 82-83 (Tex.1997).

Why did the court adopt these rules? Why should the court and the parties be restricted to the allegations against the insured to determine the duty to defend regardless of their truth, when, by contrast, the actual underlying facts determine the duty to indemnify?[9] In the first place, the use of the "groundless, false or fraudulent" language or its equivalent in standard policies requires erring on the side of coverage when there is doubt about the merits of the underlying claim. Nevertheless, some policies do not contain such language. Other considerations, however, justify the rule even in the absence of explicit policy language. One set of justifications stems from the preferences of both policyholder and insurer. For example, defendant policyholders will incur defense costs regardless of the validity of the suits against them, so it is reasonable for them to purchase "litigation" insurance to cover such costs. *See, e.g.*, E. Pryor, "The Tort Liability Regime and the Duty to Defend," 58 Md. L. Rev. 1, 16 (1999). By the same token, an insurer with potential indemnity coverage on a claim may want to be involved in the conduct of such litigation, even if the suit is not meritorious. *Id*. at 15. Thus, the rule properly gives the policyholder the benefit of the doubt in terms of the merits of the suit.

But the eight corners doctrine also gives the policyholder the benefit of the doubt with respect to whether the allegations are within coverage. The "groundless, false or fraudulent" phrase does not refer to issues of coverage, only to the merits of the underlying suit. Justification for this facet of the rule rests, in part, on the nature of liberal pleading rules, as well as on concerns for efficiency. For example, most jurisdictions permit notice pleading and do not require the injured plaintiff to allege every material fact with specificity, thus leaving unstated many facts that may affect liability coverage. *Cf. State Farm Fire & Cas. Co. v. Wade*, 827 S.W.2d 448, 452-53 (Tex. App.—Corpus Christi 1992, writ denied) (noting that state petitions may be broadly drafted with little detail and may not include sufficient facts to consider the applicability of a particular exclusion). The uncertainty relating to coverage facts, as well as fairness and economies of scale, favor insurer defense until the true facts are known. Depriving the insured of such protection would severely reduce the value of defense coverage under liberal pleading rules.

A further rationale for resolving doubt in favor of coverage is efficiency: if the duty to defend depended, from the beginning, on the actual facts, insurer and policyholder alike would have to either wait until the underlying case is fully litigated to determine whether the insurer owes a defense, or they would have to litigate the merits of certain aspects of the underlying action in a parallel declaratory judgment suit. The expense and inefficiency of forcing the insurer and the insured to litigate the underlying merits to determine defense obligations - at the same time that some of the same facts are being litigated in the underlying liability suit - would unnecessarily burden the justice system and undermine the purpose of liability insurance. Further, the carrier may not always have the same incentive to present the merits of the suit as the injured party. Finally, concerns for efficiency favor a "bright line" rule; at some point a court must decide the duty to defend without trying the underlying liability case. Thus, when in doubt about coverage, the insurer generally must defend.

Texas courts have nevertheless departed from the eight corners rule to consider extrinsic evidence in a narrow range of cases. Although every opinion approving the use of extrinsic evidence does not explicitly discuss the policies outlined above, admission of extrinsic evidence is justified in cases in which the facts remove the policy concerns that would otherwise require adherence to the eight corners rule.

Texas courts have nevertheless departed from the eight corners rule to consider extrinsic evidence in a narrow range of cases.

B. POTENTIAL EXCEPTIONS TO THE "EIGHT CORNERS" RULE.

The cases that recognize the admissibility of extrinsic evidence tend to agree on the following criteria: (1) the evidence must pertain to coverage, not to the insured's underlying liability to the injured party; (2) the evidence must not contradict factual allegations of the petition (this includes the principle that the underlying petition must not allege facts sufficient to determine application of an exclusion or other coverage fact); and (3) the evidence must be readily ascertainable from objective proof. The three most recent extrinsic evidence decisions, more or less following Judge Folsom's exhaustive review of the cases in *Westport*, formulate the exception in a similar way. *See Fielder Road Baptist Church v. Guideone Elite Ins. Co.*, 2004 WL 1119494, slip op. at *2 (Tex. App.-Fort Worth May 20, 2004, no pet.); *Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d 523, 531 (5th Cir. 2004); *Westport Ins. Corp. v. Atchley, Russell Waldrop and Hlavinka*, 267 F.Supp.2d 601, 621 (E.D. Tex. 2003). *See also Tri-Coastal Contractors, Inc. v. Hartford Underwriters Ins. Co.*, 981 S.W.2d 861, 863 n.1 (Tex.App.–Houston [1st Dist.] 1998, pet. denied).

As noted above, *Northfield* noted the limited extrinsic evidence exceptions, despite its prediction that the Texas Supreme Court would not recognize any exception to the eight corners rule. *Northfield*, 363 F.3d at 531. The court held that if the Supreme Court adopted an exception to the eight corners rule, it "would only apply in very limited circumstances: when it is initially impossible to discern whether coverage is potentially implicated *and* when the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case." *Id.* (emphasis in original). As the following discussion makes clear, this statement is in line with other Texas cases that recognize the admissibility of extrinsic evidence. In fact, the holding in *Northfield*, on its facts, fits comfortably within the framework set forth by earlier cases, as do the results in both *Westport* and *Fielder Road*.

As currently formulated, the extrinsic evidence exception may require the proponent to meet all or a combination of the following conditions. Although the Texas cases recognizing an exception for extrinsic evidence impose several conditions on admissibility, only two of those conditions – the requirement that the evidence relate only to coverage facts, not to liability facts, and the requirement that the evidence be readily ascer-

tainable from objective facts - comport with underlying policy considerations.

1. The underlying petition does not allege facts sufficient to determine coverage. The evidence does not contradict the facts alleged in the petition.

These two statements are aspects of the same rule: if the extrinsic evidence supplies a fact missing from the petition, the evidence will not contradict the facts that are alleged. In *State Farm Fire & Cas. Co. v. Wade*, the leading Texas case on this issue, the court permitted the use of extrinsic evidence, in a declaratory judgment action on coverage, to show that a business pursuits exclusion in a private boat-owners policy applied to an accident resulting in the drowning of the underlying plaintiff. 827 S.W.2d 448, 451-52 (Tex. App.-Corpus Christi 1992, writ denied). The exclusion precluded coverage for accidents involving paying passengers on the boat or other business pursuits. *Id*. at 451. The underlying plaintiff was a passenger on the boat, but the underlying petition did not allege facts indicating whether he was a paying passenger, and the court decided extrinsic evidence was admissible because of these factual gaps in the petition. *Id*. The court held that if "the petition… does not allege facts sufficient for a determination of whether those facts, even if true, are covered by the policy, the evidence adduced at trial in a declaratory judgment action may be considered along with the allegations in the underlying petition." *Id*.

Several other decisions cite this non-contradiction principle. Two Texas cases admitted extrinsic evidence because it did not contradict the petition. *See Western Heritage Ins. Co. v. River Entertainment*, 998 F.2d 311, 313-15 (5th Cir.1993) (allowing extrinsic evidence of intoxication of the insured's "guest" to show a liquor liability exclusion applied where petition did not allege how the guest/driver became incapacitated); *Acceptance Ins. Co. v. Hood*, 895 F. Supp. 131, 134 n. 1 (E.D. Tex. 1995) (considering extrinsic evidence to show employee exclusion applied). Most of the cases that cite this principle, however, preclude admission of extrinsic evidence because it relates to liability facts and/or contradicts the underlying petition. *E.g., Fielder Road Baptist Church v. Guideone Elite Ins. Co.*, 2004 WL 1119494, slip op. at *2 (declining to consider extrinsic evidence because it pertained to liability as well as coverage); *Gonzales v. American States Ins. Co.*, 628 S.W.2d 184, 186-87 (same); *City of Dallas v. Csaszar*, 1999 WL 1268076, slip op. at * 3 n.2 (Tex. App.-Dallas Dec. 30, 1999, pet. denied) (declining to consider extrinsic evidence because the petition alleged sufficient facts to determine whether police officers were acting within the scope of their employment); *Calderon v. Mid-Century Ins. Co.*, 1998 WL 898471, slip op. at *3-4 (Tex.App.—Austin Dec. 29, 1998, pet. denied) (not designated for publication) (holding extrinsic evidence relating solely to a coverage fact – whether driver was an insured – was not admissible because it contradicted the facts alleged); *Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d at 529 (declining to consider extrinsic evidence).

Finally, one federal case appears to violate this rule, permitting extrinsic evidence that contradicted conclusory allegations in the petition. *Guaranty Nat'l Ins. Co. v. Vic Mfg. Co.*, 143 F.3d 192, 194 (5th Cir. 1998) (permitting extrinsic evidence that release was not within "sudden and accidental" exception to pollution exclusion, even though the petition alleged conclusorily that release of pollutants was "sudden and accidental").[10]

In our view, *Wade's* stated rationale for considering extrinsic evidence – that it was impossible to discern from the petition whether the exclusion applied – is troublesome and difficult to apply. A comparison of *Wade* and *Heyden Newport* illustrates the problem. The *Wade* court distinguished *Heyden Newport* on the ground that, in that case, "the court was able to discern, without addressing the truth or falsity of the allegations and by broadly construing the alleged facts in the plaintiff's petition, whether the claim potentially came within the coverage of the insurance policy." *Wade*, 827 S.W.2d at 452. In *Wade*, on the other hand, the court said that it was "impossible to determine whether or not there is coverage under the private boat-owner's policy" without "addressing the truth or falsity of the allegations in the underlying petition," because it was "impossible to know how the boat was used when it left the… dock." *Id*. at 453.[11]

This observation does not distinguish the cases meaningfully. The issue in *Heyden Newport* was whether the insured/owner of a vehicle involved in an accident was an agent of Heyden Newport, thus entitling Heyden Newport to a defense under the owner's auto policy, pursuant to the policy definition of the term "insured." *Heyden Newport*, 387 S.W.2d at 23-24. The underlying petition asserted that the owner was in fact an agent, but Heyden Newport had informed the insurer that the owner of the vehicle was not its agent. *Heyden Newport*, 387 S.W.2d at 24. Thus, the allegations alleged facts within the policy definition of the term "insured." *Id*. The petition in *Wade*, like the petition in *Heyden Newport*, alleged only facts covered by the policy; there was no allegation in *Wade* that the boat was being used in a business pursuit at the time of the accident. *Wade's* notion that the inconclusiveness of the petition should permit extrinsic evidence, does not really hold water. Under a strict application of the "eight corners" rule, if the petition alleges only facts within coverage, the benefit of the doubt favors coverage for the insured and requires the court to find that the exclusion does not apply for purposes of the duty to defend. *Heyden Newport*, 387 S.W.2d at 26.

This is the flip side of the rule that if the petition alleges only facts that are excluded, the exclusion does apply. *Fid. & Guar. Ins. Underwriters, Inc. v. McManus*, 633 S.W.2d 787, 788 (Tex.1982). In *Wade*, the petition probably did raise "that degree of doubt which compels resolution… for the insured." *See Merchants Fast Motor Lines*, 939 S.W.2d at 142. *Cf*. E. Pryor, 31 Tex. Tech L. Rev. at 880 (observing that the *Wade* approach "is both too restrictive and too broad"). As in *Wade*, the courts' attempts to explain decided cases on this basis are often quite unconvincing. *See Northfield*, 363 F.3d at 531 n. 3.

The real key to the distinction between *Wade* and *Heyden Newport*, and the rationale that explains prior cases more convincingly, is the nature of the facts developed by extrinsic evidence. For example, in *Heyden Newport*, the facts about agency affected the underlying liability of Heyden Newport for the injuries in the accident.[12] In *Wade*, however, whether or not the passenger paid for the boat trip that resulted in his death would not affect the underlying liability of the boat owner; it had an impact only on coverage. The key question is whether the extrinsic facts relate to coverage, or liability or both. As discussed more thoroughly below (and as discussed at length in Professor Pryor's article), this rationale makes sense in terms of underlying policy and justifies the different results in *Wade* and *Heyden Newport*, as well as other cases. *Cf*. E. Pryor, 31 Tex. Tech L. Rev. at 890-897 (suggesting that the extrinsic evidence admissibility depends on whether the evidence affects underlying liability).

2. The extrinsic evidence must relate solely to a coverage fact, not to a fact bearing on the insured's underlying liability.

Beginning with *Heyden Newport*, Texas courts have distinguished between extrinsic evidence that relates solely to the insured's underlying liability, which is inadmissible to show a duty to defend, and extrinsic evidence that relates solely to fundamental coverage facts, which is admissible on the duty to defend. Of course, there is a third category in addition to coverage-only evidence and liability-only evidence, namely, "overlapping" evidence that relates both to coverage and liability. Although Texas courts are not consistent in identifying the type of evidence at issue, they generally are consistent in holding such overlapping extrinsic evidence inadmissible.[13]

Cook v. Ohio Casualty Insurance Co., 418 S.W.2d 712, 714 (Tex. Civ. App.-Texarkana 1967, no writ), decided soon after *Heyden Newport*, relied on the distinction between coverage evidence and liability evidence. The court considered extrinsic evidence to show that an exclusion – for damages incurred while the insured was operating a vehicle owned by a relative in the household – applied to preclude coverage. *Id.* Comparing its holding with that in *Heyden Newport*, the court stated:

> [T]he Supreme Court draws a distinction between cases in which the merits of the claim is the issue and those where the coverage of the insurance policy is in question. In the first instance the allegation of the petition controls, and in the second the known or ascertainable facts are to be allowed to prevail.

Id. at 715-16.

Most of the cases resting on this distinction, including the recent decisions in *Fielder Road* and *Westport*, exclude extrinsic evidence because it relates to underlying liability.[14] The recent decision in *Northfield Insurance Co. v. Loving Home Care, Inc.*, 363 F.3d 523, 529 (5th Cir. 2004), also fits this description. In *Northfield*, the insured, Loving Home Care ("LHC") was sued by one of its clients when a child died while under the care of a nanny provided by LHC. *Id.* at 525-526. The injuries included skull fractures and brain hemorrhages, the coroner ruled the death a homicide, and a jury found the nanny guilty of first-degree felony injury to a child and sentenced her to seven years in prison. *Id*. The petition filed by the child's parents against LHC alleged the injuries resulted from negligence, including negligent dropping and/or shaking of the child, and, in the alternative, reckless conduct and/or criminal negligence. *Id.* at 526. The latest petition had been amended to remove all allegations relating to the nanny's criminal conviction and the intentional nature of her behavior. *Id.*

LHC sought a defense under a CGL policy issued to LHC by Northfield, and Northfield defended under a reservation of rights and filed a declaratory judgment action to determine the duty to defend. *Id.* at 527. Northfield opposed coverage, in part, because of two exclusions relating to "criminal acts" and "physical/sexual abuse," and sought to introduce extrinsic evidence that the child's death resulted from "criminal acts" and/or physical abuse. *Id.* at 532. After a lengthy discussion of the Texas cases on extrinsic evidence, and its prediction that the Supreme Court would recognize no exceptions to the eight corners rule, the Fifth Circuit ultimately held that the evidence was inadmissible because it overlapped with the merits of the underlying suit. *Id.* at 535. Thus, notwithstanding the opinion's dicta, the holding is a non-controversial application of the oldest rule in the "eight corners" book: in determining the duty to defend, the courts cannot look outside the pleadings to decide issues relating to the merits of the underlying claim. *See Heyden Newport*, 387 S.W.2d at 24.

The decisions in *Westport* and *Fielder Road* also recognized limited exceptions to the strict eight corners rule. The

opinion in *Westport* stated that prior cases admitted extrinsic evidence only as to certain types of coverage facts, namely "fundamental coverage issues" which "include" the following: "(1) whether a person has been excluded by name or description from any coverage; (2) whether the property in suit has been expressly excluded from any coverage; and (3) whether the policy exists." *Westport Ins. Corp. v. Atchley, Russell Waldrop and Hlavinka*, 267 F.Supp.2d 601, 621 (E.D. Tex. 2003). *See also Fielder Road*, 2004 WL 1119494, slip op. at *2 (outlining three similar exceptions); *Tri-Coastal Contractors, Inc*., 981 S.W.2d at 863 n.1 (same).[15] Whether these courts intended to limit extrinsic evidence to only these types of coverage facts is not clear.[16] The *Westport* opinion itself is not helpful on this question because it does not describe the nature of the extrinsic evidence. 267 F. Supp.2d at 622. As noted above, the extrinsic facts in both *Fielder Road* and *Tri-Coastal* related to underlying liability, as well as to coverage. As discussed below, there is no good reason to limit extrinsic evidence of coverage to certain types of coverage facts because the policy concerns are the same whether the coverage fact relates to the definition of the insured, the application of a condition, or the application of an exclusion.

The acceptable contours of an extrinsic evidence exception should track the rationale for the eight corners doctrine itself…

3. The evidence must relate to a readily ascertainable fact.

Texas courts often state that extrinsic evidence relating to a "fundamental coverage issue must be capable of being determined by a readily ascertained fact." *Fielder Road*, 2004 WL 1119494, slip op. at *2. *See also Westport*, 267 F.Supp.2d at 621; *Tri-Coastal*, 981 S.W.2d at 863.[17] In most cases that permit consideration of extrinsic evidence, the evidence refers to a simple fact that is objectively determinable by explicit documentary or other direct evidence or from the parties' stipulations. *E.g*., *Cook v. Ohio Cas. Ins. Co.*, 418 S.W.2d at 715-16 (ownership of vehicle determined applicability of exclusion); *International Service Ins. Co. v. Boll*, 392 S.W.2d at 161 (name of driver of vehicle); *John Deere Ins. Co. v. Truckin' U.S.A.*, 122 F.3d at 272-73, (whether vehicle was insured was readily determined by looking to the its title certificate); *Western Heritage Ins. Co. v. River Entertainment*, 998 F.2d 311, 313-15 (5th Cir.1993) (considering a stipulation by the parties that the insured was intoxicated at the time of the accident). Nevertheless, the decisions do not always follow this requirement: some of the cases consider extrinsic evidence that is inherently uncertain or subjective. *Guaranty Nat'l Ins. Co. v. Vic Mfg. Co.*, 143 F.3d 192, 194 (5th Cir. 1998) (admitting extrinsic evidence of pollution discharges, spills and other events to show whether pollutant release was "sudden and accidental"); *Acceptance Ins. Co. v. Hood*, 895 F. Supp. 131, 134 n. 1 (E.D. Tex. 1995) (considering extrinsic evidence of whether employee was acting within the scope of his employment). As discussed below, we believe this criterion is a justifiable limit on the use of extrinsic evidence.

C. POLICY AND RECOMMENDATION

The acceptable contours of an extrinsic evidence exception should track the rationale for the eight corners doctrine itself, as long as this results in a rule that is relatively easy to apply. As discussed above, the salient rationales for relying on the underlying petition alone include the following: (1) the need for a "bright line" rule so insurers can make timely decisions about the defense of insureds; (2) the uncertainty created by liberal pleading rules favors erring on the side of coverage in cases of doubt; (3) concerns for efficiency and conservation of resources favor avoiding (re)litigation of underlying liability in the coverage action; and (4) issues of fairness and unequal resources favor giving the insured the benefit of the doubt.

In certain cases, however, the rationales for giving the insured the benefit of the doubt evaporate well before the underlying claim has reached finality. This occurs, first and foremost, when the facts alleged in the petition clearly preclude coverage. In such cases, Texas courts have had no trouble concluding that the carrier has no duty to defend; they even relieve the insurer of the duty to indemnify in such cases, if the same facts that preclude defense also preclude coverage entirely. *See Farmers Texas County Mutual Insurance Co. v. Griffin*, 955 S.W.2d 81, 83 (Tex. 1997). *But see* E. Pryor, 31 Tex. Tech. L. Rev. at 886-890 (criticizing *Griffin's* approach). When there is no uncertainty about the lack of coverage, there is no danger of excessive or duplicative litigation, and the insurer's command of greater resources does not create any danger of overreaching. When there is no meaningful coverage dispute, the rationale favors deciding coverage immediately rather than later.

A second situation also justifies relaxation of the eight corners rule: when a readily ascertainable fact, known to the carrier or the policyholder, but not alleged in the underlying suit and not related to the insured's liability, clearly affects coverage. When an objective extrinsic fact relates solely to coverage, there is no reason to give the insured the "benefit of the

doubt," or to err on the side of coverage, and courts should consider such evidence in coverage litigation whether it precludes coverage or triggers it. Consideration of extrinsic evidence in these circumstances violates no policy consideration inhering in the eight corners rule and promotes other policies that the legal system values: fairness and efficiency. In such cases, the public interest in avoiding the perpetration of fraud on the courts,[18] reducing waste of resources, and mitigating the impact of artful pleadings that misrepresent the true nature of the suit,[19] overcomes any remaining interest in erring on the side of coverage. As long as courts limit the exception to "readily ascertainable" facts derived from objective evidence, these policy considerations will be well-served. Of course, the extrinsic evidence must preclude any potential for coverage, just as the allegations of the complaint must do under eight corners analysis.[20]

Our approach agrees with Professor Pryor's recommendation, with one exception. Professor Pryor thinks carriers should be permitted to use "overlapping" extrinsic evidence (which pertains to underlying liability as well as coverage), if they can show the evidence will not prejudice the insured's defense in the underlying suit. *See* E. Pryor, 31 Tex. Tech L. Rev. at 891, 895-896. This proposal is one we believe the Texas Supreme Court is unlikely to adopt for several reasons. Although this rule would comport with some underlying policy considerations, it is difficult to apply and defeats a bright line approach. *Cf.* E. Pryor, 31 Tex. Tech. L. Rev. at 895 n. 189 (noting that the courts should not allow the insurer, at the outset of the claim, to base its initial denial of coverage on overlapping extrinsic evidence because the standard "is not sufficiently bright around the edges" to govern at the outset). In any given coverage suit, it will be difficult to foresee the effects on the liability suit of permitting discovery and jury consideration of liability-related facts. As a practical matter, coverage courts will inevitably disagree with each other on the perceived impacts of certain types of evidence in similar cases. Such inconsistencies in the decisions will only aggravate the difficulties inherent in trying to predict prejudicial impacts. On balance, we believe fairness, simplicity, judicial economy and other factors weigh in favor of limiting the extrinsic evidence exception to coverage-only facts.

…coverage courts will inevitably disagree with each other on the perceived impacts of certain types of evidence in similar cases.

The exception we propose also has the advantage of avoiding the difficulties that inhere in the "insufficient pleadings" analysis, which was initiated by *Wade* and has been confusing courts ever since, as recently as the *Northfield* case. In *Northfield*, the Fifth Circuit panel attempted to distinguish two prior Fifth Circuit decisions that permitted the use of extrinsic evidence. *See Northfield*, 363 F.3d at 531, n.3. For example, the court attempted to distinguish *Western Heritage Insurance Co. v. River Entertainment*, 998 F.2d 311, 313-15 (5th Cir.1993), which had considered extrinsic evidence in holding that a liquor liability exclusion in a general liability policy precluded coverage although the underlying petition did not mention alcohol or intoxication. The *Northfield* court stated that the facts alleged in *Western Heritage* as to the restaurant's failure to prevent the patron from driving away or failure to call him a cab, 998 F.2d at 314, were clearly not sufficient to determine whether policy coverage for negligence was potentially implicated. Such alleged facts did not explain how the restaurant came to have any sort of duty regarding the patron. *Northfield*, 363 F.3d at 531, n. 3. However, in our view, the pleadings in *Western Heritage* were sufficient to trigger coverage for the restaurant's negligence; they were not, however, sufficient to determine whether the liquor liability exclusion applied. As we discussed above in connection with *Wade*, in cases of "pleading insufficiency" where the allegations do not clearly allege facts excluded by the policy, the insurer has a duty to defend.

Even so, the insurer in such a case would have no duty to defend if there was an ascertainable extrinsic fact, unrelated to underlying liability, that showed the exclusion applied. The court in *Western Heritage* was unwilling, apparently, to find coverage when the parties had stipulated that the driver was intoxicated, despite the allegations of impairment in the underlying petition, which were carefully crafted. *See Western Heritage*, 998 F.2d at 313 (noting that the amended complaint had deleted all references to intoxication). The rule we propose would not change the result. The underlying suit in *Western Heritage* was one for simple negligence, the injured plaintiff having deleted causes of action for negligence in continuing to serve an intoxicated patron. *Id.* In their efforts to plead into coverage, the plaintiffs had, ironically, made intoxication irrelevant to liability. The reason for the impairment of the driver did not, therefore, influence underlying liability and the parties' stipulation about intoxication would have been admissible as a coverage-only fact. The proposed exception would avoid the specious "insufficient pleadings" language with a workable, simple and direct standard that would change the result in few, if any, cases.

Further, there is no reason to limit extrinsic evidence to certain types of coverage-only facts. As discussed above, several cases appear to limit extrinsic evidence to "fundamental" coverage facts such as whether the person or property involved in the relevant accident is insured.[21] In fact, the Fifth Circuit panel that decided *Northfield* would have narrowed this condition further to preclude extrinsic evidence relating to applicability of any exclusion even if it does not relate to underlying liability. 363 F.3d at 535. These distinctions make little sense in terms of the underlying rationales. There is no reason to limit extrinsic evidence in this way because the policy concerns relating to efficiency, fairness and conservation of resources are the same whether the coverage fact relates to the definition of the insured, the application of a condition, or the application of an exclusion.

Finally, a narrow exception for the eight corners rule would not necessitate a corresponding expansion of the insurer's duty to investigate. Generally, speaking, Texas law does not impose on the carrier any duty to investigate the underlying suit in assessing its duty to defend. *See, e.g., Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 821 (Tex. 1997) ("under the 'complaint allegation' rule an insurer is entitled to rely solely on the factual allegations contained in the petition in connection with the terms of the policy to determine whether it has a duty to defend."). The limited exception we advocate would not change the basis for this rule: because our exception works in favor of both insured and insurer, depending on the evidence, there is no inherent reason to impose any additional burden of investigation on the insurer.

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3. The leading case is *State Farm Fire & Cas. Co. v. Wade*, 827 S.W.2d 448, 452-53 (Tex. App.-Corpus Christi 1992, writ denied). The Texas decisions that have actually agreed to consider extrinsic evidence in deciding the duty to defend are discussed throughout this article.

4. 363 F.3d 523, 531 (5th Cir. 2004).

5. 267 F.Supp.2d 601, 621 (E.D. Tex. 2003).

6. 2004 WL 1119494 (Tex. App.-Fort Worth May 20, 2004, no pet.)

7. Professor Pryor thoroughly discussed the important decisions on the use of extrinsic evidence, among many other significant duty to defend issues, and Texas practitioners would be well-served by reviewing the article. Professor Pryor has also discussed similar issues in a multi-jurisdictional survey of the duty to defend. *See* E. Pryor, The Tort Liability Regime and the Duty to Defend, 58 Md. L. Rev. 1, 31 (1999).

8. In adopting the rule, the court followed its "outright" refusal of writ in *Maryland Casualty Co. v. Moritz*, a case that also adopted the "eight corners" rule in the context of rejecting proof of facts relating to the insured's underlying liability. *See Maryland Casualty Co. v. Moritz*, 138 S.W.2d 1095, (Tex.Civ.App.-Austin 1940, writ ref'd).

9. The duty to indemnify, unlike the duty to defend, depends on the proven, adjudicated facts in the underlying suit. *See Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 821 (Tex. 1997).

10. *See also Ohio Casualty Insurance Co. v. Cooper Machinery Corp.*, 817 F. Supp 45, 48 (N.D. Tex. 1993) (McBryde, J., stating, in dicta, that the insurer is entitled to contest, in a declaratory judgment action, facts alleged in the underlying suit that relate to coverage); *McLaren v. Imperial Cas. and Indem. Co.*, 767 F. Supp. 1364, 1374 (N.D. Tex. 1991), *aff'd*, 961 F.2d 213 (5th Cir. 1992), *cert. denied*, 113 S. Ct. 1269 (1993) (McBryde, J., stating similar dicta); *Blue Ridge Ins. Co. v. Hanover Ins. Co.*, 748 F. Supp. 470, 473 (N.D. Tex. 1991) (same).

11. Because of the procedural posture of the case, however, the *Wade* court did not consider any particular extrinsic evidence. The trial court had granted the insured's special exceptions asserting that State Farm's petition for declaratory judgment "failed to set forth a cause of action for which relief may be granted." *Wade*, 827 S.W.2d at 450. The court of appeals merely reversed the dismissal and remanded for further proceedings. *Id*. at 453. The concurring justices would have held that the trial court was limited to examining the petition in deciding the duty to defend, but concurred that the dismissal of the entire declaratory judgment suit was erroneous. *Id*. at 454-455 (concurring opinion by Dorsey, J., joined by Hinojosa, J.).

12. This explains why the company denied the vehicle owner was its agent when that admission would preclude indemnity coverage for the company.

13. *See, e.g., Fielder Road*, 2004 WL 1119494, slip op. at *2 (refusing to consider evidence relating to dates of employment of insured's employee who allegedly assaulted the underlying plaintiff); *Tri-Coastal Contractors, Inc.*, 981 S.W.2d at 863 n.1 (refusing to consider evidence relating to an employee's receipt of workers compensation benefits for purposes of an exclusion for workers compensation obligations in an employers liability policy); *Gonzales v. American States Ins. Co. of Texas*, 628 S.W.2d 184 (Tex. App. -Corpus Christi 1982, no writ) (refusing to consider evidence that showed the insured did not own a piece of equipment that injured the underlying plaintiff because it related to "liability rather than coverage."). *Cf.* E. Pryor, 31 Tex. Tech L. Rev. at 882 (pointing out that the evidence in *Gonazales* bore on both liability and coverage).

14. *E.g., Fielder Rd. Baptist Church v. Guideone Elite Ins. Co.*, 2004 WL 1119494, slip op. at *2 (Tex. App.-Fort Worth May 20, 2004, no pet.) (refusing to consider extrinsic evidence that related to dates of employment of sexual assault perpetrator because it bore on the liability of the insured church that employed him); *Tri-Coastal Contractors, Inc. v. Hartford Underwriters Ins. Co.*, 981 S.W.2d 861, 863 n.1 (Tex.App.- Houston [1st Dist.] 1998, pet. denied) (refusing to consider extrinsic evidence relating to whether the insured collected workers compensation insurance because it went to the

merits of the underlying claim); *Gonzales v. American States Ins. Co. of Texas*, 628 S.W.2d 184 (Tex. App.–Corpus Christi 1982, no writ) (refusing to consider evidence that showed the insured did not own a piece of equipment that injured the underlying plaintiff because it related to "liability rather than coverage."); *Gulf Chemical & Metallurgical Cor. v. Associated Metals & Minerals Corp*., 1 F.3d 365, 371-72 (5th Cir. 1993) (refusing to consider insurer's evidence that insured sued for shipping dangerous chemicals never shipped them until after the policy expired because the evidence bore on the insured's liability vis-a-vis the other defendants); *Westport*, 267 F.Supp.2d at 621-22.

15. Cases illustrating admissibility of such evidence follow:

(1) whether a person has been excluded by name or description from any coverage. *See Int'l Serv. Ins. Co. v. Boll*, 392 S.W.2d 158, 161 (Tex. Civ. App.–Houston 1965, writ ref'd n.r.e.) (holding extrinsic evidence allowed to show person involved in accident was excluded from policy);

(2) whether the property in suit has been excluded from any coverage. *E.g., State Farm Fire & Cas. Co. v. Wade*, 827 S.W.2d 448, 452-53 (Tex. App.–Corpus Christi 1992, writ denied) (admitting extrinsic evidence to show that an exclusion for a boat carrying passengers in a boat-owners policy applied to an accident resulting in the drowning of the underlying plaintiff); *Cook v. Ohio Cas. Ins. Co*., 418 S.W.2d 712, 715-16 (Tex.Civ.App.-Texarkana 1967, no pet.) (holding extrinsic evidence allowed to show automobile involved in accident was excluded from coverage); *John Deere Insurance Co. v. Truckin' U.S.A.*, 122 F.3d 270, 272-73 (5th Cir.1997) (considering extrinsic evidence to show whether the vehicle involved in an accident was a "covered auto" under an auto policy);

(3) whether the policy exists (no cases located); and

(4) a fourth category, not mentioned in *Westport*, might entail the question of whether a policy condition, such as the policy period condition, applies. *See Harken Exploration Co. v. Sphere Drake Ins. PLC*, 261 F.3d 466, 476 (5th Cir. 2001) (considering extrinsic evidence relating to application of the policy period condition, but holding the evidence indicated the condition did not apply to preclude coverage).

16. In fact, the Fifth Circuit panel that decided *Northfield* would narrow this condition further to preclude extrinsic evidence relating to applicability of any exclusion even if it does not relate to underlying liability. 363 F.3d at 535.

17. The phrase "readily determined fact" comes from *King v. Dallas Fire*, 85 S.W.3d 187, 189 (Tex. 2002), in which the court held that whether an assault was an occurrence within a CGL policy was to be viewed from perspective of the insured employer. The *King* court distinguished *Fidelity & Guaranty Insurance Underwriters, Inc. v. McManus*, 633 S.W.2d 787 (Tex.1982), which had held that an exclusion for injuries caused by the "ownership, maintenance, operation, use, loading or unloading of a recreational motor vehicle away from the residence" barred the insurer's duty to defend a negligent entrustment claim, on the ground that, in *McManus*, it was not necessary to consider the insured's relationship to the event, because the exclusion was premised on a "readily determined" fact. *King*, 85 S.W.3d at 189.

18. *E.g, State Farm Fire and Cas. Co. v. Gandy*, 925 S.W.2d 696, 705 (Tex. 1996) (avoidance of "fraud on the court" by requiring actual trial).

19. *See, e.g., Farmers Tex. County Mut. Ins. Co. v. Griffin*, 955 S.W2d 81, 82 (Tex. 1997) (a court must focus on the factual allegations rather than the legal theories asserted in reviewing the underlying petition).

20. *See, e.g., Montrose Chem. Corp. v. Superior Court*, 861 P.2d 1153, 1159-60 (Cal. 1993) (noting that the "critical distinction" between admissible and inadmissible extrinsic evidence is whether it "presents undisputed facts which conclusively eliminate the potential for liability"); *Wausau Underwriters Ins. Co. v. Unigard Sec. Ins. Co.*, 80 Cal. Rptr. 2d 688, 689 (Cal. Ct. App. 1998) (declining to consider extrinsic documentary evidence because it did not rise to the level of "undisputed facts" necessary to satisfy the *Montrose Chemical* standard).

21. *See, e.g., Westport*, 267 F.Supp.2d at 621; *Fielder Road*, 2004 WL 1119494, slip op. at *2; *Tri-Coastal Contractors, Inc*., 981 S.W.2d at 863 n.1.

BY RANDALL L. SMITH AND FRED A. SIMPSON

Excess Other Insurance Clauses and Contractual Indemnity Agreements: Shifting an Entire Loss to a Particular Insurer

In today's commercial world, it is not unusual for companies doing business together to be insured under separate liability policies that cover the same types of business risks. This condition gives rise to disputes over which insurers are contractually bound by indemnity agreements between or among parties having insurance coverages for the same types of losses. The condition compounds when business enterprises have hierarchies of coverage consisting of "primary coverage" and "excess" levels of coverage above that primary coverage.[3]

This article shows how indemnity agreements (such as the model below) between or among insured businesses may place total liability for damages on the insurer for only one of the parties. In the process, this article reviews cases where courts consider whether to ignore legitimate indemnity agreements or whether to allocate losses on some reasonable basis.

EXAMPLE INDEMNITY AGREEMENT

An example of the type of indemnity agreement we examine is as follows:

> [ABC Company] shall protect, defend, hold harmless and indemnify [XYZ Company] from and against any and all claims [and] actions… arising out of any actual or alleged death or of injury to any person… or other damages or losses, by whomsoever suffered, resulting or claimed to result in whole or in part from any actual or alleged defect in [ABC Company's] merchandise …
>
> [ABC Company] agrees to save [XYZ Company] … harmless and indemnified from all claims, liability, losses, damages and expenses, including reasonable attorneys' fees, sustained from the purchase, use or sale of any goods or from breaches of any guaranties or warranties hereunder… and such obligations shall survive acceptance of goods and payments therefore by [XYZ Company].[4]

According to this form of indemnity agreement, ABC promises to indemnify and hold XYZ harmless from all liability or loss that may arise from XYZ's sale of ABC's merchandise. However, ABC Company may have products liability insurance under which both ABC and XYZ also have coverage (XYZ by way of a "vendor's endorsement" or otherwise), and XYZ may also have its own independent insurance coverage for XYZ's liability that may arise from selling ABC's products.

THE OPERATION OF "OTHER INSURANCE" CLAUSES

We describe situations that suggest the potential for a duplication of coverage. However, insurers have methods to deal with unintended coverage duplications and the potential for unjust enrichment. Insurers typically write "other insurance" clauses into their policies, attempting to control the manner in which each insurer contributes to or shares in covered losses. "Other insurance" clauses are usually written into liability insurance policies in the form of "excess other insurance" clauses[5] designed to make all other primary insurance policies covering the same risk "excess" to the policies in which the clauses appear. However, it is possible for two or more primary policies to contain the same type of "other insurance" clauses, each policy thereby purporting to be excess to all others. In those instances, courts tend to "cancel out" those conflicting clauses and prorate losses among the insurers on grounds that the insureds would otherwise be unfairly deprived of all the insurance protection they paid for.[6]

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SUBROGATION & CONTRIBUTION

This article contemplates two types of insurance claims among insurers. One such claim arises from principles of subrogation, the other from principles of contribution.

Although the doctrines of contribution and subrogation are both equitable remedies, they are each nevertheless distinct.[7] Subrogation is the substitution of one person in place of another person so that he/she who is substituted succeeds to the rights of the other in relation to a debt or claim.[8] The "subrogee," or substituted person, is said to become equitably subrogated to the claimant (or "subrogor"), succeeding to the subrogor's rights against a true "obligor," or person primarily liable.[9] The doctrine of equitable subrogation is broad enough to include every instance in which one person, not acting as a mere volunteer or intruder, honors a duty to pay the debt for which another obligor is primarily liable, and which in equity and good conscience should have been discharged by that obligor.[10] In the law of insurance, subrogation allows insurers to assume their insureds' positions in order to pursue recovery from other third parties who are legally responsible for the losses the insurers paid.

The right of subrogation is purely derivative. Subrogation allows insurers to acquire nothing to which their insureds have no rights. Insurers entitled to subrogation are therefore in the same position and succeed only to the rights of their insureds.[11] The subrogated insurers are said to "step into the shoes" of their insureds, with no greater rights than their insureds and subject to the same defenses that primary obligors may assert against their insureds.

Equitable contribution presents a different principle: the right to recover, not from the party primarily liable for the loss, but from someone who has joint responsibility for the same liability as the party who seeks contribution.[12] In an insurance context, contribution rights arise when several insurers independently (and unknowingly) agree to indemnify (or to defend) the same loss or claim, and one insurer pays more than that insurer's share of the loss (or one insurer defends an underlying lawsuit but other obligated insurers fail in their burden).[13] Where multiple insurers insure the same insureds and cover the same risks, each insurer has independent standing to assert a cause of action against its coinsurers for equitable contribution when the complaining insurer undertakes indemnification (or the defense) of the common insured.[14] Equitable contribution permits the insurer who paid the loss to seek reimbursement for the excess that insurer paid over that insurer's proper proportionate share. This is accomplished on a theory that the debt the paying insurer paid was equally and concurrently owed by the other insurers and those others should share in an amount that is equal to each insurer's proportion share of coverage of the risk.[15] The purpose of equitable contribution is to accomplish substantial justice from the equalization of the common burden shared by coinsurers, and to prevent one insurer from profiting at the expense of others.

THE DILEMMA

Assume the following hypothetical facts. Capital manages Tower apartments, owned by Johnson. The Capital-Johnson agreement contains an indemnity clause whereby Johnson, the owner, agrees to indemnify Capital, the manager. Henry, a Tower tenant, is seriously injured on the Tower premises when the roof collapses. Henry sues the property manager, Capital, for negligence.

Capital is insured under a commercial general liability ("CGL") policy issued by American Insurance Company. Capital is also automatically insured under a CGL policy written for Johnson by Great Insurance Company by virtue of a policy provision covering "property managers." Both CGL policies have identical "other insurance" clauses.[16] Capital tenders the defense to both insurers. Great Insurance agrees to defend Capital but American Insurance denies coverage. Great Insurance sued American Insurance after settling Henry's claim for Great Insurance's $1 Million policy limit.

Great Insurance focuses on the "other insurance" clauses of both insurance policies, arguing that both policies insure the same risk at the same coverage level and that Great Insurance has an equitable contribution claim against American Insurance. On the other side, American Insurance, which issued the policy to Capital, focuses on the indemnity clause of the property management agreement, claiming rights to subrogation against Johnson that Great Insurance must pay. American Insurance argues that these subrogation rights cause the American Insurance to be excess to Great Insurance's policy and that Great Insurance therefore has no right to any contribution from American Insurance.

THE SOLUTION

The more reasoned cases show how courts value and honor the commercial bargaining that took place between the contracting parties. Indemnity agreements are an essential part of the total exchange of consideration. When determining if those bargained for rights to indemnification should control over terms of insurance contracts that call for a proration among insurers, one equitable principle that stands out: each insurance company in the picture accepted premiums with knowledge that an indemnity situation may give rise to a claim that must be paid. Under those circumstances, any apportion of losses pursuant to "other insurance" clauses in the policies would unfairly override and negate the indemnity agreements,

imposing liability on indemnitees' insurers, ignoring the fact that those indemnitees bargained in a way that would avoid such an outcome.[17]

For example, in *J. Walters Constr., Inc. v. Gilman Paper Co.*,[18] Walters agreed to do construction for Gilman. One of Walters' employees suffered serious injuries and sued Gilman for negligence. Gilman eventually settled and sued Walters, alleging that the Walters/Gilman contract compelled Walters to secure insurance coverage with Gilman listed as a named insured. Walters also agreed to hold Gilman harmless from any injuries arising out of the construction work. Walters purchased insurance coverage from CNA which fully covered the injured employee's claim, and Gilman had separate coverage from Liberty Mutual. Gilman claimed that CNA's policy was intended to cover all losses and that CNA should reimburse Gilman for the total settlement.

Walters and CNA argued that, although the CNA policy did cover all claims arising from the contracted work, and while the parties may have intended the CNA policy to cover the employee's claim, CNA was nevertheless responsible for only half of the settlement amount because Liberty Mutual's policy covered the same claim. The court resolved the issue by ruling that the "other insurance" provisions of the policies did not abrogate the indemnity agreement between Walters and Gilman.

In *Rossmoor Sanitation, Inc. v. Pylon, Inc.*,[19] Pylon contracted with Rossmoor to construct sewage facilities,[20] with Pylon agreeing to indemnify and hold Rossmoor harmless for all property damage or personal injury claims.[21] Two Pylon employees died from a trench cave-in. Rossmoor was held liable. Rossmoor and its insurer, INA, claimed indemnity from Pylon and its insurer, U.S. Fire. U.S. Fire counterclaimed against INA seeking apportionment or contribution under the "other insurance" clauses of the two policies. The trial court found that Pylon, the indemnitor, was negligent and Rossmoor, the indemnitee, was not actively negligent. Therefore, Pylon had to indemnify Rossmoor under the terms of the indemnity agreement. The California Supreme Court affirmed, reasoning that INA was subrogated to Rossmoor's right to indemnity from Pylon and U.S. Fire for payments in satisfaction of the tort judgment against Rossmoor. The Supreme Court viewed "one factor as compelling": "[T]o apportion the loss in this case pursuant to the other insurance clauses would effectively negate the indemnity agreement and impose liability on [the owner's insurer] when [the owner] bargained with [the contractor] to avoid that very result as part of the consideration for the construction agreement. We therefore conclude that the rights of indemnity and subrogation must control, and are persuaded the trial court was correct in finding that because the [contractor's insurance policy naming the owner as an additional insured] was part of the consideration for the construction job, [the contractor's policy] must be viewed as primary insurance under the facts of this case and that [the owner's direct insurer] was subrogated to the rights of [the owner]."[22]

Rossmoor was decided on the particular circumstances of the case and did not hold that an indemnitee's policy will always be excess.[23] The California Supreme Court said that the "one factor" it found "compelling" was that the parties specifically bargained for Pylon to bear the entire costs of its negligent conduct and for Rossmoor to be relieved of any liability where it was not actively negligent.[24]

The more reasoned cases show how courts value and honor the commercial bargaining that took place between the contracting parties.

In *Am. Indem. Lloyds v. Travelers Prop. & Cas. Co.*,[25] Elite Masonry became a subcontractor of Caddell Construction Company, with Elite providing masonry services in the construction of a prison. The subcontract contained an indemnity agreement under which Elite agreed to "indemnify [Caddell] against and hold [Caddell] harmless from any and all claims, demands, liabilities, losses, expenses, suits and actions (including attorneys fees) for or on account of any injury to any person… which may arise (or which may be alleged to have arisen) out of or in connection with the work covered by this Subcontract, even though such injury… may be (or may be alleged to be) attributable in part to negligence or other fault on the part of [Caddell] or its officers, agents or employees."[26] The subcontract also stated that, although Elite was obliged to indemnify and hold Caddell harmless, that obligation "shall not be enforceable if, and only if, it be determined by judicial proceedings that the injury… complained of was attributable solely to the fault or negligence of [Caddell], or its officers, agents or employees."[27] Elite also agreed to "defend all claims, suits and actions against [Caddell]… on account of any injury" and to "…reimburse [Caddell] for all expenses, including reasonable attorneys fees, incurred by reason of such claim, suit or action or incurred in seeking indemnity or other recovery from [Elite] hereunder."[28]

An injured Elite employee sued Elite and Caddell. Although Aetna insured Caddell under a CGL policy, American Indemnity, Elite's insurer, defended both Caddell and Elite, settling the lawsuit for $625,000.00.

American Indemnity then sued Travelers seeking a determination that American Indemnity was entitled to recover one half of the settlement it paid from Travelers. American Indemnity argued that the "other insurance" clauses of both policies compelled each insurer to pay an equal share of the settlement and defense costs. The court rejected this argument, concluding that valid indemnity agreements must be given priority over the "other insurance" policy clauses, and stating:

> To hold otherwise would render the indemnity agreement between Elite and Caddell completely ineffectual, 'for it is the parties' rights and liabilities to each other which determine the insurance coverage; the insurance coverage does not define the parties' rights and liabilities one to the other.'[29]

WHAT IF BOTH EXCESS AND PRIMARY COVERAGES ARE INVOLVED?

As a general rule, primary insurers have no right to contribution from excess insurers, and vice versa.[30] However, where different insurers cover different liabilities, either class of insurer may proceed against the other for reimbursement under principles of subrogation rather than principles of contribution.[31] For example, in *St. Paul Fire & Marine Ins. Co. v. Am. Int'l Specialty Lines Ins. Co.*,[32] VMS Lansdowne ("VMS") and Benchmark Management Co. ("Benchmark") entered a Management Agreement ("MA") for VMS's resort, with Benchmark becoming the resort's "operator."[33]

Under the MA, VMS indemnified Benchmark and its agents for damages arising from ordinary negligence, and Benchmark indemnified VMS for damages arising from grossly negligent conduct, fraud, or willful conduct.[34] VMS met its obligation to provide primary and excess comprehensive general liability insurance with coverage from CAN Casualty Co. and American International Specialty Lines Insurance Company ("AISLIC").[35] VMS was the named insured on those policies which extended coverage to Benchmark as VMS's "real estate manager." A "named insured endorsement" to CNA's policy showed a VMS subsidiary and the resort as additional insureds.[36]

Benchmark and its subsidiary purchased coverage from St. Paul and TIG, with St. Paul providing $1 Million of "primary" coverage,[37] and TIG's umbrella policy providing $10 Million. All insurance policies contained "other insurance" clauses.[38] Coverage may be depicted this way:

INSURERS			
CNA Primary $1 Million	**AISLIC** Excess $50 Million	**ST. PAUL** Primary $1 Million	**TIG** Excess $10 Million
INSUREDS			
VMS (property owner)		**BENCHMARK** (as manager)	
VMS's subsidiary		**BENCHMARK's subsidiary**	
Landsdowne Resort			

A resort patron sued both the property owner and manager claiming he suffered food poisoning. The lawsuit settled for $4 Million, of which St. Paul and CNA paid $3 Million, reserving their respective rights to resolve issues of coverage and allocation.[39] St. Paul then sued CNA, AISLIC, and TIG, claiming that St. Paul's policy covered none of the damages. The trial court dismissed AISLIC and ordered TIG to pay the remaining $1 Million.[40] The trial court found the St. Paul/TIG line of coverage existed only if the CNA/AISLIC coverage lapsed or was exhausted.[41] Because it was undisputed that Benchmark was covered under the CNA/AISLIC line by virtue of Benchmark's being VMS's real estate manager, the court concluded that the St. Paul and TIG policies did not cover Benchmark's settlement liability.[42]

The court concluded that because Benchmark's subsidiary was not listed by name in the CNA and AISLIC policies,[43] Benchmark's subsidiary was not covered under any provision in the CNA and AISLIC policies.[44] The court also concluded that St. Paul and TIG were the Benchmark subsidiary's primary and excess insurers, and thus were obligated to pay into the settlement.[45]

The court then allocated the settlement payments among the insurers: CNA and St. Paul's primary policies would be exhausted by payment of their limits, and AISLIC and TIG, "concurrent excess insurers," would equally divide the remaining $2 million between them. Because TIG did not contribute to the settlement, the court ordered TIG to pay.[46]

On appeal, AISLIC argued that the settlement should be divided three ways: between (1) VMS, (2) Benchmark, and (3) Benchmark's subsidiary, because the sole basis for liability asserted by the tort plaintiff against those three defendants was ownership of the resort.[47] However, the complaint actually claimed that Benchmarks' subsidiary and Benchmark were liable because (a) Benchmarks' subsidiary employed the persons who prepared the food and (b) Benchmark because its employees sold the food.[48] AISLIC argued that VMS, as the collective "owner," should only be assigned one share of the settlement liability,[49] Benchmark's subsidiary, the "employer," should pay one share, and Benchmark, as "operator," should pay one share.[50] AISLIC also argued that, because all four policies contained "other excess insurance" clauses, the court

could not consider the St. Paul/TIG line of coverage and the CNA/AISLIC line of coverage superior to the other lines because the clauses were "mutually [district] repugnant."[51] Thus, SISLIC argued that the court should equally divide Benchmark's liability between the two lines of insurance coverage. As for Benchmark's subsidiary, covered by all four insurance polices, the same allocation should be made for its settlement share.[52]

The district court failed to address St. Paul's argument that VMS had a duty to indemnify Benchmark's subsidiary, or that the CNA/AISLIC line insured that liability irrespective of whether the Benchmark subsidiary was a named insured under that line of coverage.[53] St. Paul also argued that if the settlement liabilities of the Benchmark entities must be indemnified by the VMS subsidiary, and if the CNA/AISLIC line must cover that indemnity obligation, then St. Paul and TIG would owe nothing on the settlement.

St. Paul asserted that CNA and AISLIC must pay first to satisfy the settlement because the MA requires VMS's subsidiary to indemnify Benchmark, as the operator, and Benchmark's subsidiary, as Benchmark's agent, for their share of the settlement.[54] St. Paul cited cases where the courts gave priority to indemnification agreements which bound insureds in assessing insurer obligations.[55] These cases held that indemnity agreements may shield an indemnitee's insurer from liability for a covered loss, even though the policies contain "other insurance" clauses. The court of appeals chose to follow the Eighth Circuit in *Wal-Mart Stores, Inc. v. RLI Ins. Co.* [56]

In *Wal-Mart*, the Eighth Circuit followed the growing trend of jurisdictions which allow valid, enforceable indemnification agreements to "determine the allocation of liability in an insurance dispute."[57] Wal-Mart entered a vendors agreement with Cheyenne, a company that distributed halogen lamps.[58] Wal-Mart sold those lamps in its stores. The sales agreement contained the following indemnity agreement:

> [Cheyenne] shall protect, defend, hold harmless and indemnify [Wal-Mart] from and against any and all claims [and] actions… arising out of any actual or alleged death or of injury to any person… or other damages or losses, by whomsoever suffered, resulting or claimed to result in whole or in part from any actual or alleged defect in [Cheyenne's] merchandise…
>
> [Cheyenne] agrees to save [Wal-Mart]… harmless and indemnified from all claims, liability, losses, damages and expenses, including reasonable attorneys' fees, sustained from the purchase, use or sale of any goods or from breaches of any guaranties or warranties hereunder… and such obligations shall survive acceptance of goods and payments therefore by [Wal-Mart].[59]

Tort plaintiffs sued Wal-Mart and Cheyenne for injuries from a malfunctioning lamp which caused a fire.[60] St. Paul insured Cheyenne and Wal-Mart under a primary policy with limits of $1 Million. RLI provided excess insurance coverage of $10 Million. Wal-Mart had its own $10 Million policy with National Union. National Union's policy did not cover Cheyenne. RLI's policy was also excess over National Union's policy. The insurance structure looked like this:

INSURERS		
NATIONAL UNION $10 Million	**ST. PAUL** Primary $1 Million	**RLI** Excess $10 Million
INSUREDS		
WAL-MART	**CHEYENNE**	
	WAL-MART	

The underlying lawsuit settled for $11 million.[61] St. Paul paid the first $1 Million, but the remaining $10 Million was disputed. RLI finally paid the $10 Million, reserving its right to seek recovery from Wal-Mart and National Union.[62] Subsequently, Wal-Mart and National Union filed this declaratory judgment action to find whether they must pay any part of the settlement. RLI counterclaimed, arguing that the Wal-Mart/Cheyenne agreement governed liability apportionment among Wal-Mart's and Cheyenne's insurers. RLI claimed excess insurer status over National Union, entitling RLI to contribution from National Union for all or part of the $10 Million RLI paid to settle.

Before the court of appeals allocated payment of the settlement among the insurers, the court gave priority to the indemnity agreement, holding that neither Wal-Mart nor National Union were obligated to pay any portion of the underlying settlement. "[E]xamination of the relationships between the parties has convinced us that Cheyenne intended to and did make a valid promise to indemnify Wal-Mart for claims arising from the halogen lamps."[63]

The *Wal-Mart* court determined that "RLI provided liability insurance to Cheyenne that covers both the [tort lawsuit] settlement and Cheyenne's indemnification obligation."[64] Given those circumstances, "consideration of the indemnity agreement reflects the intention of [and relationship between] the parties and does not unfairly prejudice the insurers."[65] The appellate court reasoned that it was proper to consider Cheyenne's indemnification obligation because "mak[ing] Wal-Mart or National Union liable to RLI… the anticipated result of considering the policies without consideration of the

indemnification agreement… would simply be the first step in a circular chain of litigation that ultimately would end with RLI still having to pay the $10 million."[66] As a result, Cheyenne's insurers paid the entire loss, consistent with the indemnity agreement between the parties.

In *Cont'l Cas. Co. v. Auto-Owners Ins. Co.*,[67] both Fitzsimmons Service Company and Hulcher Services, Inc. contracted with Burlington Northern to do salvage work after a train derailment.[68] Each contract had an indemnity agreement in Burlington's favor. Auto-Owners insured Fitzsimmons, and Continental Casualty Co. insured Hulcher, both under CGL policies.[69] Pursuant to their respective Burlington contracts, Fitzsimmons and Hulcher both purchased railroad protective policies naming Burlington as the insured: Fitzsimmons secured a railroad protective policy for Burlington from Interstate Fire Insurance Co., and Pacific Insurance Co. provided coverage for Hulcher. The coverage arrangement looked like this:[70]

INSURERS			
PACIFIC (Hulcher)	**INTERSTATE** (Fitzsimmons)	**AUTO-OWNERS**	**CONTINENTAL**
INSUREDS			
BURLINGTON		**FITZSIMMONS**	**HULCHER**

An injured Fitzsimmons employee sued Burlington and Hulcher.[71] After all four insurers funded a settlement, Continental filed a declaratory judgment to have the court decide which insurers must pay Burlington's portion of the settlement.[72] The district court ruled that Auto-Owners and Interstate were liable for one-third and two-thirds, respectively, of Burlington's part of the settlement. Auto-Owners appealed.[73] (There was no "other insurance" clause issue between Auto-owners and Interstate because their insureds were different companies.)

The court of appeals began its analysis by pointing out that Continental's policy (covering Hulcher) provided coverage for contractual indemnity claims. However, in Burlington's contract with Hulcher, Hulcher agreed to indemnify Burlington only for liability "caused, in whole or in part, by the negligence of [Hulcher]," whereas Hulcher was dismissed from liability by summary judgment in the underlying tort lawsuit.[74] The court ruled that Continental was liable for Burlington's settlement because Burlington had no right to indemnity from Hulcher.[75]

The court also decided that Pacific was not liable because Pacific promised to pay Burlington for "bodily injury" that arose "out of acts or omissions… which are related to or are in connection with the 'work' described in the Declarations."[76] The policy defined the term "work" as "work or operations performed by the 'contractor,'" and Hulcher was the contractor.[77] The relevant part of the policy therefore covered liabilities arising only from work that Hulcher performed. The court concluded that the evidence showed that the employee's injury did not arise out of Hulcher's work. Pacific therefore had no legal duty to contribute to the settlement, there being no coverage.[78]

Interstate's railroad protective policy covered losses associated with the employee's injury, because Interstate's policy covered "those sums that [Burlington] becomes legally obligated to pay because of 'bodily injury'" that arose from "operations performed by the contractor," Fitzsimmons.[79]

Auto-Owners's CGL policy was designed to pay "those sums that [Fitzsimmons] becomes legally obligated to pay as damages because of 'bodily injury,'" if that obligation arose under Fitzsimmons's contract to indemnify Burlington for sums that Burlington paid on account of injuries arising from Fitzsimmons's work.[80] Because the worker's injury did in fact arise from Fitzsimmons's work, and because Fitzsimmons promised to indemnify Burlington for such injuries, the Auto-Owners policy also covered the loss.

When the district court ruled that both the Interstate and Auto-Owners policies covered the settlement, the district court failed to properly consider the subrogation clause of Interstate's policy which provided that if Burlington "has rights to recover all or part of any payment we [Interstate] have made under this policy, those rights are transferred to us."[81]

Therefore, Interstate was subrogated with respect to Burlington's claim for indemnification under Burlington's contract with Fitzsimmons. Interstate thus being subrogated to Burlington's rights, could reach Fitzsimmons and Fitzsimmons's CGL carrier, Auto-Owners. Therefore Auto-Owners, under an insurance policy purchased by Fitzsimmons, was obliged to bear the entire loss.[82]

In *Chubb Ins. Co. of Can. v. Mid-Continent Cas. Co.*,[83] Smith Brothers, Inc. contracted to perform workover operations on an oil well operated by Coho Resources, Inc.[84] The Smith Brothers' rig overturned during these operations, injuring one person and killing another. Coho was sued for damages totaling $5.5 Million.[85] Chubb insured Coho under a CGL policy with a $1 million limit of liability, and Mid-Continent insured Smith Brothers with primary coverage under a CGL policy with a $1 million limit.[86]

Chubb assumed Coho's defense and asked Smith Brothers to defend and indemnify Coho pursuant to Smith Brothers' indemnity obligation in the contract between Coho and Smith Brothers.[87] Mid-Continent agreeing that Smith Brothers' indemnity obligation was covered under Mid-Continent's policy, defended Coho. But Mid Continent claimed that Chubb

shared the indemnity obligation equally by virtue of an "other insurance" clause in each policy.[88] Chubb filed this declaratory judgment action seeking adjudication that Mid-Continent's policy was primary.

Chubb recognized that Smith Brothers specifically contracted to defend and indemnify Coho for the kinds of claims asserted against Coho by the injured parties. Therefore, argued Chubb, Mid-Continent, as Smith Brothers' insurrer, must defend and indemnify Coho. The court agreed, because to hold otherwise would render the indemnity agreement between Smith Brothers and Coho completely ineffectual. Under the circumstances, Smith Brothers' and Coho's rights and liabilities to each other are the factors that determined coverage. The agreement between Coho and Smith Brothers is what defined their respective rights and liabilities one to the other, not the provisions of the insurance policies.[89]

In *Reliance Nat'l Indem. Co. v. Gen. Star Indem. Co.*,[90] Reliance sued General Star for indemnity and contribution, seeking recovery of the full amount Reliance paid to defend and settle an underlying personal injury lawsuit involving two insureds, Don Law Company, Inc. contracted with Lollapalooza Joint Venture to sponsor a music festival for which Don Law agreed to indemnify and hold Lollapalooza harmless from any personal injury loss, damage or expense in connection with the festival.[91] Don Law was required to purchase insurance naming Lollapalooza as an additional insured.[92] Gulf insured Don Law under a primary policy with a limit of liability of $1 Million. General Star provided Don Law excess coverage, and Lollapalooza a was named an additional insured under that excess policy, as agreed. A third insurer, Reliance, directly insured Lollapalooza with primary insurance of $1 Million, and additional layer of excess coverage.

INSURERS		
GULF Primary $1 Million	**GENERAL STAR** Excess $10 Million	**RELIANCE** Primary - $1 Million + Excess Coverage
INSUREDS		
DON LAW – Named Insured		**LOLLAPALOOZA**
LOLLAPALOOZA Additional Insured		

An injured festival audience member sued both Don Law and Lollapalooza. All insurers contributed to the lawsuit's settlement ($2,142,858), with Reliance defending and contributing $1 Million.[93] Reliance also paid $71,429 under its excess policy. Gulf provided a defense and tendered its policy limit.[94] General Star contributed $71,429 under its excess policy.[95] Reliance and General Star filed cross actions for declaratory relief regarding their respective defense and indemnification duties in the underlying lawsuit.[96]

The trial court dismissed General Star by summary judgment, ruling that the insurer's duty to indemnify the plaintiff in the underlying action did not arise until after the Gulf and Reliance primary policies were exhausted.[97] The court of appeals affirmed, concluding that another case, *Rossmoor Sanitation, Inc. v. Pylon, Inc.*,[98] did not apply because *Reliance Nat'l* involved a coverage dispute between primary and excess insurance carriers.[99] The *Reliance Nat'l* court of appeals first looked to the insurance policies and, applying standard rules of contract interpretation, concluded that Reliance's coverage for Lollapalooza was primary and that General Star's coverage was excess. The court of appeals observed that General Star's policy also specifically provided that "Nothing here shall be construed to make this Policy subject to the terms, conditions, and limitations of other insurance, reinsurance or indemnity."[100]

The California Court of Appeals rejected Reliance arguments that the Don Law/Lollapalooza indemnity agreement controlled, relying on settled California law that excess policies do not cover losses until all primary insurance is exhausted and that an "other insurance" clause dispute cannot arise between excess and primary insurers because they are not "on the same level."[101] The court reviewed the concepts of subrogation and contribution, pointing out that as a general rule, no right to equitable contribution exists between primary and excess insurers.[102]

The court of appeals considered *Rossmoor*, an action between insureds on an indemnity contract in which the owner of the premises sought apportionment of a loss between two primary carriers.[103] The court observed that in equitable contribution cases, courts generally enforce primary and excess provisions in insurance contracts so long as the rights of policyholders are not adversely affected,[104] emphasizing several points. First, the general rule in equitable contribution cases is that there is no right of contribution between primary and excess insurers without specific enabling agreements; and there was no right of contribution established, as Reliance and General Star did not share the same level of coverage, which the court considered "a materially distinguishing characteristic" between *Reliance Nat'l* and *Rossmoor.*[105] Second, "*Rossmoor* did not purport to establish a general rule that a contractual indemnification agreement between an insured and a third party takes precedence over well-established general rules of primary and excess coverage in an action between insurers," particularly where the policy expressly stated it was not "subject the to terms, conditions, or limitations of other insurance, reinsurance or indemnity."[106] Third, the appellate court recognized a division of authority on whether insurers are entitled to subrogation against parties who, by separate contract, agree to assume responsibility for the same losses but did not cause those losses. The court observed that the test for subrogation "'involves a consideration of, and must necessarily

depend upon the respective equities of the parties.'"[107]

The court concluded that, based on the undisputed facts and the equities, Reliance could not recover. Circumstances weighing against Reliance's recovery included: (1) the parties to the indemnity agreement were not present in this action between primary and excess insurers; (2) the risks involved in primary coverage are different from those of excess coverage, and these differences are reflected in the premium charges by the respective insurers. Finally, the court observed if the court accepted Reliance's arguments, the basic rules for construing primary and excess policies would be inappropriately altered. The court's ruling was consistent with the fact that primary insurers charge higher premiums for insuring greater risks. Primary insurers would then be allowed to shift losses to excess insurers which charge lower premiums. This is not a case between two primary insurers that each received premiums for bearing losses which ultimately occurred. *Reliance Nat'l*, an action between excess and primary insurers, resulted in Reliance paying the loss at issue, being consistent with what was bargained for, "particularly given the absence of any evidence that [Reliance] calculated its premium with an understanding that an indemnity agreement would exist between its insured and Don Law."[108] Under the circumstances, *Rossmoor*, a dispute between two primary insurers and their insured, was not controlling in this case.[109]

CONCLUSION

In the final analysis, courts recognize the rights and obligations of parties to commercial contracts, irrespective of what insurance companies may write into their policies to benefit the insurers' interests and avoid unjust enrichment. Insurance companies are free to set their premiums for the risks they agree to assume. In that process, insurers have adequate opportunities to assess the probable scope of those risks well in advance, before they set their premiums. As a result, insured parties are free to commercially bargain for indemnity protection, and may do so without fear that adverse results of their contract subject matter will lead to increased premiums from hostile claims experience caused by losses from which the insureds adequately protected themselves by passing the risk of loss along to the others.

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2. Fred A. Simpson is a partner in the firm of Jackson Walker L.L.P., Litigation Section, Houston, Texas, specializing in appellate law and insurance matters, mediation and arbitration.

3. However, bona fide disputes arise only where two or more policies insure the same risk at the same level, typically between and among primary insurers, not between primary insurers and excess insurers. *See Reliance Nat'l Indem. Co. v. Gen. Star Indem. Co.*, 72 Cal. App. 4th 1063, 1075, 85 Cal. Rptr.2d 627, 635-36 (1999).

4. For the purposes of this article we ask readers to assume that this form of indemnity agreement satisfies requisite tests under state law to establish the validity of contractual indemnity agreements.

5. The following is an example of an excess other insurance clause:

> This insurance is excess over any of the other insurance, whether primary, or excess or contingent on any other basis.

COMMERCIAL GENERAL LIABILITY POLICY HANDBOOK 51 (3d Ed. 1993 Independent Insurance Agents of Texas).

6. *Travelers Cas. & Sur. Co. v. Am. Equity Ins. Co.*, 93 Cal.App.4th 1142, 1149-50, 113 Cal.Rptr.2d 613, 618 (2001).

7. *Eslon Thermoplastics v. Dynamic Sys., Inc.*, 49 S.W.3d 891 (Tex. App. — Austin 2001, no pet.).

8. *Argonaut Ins. Co. v. Allstate Ins. Co.*, 869 S.W.2d 537, 541 (Tex. App. — Corpus Christi 1993, writ denied). *See Reliance Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 102 Fed. Appx. 539 (9th Cir. 2004).

9. *Argonaut Ins.*, 869 S.W.2d at 541-42.

10. *Argonaut Ins.*, 869 S.W.2d at 541-42; In re Ted True, Inc., 94 B.R. 423, 4 (Bkrtcy. S.D. Tex. 1988).

11. *Monk v. Dallas Brake & Clutch Serv. Co., Inc.*, 697 S.W.2d 780 (Tex. App. — Dallas 1985, writ ref'd n.r.e.).

12. *See Fireman's Fund Ins. Co. v. Md. Cas. Co.*, 65 Cal.App.4th 1279, 1294, 77 Cal.Rptr.2d 296, 304 (1998) (explaining differences between contribution and subrogation).

13. *Employers Cas. Co. v. Transport Ins. Co.*, 444 S.W.2d 606, 608 (Tex. 1969).

14. *Employers Cas.*, 444 S.W.2d at 609-10.

15. *United States Fire Ins. Co. v. Stricklin*, 556 S.W.2d 575, 578 (Tex. Civ. App. — Dallas 1977), *writ ref'd n.r.e.*, 565 S.W.2d 43 (Tex. 1978).

16. As we note in this article, the presence or absence of other insurance clauses is not really important to the assertion of subrogation claims. *See Cont'l Cas. Co. v. Auto-Owners Ins. Co.*, 238 F.3d 941 (8th Cir. 2000).

17. *See, e.g., Rossmoor Sanitation, Inc. v. Pylon, Inc.*, 13 Cal.3d 622, 532 P.2d 97, 119 Cal.Rptr. 449 (1975).

18. 620 So.2d 219 (Fla. App. 1993).

19. 13 Cal.3d 622, 532 P.2d 97, 119 Cal. Rptr. 449 (1975).

20. *Rossmoor*, 13 Cal.3d at 625, 532 P.2d at 98, 119 Cal. Rptr. at 450.

21. *Rossmoor*, 13 Cal.3d at 626, 532 P.2d at 98, 119 Cal. Rptr. at 450.

22. *Rossmoor*, 13 Cal.3d at 634-35, 532 P.2d at 104-05, 119 Cal.Rptr. 456-57.

23. *Rossmoor*, 13 Cal.3d at 634, 532 P.2d at 104-05, 119 Cal.Rptr. at 456.

24. *Rossmoor*, 13 Cal.3d at 634, 532 P.2d at 104, 119 Cal.Rptr. at 456.

25. 189 F. Supp.2d 630 (S.D. Tex. 2002).

26. *Am. Indem.*, 189 F. Supp.2d at 632.

27. *Am. Indem.*, 189 F. Supp.2d at 632-33.

28. *Am. Indem.*, 189 F. Supp.2d at 633.

29. *Am. Indem.*, 189 F. Supp.2d at 634.

30. *See Employers Cas. Co. v. Transport Ins. Co.*, 444 S.W.2d 606, 609 (Tex. 1969).

31. *Employers Cas. Co. v. Transport Ins. Co.*, 444 S.W.2d 606, 610 (Tex. 1969).

32. 365 F.3d 263 (4th Cir. 2004).

33. *Am. Int'l*, 365 F.3d at 266.

34. *Am. Int'l*, 365 F.3d at 273.

35. *Am. Int'l*, 365 F.3d at 266.

36. *Am. Int'l*, 365 F.3d at 266.

37. *Am. Int'l*, 365 F.3d at 266.

38. *Am. Int'l*, 365 F.3d at 266-67.

39. *Am. Int'l*, 365 F.3d at 265-66.

40. *Am. Int'l*, 365 F.3d at 266.

41. *Am. Int'l*, 365 F.3d at 267.

42. *Am. Int'l*, 365 F.3d at 267.

43. *Am. Int'l*, 365 F.3d at 267.

44. *Am. Int'l*, 365 F.3d at 267.

45. *Am. Int'l*, 365 F.3d at 267.

46. *Am. Int'l*, 365 F.3d at 267.

47. *Am. Int'l*, 365 F.3d at 268.

48. *Am. Int'l*, 365 F.3d at 268-69.

49. *Am. Int'l*, 365 F.3d at 269.

50. *Am. Int'l*, 365 F.3d at 269.

51. *Am. Int'l*, 365 F.3d at 270.

52. *Am. Int'l*, 365 F.3d at 270.

53. *Am. Int'l*, 365 F.3d at 270.

54. *Am. Int'l*, 365 F.3d at 270.

55. *Am. Int'l*, 365 F.3d at 270.

56. 292 F.3d 583 (8th Cir. 2002).

57. *Wal-Mart*, 292 F.3d at 588.

58. *Wal-Mart*, 292 F.3d at 585.

59. *Wal-Mart*, 292 F.3d at 587-88.

60. *Wal-Mart*, 292 F.3d at 585.

61. *Wal-Mart*, 292 F.3d at 585.

62. *Wal-Mart*, 292 F.3d at 586.

63. *Wal-Mart*, 292 F.3d at 587.

64. *Wal-Mart*, 292 F.3d at 587.

65. *Wal-Mart*, 292 F.3d at 588.

66. *Wal-Mart*, 292 F.3d at 588.

67. 238 F.3d 941 (8th Cir. 2000).

68. *Cont'l Cas.*, 238 F.3d at 943.

69. *Cont'l Cas.*, 238 F.3d at 943.

70. The reported case does not show limits of coverage by any insurer.

71. *Cont'l Cas.*, 238 F.3d at 943.

72. *Cont'l Cas.*, 238 F.3d at 944.

73. *Cont'l Cas.*, 238 F.3d at 944.

74. *Cont'l Cas.*, 238 F.3d at 944.

75. *Cont'l Cas.*, 238 F.3d at 944.

76. *Cont'l Cas.*, 238 F.3d at 944.

77. *Cont'l Cas.*, 238 F.3d at 944.

78. *Cont'l Cas.*, 238 F.3d at 944.

79. *Cont'l Cas.*, 238 F.3d at 944.

80. *Cont'l Cas.*, 238 F.3d at 944.

81. *Cont'l Cas.*, 238 F.3d at 945.

82. *Cont'l Cas.*, 238 F.3d at 945.

83. 982 F. Supp. 435 (S.D. Miss. 1997).

84. *Mid-Continent*, 982 F. Supp. at 436.

85. *Mid-Continent*, 982 F. Supp. at 436.

86. *Mid-Continent*, 982 F. Supp. at 436.

87. *Mid-Continent*, 982 F. Supp. at 436.

88. *Mid-Continent*, 982 F. Supp. at 437

89. *Mid-Continent*, 982 F. Supp. at 437-38.

90. 72 Cal. App. 4th 1063, 85 Cal. Rptr. 2d 627 (1998).

91. *Reliance Nat'l*, 72 Cal. App. 4th at 1063-69, 85 Cal. Rptr. 2d at 628-30.

92. 72 Cal. App. 4th 1063, 85 Cal. Rptr. 2d 627 (1998).

93. *Reliance Nat'l*, 72 Cal. App.4th at 1071, 85 Cal. Rptr.2d at 630.

94. *Reliance Nat'l*, 72 Cal. App.4th at 1071, 85 Cal. Rptr.2d at 630.

95. *Reliance Nat'l*, 72 Cal. App.4th at 1071, 85 Cal. Rptr.2d at 630.

96. *Reliance Nat'l*, 72 Cal. App. 4th at 1071, 85 Cal. Rptr. 2d at 630.

97. *Reliance Nat'l*, 72 Cal.App.4th at 1072, 85 Cal.Rptr.2d at 631.

98. 13 Cal..3d 622, 532 P.2d 97, 199 Cal.Rptr. 449 (1975).

99. *Reliance Nat'l*, 72 Cal. App.4th at 1068, 85 Cal. Rptr.2d at 628.

100. *Reliance Nat'l*, 72 Cal.App.4th at 1075, 85 Cal. Rptr.2d at 633.

101. *Reliance Nat'l*, 72 Cal.App.4th at 1077, 85 Cal.Rptr.2d at 634-35.

102. *Reliance Nat'l*, 72 Cal.App.4th at 1077-78, 85 Cal.Rptr.2d 635.

103. *Reliance Nat'l*, 72 Cal.App.4th at 1079-80, 85 Cal.Rptr.2d at 636.

104. *Reliance Nat'l*, 72 Cal.App.4th at 1080, 85 Cal.Rptr.2d at 636-37.

105. *Reliance Nat'l*, 72 Cal.App. 4th at 1081, 85 Cal.Rptr.2d at 637.

106. *Reliance Nat'l*, 72 Cal.App.4th at 1081, 85 Cal.Rptr.2d at 637.

107. *Reliance Nat'l*, 72 Cal.App.4th at 1081, 85 Cal.Rptr.2d at 638.

108. *Reliance Nat'l*, 72 Cal.App.4th at 1083, 85 Cal.Rptr.2d at 639.

109. *Reliance Nat'l*, 72 Cal.App.4th at 1083, 85 Cal.Rptr.2d at 639.

BY JOHN TOLLEFSON

DALLAS, TEXAS

Musical Chairs: The Case In Texas for the Proposition That Only the Liability Policy In Effect When Property Damage First Manifests Must Respond To Continuous Loss Claims

When, due to negligence, a structure suffers property damage over an extended period of time, the majority[2] of courts in Texas hold that the liability insurer on the risk at the time the loss becomes "manifest", or reasonably apparent must pay, absent some other limitation on coverage. It is said that this policy is "triggered".[3] Often, because the policy is insufficient to respond, or because one carrier would like to seek contribution from earlier or later insurers of the tortfeasor, efforts are made to persuade the court that multiple policies are triggered.

The recent spate of EIFS, mold and foundation failure cases in Texas are prime examples. In order to involve more than one policy, and thereby fatten the bankroll available for settlement or judgment, some have used the argument that each aspect of negligence results in a separate damage to the claimant, at a separate, later time, and therefore involves a separate, later policy. For example, a poor foundation poured in 1998 may result in broken plumbing in 2000, cracked walls in 2002, and mold in 2003. If the contractor has policies with different insurers in each of those periods, which must respond?[4]

Using a dog's breakfast of similar sounding but conceptually discrete coverage principles, some courts have been led to believe that each different damage of the same general bad work constitutes a different occurrence and therefore may trigger a different policy. See, e.g., *Encore Homes, Inc. v. Assurance Co. of America* 2000 WL 798192, *3 (N.D.Tex.,2000)[5]. The historic source of much confusion in the area is *Cullen/Frost Bank of Dallas, N.A. v. Commonwealth Lloyd's Ins. Co.*, 852 S.W.2d 252, (Tex.App. – Dallas, 1993, writ denied). Understanding everything that is wrong with it will teach the practitioner and student much about the rudiments of Texas law governing the discrete, mystic and mythic terms, "occurrence", "property damage" and "trigger" and, hopefully, avoid the unwarranted risk-spreading that it is being touted to support.

In *Cullen/Frost*, the facts were as follows: In October, 1982, a bank foreclosed on nine units of a ten unit condominium project. The bank began selling individual units in May, 1983. On September 23, 1987, various condominium owners who had purchased the units from the bank in 1984 and 1985 filed a lawsuit against the bank. In the second amended petition filed in that matter, the plaintiffs alleged violations of the Deceptive Trade Practices Act, breach of warranty, recession, and negligence in disbursing funds. The basis for the suit was that some of the condominiums were defectively constructed, and had to be repaired. The plaintiffs, sought to recover the costs of repairing the defects, or, alternatively, the difference in market value between the condominiums as represented and as delivered.

The bank demanded defense and indemnity from Commonwealth Lloyds, its liability carrier, from February 15, 1983 – November 6, 1987 and from U.S. Fire, its liability carrier from November 6, 1987 through November 6, 1989. The carriers declined, asserting that the claims did not involve "property damage," were not caused by an "occurrence," but if so, there was only one occurrence, in 1986. They also asserted that the loss arose out of property that had been alienated by

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the bank, and therefore excluded, and asserted the completed operations exclusions in the policy.

The trial court granted summary judgment for the insurers. The appellate court reversed. It held that the "property damage" requirement was met by the fact that the plaintiffs had alleged, among other things, drainage problems in the garage floor, excessive floor displacement, warped and swollen door and window frames, etc. The petition also alleged repeated break down of the elevators and asserted that the bank's failure to correct the complained of conditions resulted in their loss of use of the property. Thus, the court held that the claim was not simply for economic loss.[6]

The court then turned to the issue of whether or not there was one or multiple occurrences.[7] The bank asserted that the plaintiffs had alleged continuous or multiple occurrences that fell within the coverage periods of all five policies, in an attempt to "stack" the policies. The insurers argued that there was only one occurrence, in the spring of 1986, when, after an inspection of the property, the Thompkins plaintiffs discovered property damage.

This is fundamentally wrong, for several reasons. The court equated the term "occurrence" with "property damage," confounding "trigger" and "number of occurrence" analyses. In its effort to extend coverage over sequential policies, the court then held:

> In dealing with the definition of occurrence in the instant case, both sides cite *Dorchester*… This court held that coverage is not afforded unless an identifiable damage or injury, other than merely causative negligence, takes place during the policy period. … The time of the occurrence is when the complaining party actually was damaged, not the time that the wrongful act was committed. *Dorchester Development Corp.*, 737 S.W.2d at 383. **In cases involving continuous or repeated exposure to a condition, there can be more than one manifestation of damage and, hence, an occurrence under more than one policy. Under the definitions of occurrence at issue here, <u>there can be a new occurrence each time the complaining party suffers damage.</u> *See Dorchester Dev. Corp.*, 737 S.W.2d at 383. We reject the argument that there can be only one occurrence when the facts allege continuous or repeated exposure causing continued or multiple property damages over an extended period of time.**

Although the first part of the proposition is a correct statement of trigger law, it has nothing to do with determining the number of occurrences. And the second part of the statement (above – see particularly the underlined part) is just flat wrong under Texas' well-settled method of determining the number of occurrences. Essentially, what the court has done is determine the number of occurrences by the number of injuries resulting from the single bad act (faulty construction and marketing). This is, simply, calculating "occurrences" by counting the number of injurious effects (or, more precisely, the number of manifestations of injurious effects), instead of by looking to the number of causative bad acts.

However, it is not the case that each time a party suffers or notices damage from a single occurrence that a new occurrence occurs. In Texas, the number of occurrences is determined by examining the **cause** of the losses sustained, not the **effect** of the losses. To say that the manifestation of new damage gives rise to a new occurrence flies in the face of the policy and established Texas case law. In its most recent expression of the law, the Fifth Circuit put it this way, in *Ran-Nan Inc. v. General Acc. Ins. Co. of America*, 252 F.3d 738, *740 (C.A.5 (Tex.),2001)(Emphasis added):

> Texas law does not support the definition of "occurrence" proffered by General Accident because "the proper focus in interpreting 'occurrence' is on the events that cause the injuries and give rise to the insured's liability, **rather than on the number of injurious effects**." *H.E. Butt Grocery Co. v. National Union Fire Insurance Co.*, 150 F.3d 526, 530 (5th Cir.1998) (applying Texas law). The few Texas cases that have addressed this issue apply a "cause" analysis in determining whether a set of facts involves one or several occurrences. *See Goose Creek Consol. ISD v. Continental Cas. Co.*, 658 S.W.2d 338, 339 (Tex.App. – Houston, 1983 [1st. Dist.], no writ) (holding that "where there are two fires at two different places with two separate causal factors, there are two loss occurrences."). This "cause" approach to analyzing the number of "occurrences" is utilized by the great majority of courts and jurisdictions nationwide. *See Transport Insurance Co. v. Lee Way Motor Freight, Inc.*, 487 F. Supp. 1325, 1330 (N.D. Tex. 1980) (cataloging law of other jurisdictions). This court has also utilized the "cause" method when determining the number of "occurrences" under a general liability insurance policy and Texas law. *Maurice Pincoffs Co. v. St. Paul Fire and Marine Insurance Co.*, 447 F.2d 204, 206 (5th Cir.1971).

See also, *H.E. Butt Grocery Co. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 150 F.3d 526, *530 (C.A.5 (Tex.), 1998)("To the extent that Judge Benavides rejects a test that examines the "cause" of the injuries for determining the number of "occurrences," the case law rests squarely against him.")

The result in *Cullen/Frost* – that each time new property damage manifested itself then a new occurrence arose – is consistent with the wrong logic of *Cullen/Frost*, but totally incorrect under the law itself. Neither *Dorchester*, nor the ISO-issued liability policies at issue in Cullen/Frost, stand for the proposition that for coverage, an occurrence must happen within the policy period. Rather, as the policy in this case specifically states, "this insurance applies to… "property damage" only if… the… "property damage" occurs during the policy period." *See* Insuring Agreement, at 1.b.(2), p. 1 of 12, CG 00 01 1 93. In sum, "property damage" and "occurrence" are simply not interchangeable terms, as *Cullen/Frost* assumes.

Why The Court Erred

It is apparent that the court's error lies in its mixing up two different concepts, trigger and number of occurrences. *Dorchester*, a trigger case, does not relate to the issue of "number of occurrences" and therefore does not support the proposition for which it is cited. *Dorchester* stood simply for the proposition that where property damage does not manifest at the time of the occurrence, the bad act, but rather becomes apparent later, that the policy on the risk at the time of the manifestation of property damage is the policy that must respond. Trigger and number of occurrences are distinct concepts. "Number of occurrences" issues relate to limits and deductibles, not to the determination of which policy or policies are triggered. By the same token, manifestation analysis, a trigger analysis, does not govern the number of occurrences, which is the issue that *Cullen/Frost* had at hand.

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At least two published decisions have held that it is error to use the effect test (manifestation trigger) to determine the number of occurrences and it is error to use the cause test to determine the time of the property damage. *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56 (3d Cir.1982)(While the "cause" test is appropriate for determining whether there is a single occurrence or multiple occurrences, it is not applicable in determining when an occurrence takes place.) Similarly, in *Chemstar, Inc. v. Liberty Mut. Ins. Co.*, 797 F. Supp. 1541, *1547 (C.D.Cal.,1992):

Although most of the insurers agree with this conclusion, two of the excess insurers, American and Wausau, suggest that the California courts define "occurrence" as the property damage itself, rather than its underlying cause. They rely on California cases holding that " '[t]he time of the occurrence of an accident within the meaning of an indemnity policy is not the time the wrongful act was committed, but the time when the complaining party was actually damaged.' " *Home Ins. Co. v. Landmark Ins. Co.*, 205 Cal.App.3d 1388, 1392, 253 Cal.Rptr. 277 (4th Dist.1988); *Hallmark Ins. Co. v. Superior Court*, 201 Cal.App.3d 1014, 1018, 247 Cal.Rptr. 638 (2d Dist.1988). **In these cases, however, the courts were not defining "occurrence" for the purpose of applying per occurrence limits on liability. Rather, they were determining whether property damage "occurred" during the policy periods of one or more insurers, thus triggering liability. Hence, these cases addressed the issue of whether coverage under a particular policy was triggered, rather than how much coverage was available if the policy was in fact triggered. These are two distinct questions to which different rules apply.** *Compare Event as Occurring Within Period of Coverage of "Occurrence" and "Discovery" or "Claims Made" Liability Policies*, 37 A.L.R.4th 382 (1988), *with What Constitutes Single Accident*, 64 A.L.R.4th 668.

In addition, American and Wausau's theory is not supported by the terms of the policies. The policies cover property damage that occurs **during** the policy period, as long as it is caused by an occurrence, without regard to the date of the occurrence. *See, e.g.*, Liberty Policy (covering "damages because of injury to… tangible property during the policy period… caused by an occurrence"); National Policy (covering property damage that "occurs during the policy period" as long as it is "caused by an occurrence"); American Policy (covering "injury to or destruction of property during the policy period" if it is "unexpectedly cause[d]" by an occurrence). Thus, the policies distinguish "occurrence" from "property damage" and require only that the latter happen during the policy period.

Chemstar, Inc. v. Liberty Mut. Ins. Co., 797 F. Supp. 1541, *1547 (C.D.Cal.,1992), affirmed, *Chemstar, Inc. v. Liberty Mut. Ins. Co.*, 41 F.3d 429 (C.A.9 (Cal.),1994), disagreed with on other grounds, in *Montrose Chem. Corp. v. Admiral Ins. Co.*, 42 Cal.Rptr.2d 324, 913 P.2d 878, 10 Cal.4th 645 (1995).

Cullen Erroneously Applies Trigger Law Too

After dealing with the "number of occurrences" issue, the *Cullen Frost* court then turned to the issue of "trigger." The court noted:

> The petitions in the Tompkins suit alleged, among other things, drainage problems in the garage floor, excessive floor displacement, warped and swollen windows and doors, rotten woodwork, leaking in the roof, warped and uneven floors, and continual breakdown of the elevators. Property damage was discovered when an inspection in Spring 1986 revealed the complained-of defects. The petition in the Tompkins suit does not make it clear that all of the property damage, including loss of use of the property, had manifested itself by Spring 1986. **The petition asserts that Bank's failure to remedy the defects has caused repeated and continued exposure causing loss of use of the property.** We must resolve any doubt as to coverage in Bank's favor. *Cluett*, 829 S.W.2d at 829. **With this in mind, we conclude that the pleading in the Tompkins suit alleged that at least some property damage manifested itself after Spring 1986.** Thus, we conclude that the Tompkins suit involves more than one occurrence.
>
> *Cullen Frost*, at 258.

The failure to repair **may** have been a different occurrence (doubtful) but it was not an additional manifestation of damage, "triggering" later policies. If this were so, all policies would always be triggered until a tort defendant insured paid the judgment sought by the claimant and the repairs were made. In addition, later in the opinion the court held that trigger is determined by counting occurrences:

> ***Failure to Come Within Policy Periods***
>
> In the fourth point, Bank complains that the trial court erred in granting summary judgment on the basis that the allegations in the Tompkins suit fail to come within three of the policy periods. Insurers contend this case involves a single occurrence that took place in Spring 1986. Hence, they argue, there is no duty to defend under the three policies that were issued after Spring 1986. [FN4] **The dispositive issue under this point is whether the petition in the Tompkins suit alleges one occurrence or multiple occurrences.** We previously held that the Tompkins plaintiffs alleged continuous or repeated manifestation of property damage *beginning in Spring 1986*. The pleading in the Tompkins suit alleges continuing property damage. The Tompkins plaintiffs, therefore, claim property damage that may fall within coverage of the three policies issued after Spring 1986. The petition does not allege facts that clearly show that no property damage manifested itself during the coverage periods of the three policies issued after Spring 1986. The possibility of an occurrence within the coverage periods of the policies issued after Spring 1986 therefore gives rise to a duty to defend under these policies. We sustain the fourth point of error.

Id., at 259 (Emphasis in the bold added, italics in the original). However, as shown previously, under Texas law, the dispositive issue regarding whether a loss falls within a certain policy period is **not** whether the petition in the underlying suit alleges one occurrence or multiple occurrences, it is when the effect of the occurrence first manifests. The number of occurrences has little or nothing to do with it.

Cullen/Frost Court Erred in Distinguishing Other "Cause" Cases

The *Cullen/Frost* court distinguished single occurrence cases from other jurisdictions,[8] holding that the definition of occurrence in those policies was different from the definition at issue in *Cullen/Frost*, and that the facts in each were different. Because of the foregoing, this analysis is not particularly relevant, but is flawed in any case.

First, the court found that the policies involved in the cases cited specifically provided that "all damages arises out of exposure to substantially the same general conditions were considered as arising out of one occurrence." This is sometimes, but not often, called a "batch clause."[9] The court found that neither the Commonwealth Lloyds nor US Fire policies contained this language, and therefore it was free to hold that each new manifestation of damage was a new occurrence and not a manifestation of damage flowing from the original bad act. In other words, the absence of a batch clause permitted the finding of multiple occurrences based on multiple manifestations.

Again, the manifestation/occurence analysis is wrong. So, even if the absence of a batch clause did not prevent the potential for its use, the law of Texas does. Further, the absence of the "all such exposure" language that the *Cullen/Frost* court thought so important was recognized, but did not affect the result in a later case, *Foust v. Ranger Ins. Co*., 975 S.W.2d 329, 334 (Tex.App. – San Antonio, 1998, review denied). In that case, the court held a single occurrence arose out of the multiple application of defective herbicide.

Second, the *Cullen/Frost* court distinguished the multiple occurrence cases, based on the facts alleged therein (which the court found, impliedly, did not "arise from exposure to substantially the same general condition emanating from one source." *Cullen/Frost*, at 257. The text is set forth in the accompanying footnote.[10] The court pointed to no facts in the record that would support its view that there were separate events or causes that gave rise to the numerous defects in the condos, which in itself is a problem with the analysis but, more importantly, even if such separate "causes" did exist in that case, it is clear they do not often do so except in minds of those engaged in the course of expanding the meaning of the phrase by unwarranted microscopic inquiry. The sole cause of the damages in most cases is the failure of the insured to fulfill the tasks set forth in the contract.

Thus, *Cullen/Frost* is avoidable absent the the court particularizing each task executed in the course of the insured's endeavor as a separate "cause," of sequential damages. For example, it should have no application at all where the court looks at a construction defect loss and determines that the damages arose from a single causal event: bad workmanship, rather than the mold resulting from the leaky windows, the foundation cracks from the inadequate pilings, etc., or where the facts clearly permit such particularized inquiry.

The exposure theory holds coverage is triggered when the claimant or his property is first exposed to the injury causing agent…

The Subsequent History Of *Cullen/Frost*

Tellingly, when Commonwealth Lloyds and US Fire filed a petition for review of the Dallas Court of Appeals' decision, the Texas Supreme Court initially granted it. And, although the Texas Supreme Court withdrew its writ of review several months later, it did so with the notation that "we granted the insurers' applications for writ or error, but a majority of the court now withdraws our order granting the writ and denies the insurers' applications for writ of error. **In doing so, we neither approve nor disapprove of the opinion of the Court of Appeals**." *Commonwealth Lloyds Ins. Co. v. Cullen/Frost Bank of Dallas, N.A.*, 889 S.W.2d 266 (Tex. 1994).

Further, five years after it rendered *Cullen/Frost*, the Dallas Court of Appeals undermined it in *Aetna Cas. & Surety Co. v. Naran*, 1999 WL 59782, at 4 (Tex.App. – Dallas, 1999, review denied, rehearing of petition for review overruled). In that case, the court specifically held that it was "unpersuaded" by the insured's "urging to adopt an exposure or injury in trigger theory in this instance. The exposure theory holds coverage is triggered when the claimant or his property is first exposed to the injury causing agent and on each subsequent exposure to the injury causing agent… we discern no reason to depart in this instance from the manifestation theory previous espoused in *Dorchester*." Compare, the operative language in *Cullen/Frost*: "There can be a new occurrence each time the complaining party suffers damage… we reject the argument that there can be only one occurrence when the facts allege continuous or repeated exposure causing continued or multiple property damage over an extended period of time."

Further, at least one other court has expressly refused to follow certain aspects of *Cullen/Frost*. In *State Farm Lloyds v. Kessler*, 932 S.W.2d 732, 737 (Tex.App. – Fort Worth, 1996, the writ denied), the Fort Worth Court of Appeals rejected altogether the apparent acceptance by *Cullen/Frost* of the idea that economic damages resulting from misrepresentations could constitute "property damage." *See Kessler*, at 737, n.31.

Other cases have also disregarded or rejected the continuous trigger principles set forth in *Cullen/Frost*. For example, in *Carpenter Plastering Co. v. Puritan Ins. Co*., 1988 WL 156829 (N.D. Tex. 1988) (Buchmeyer, C.J.), the court held that "even though the injurious affects of an occurrence may extend into future policy periods, only the insurer which has coverage at the time damages first manifest themselves has a duty to defend and provide coverage for all resulting damages." Similarly, in *AAF-McQuay, Inc. v. Northbrook Property & Cas. Ins. Co*., 1999 WL 33447378 (E.D. Tex. 1999, reconsideration denied), the court followed *Carpenter Plastering* and held:

> The Court is further persuaded by the district court's decision in *Carpenter Plastering Co. v. Puritan Ins. Co*., No. 3-87-2435-R, 1988 WL 156829 (N.D.Tex. Aug.23, 1988). Though not squarely on point, this case is instructive. It

> involved progressive injuries to a building that were sustained as a result of continuous exposure to water leakage caused by defective wall panels. *Id*. at *4. Applying the manifestation theory, the court in *Carpenter Plastering* determined that the relevant focus for purposes of determining coverage was determining the date on which the insured received its first indication of the problem. *Id*. at *5. The court went on to state that "even though injurious effects of an occurrence may extend into future policy periods, only the insurer which has coverage at the time damages first manifest themselves has a duty to defend and provide coverage for all resulting damages." *Id*. Finally, the court explicitly rejected the application of the continuous trigger theory. *Id*. at *4.

In sum, the *Cullen/Frost* decision attempts to establish "continuous exposure" trigger through the incorrect application of "number of occurrences" theory, while still holding forth that it embraces the "manifestation" trigger set forth in Dorchester.

Fortuity Can Prevent Coverage

In Texas, the fortuity doctrine precludes insurance coverage, and thus negates a duty to defend or indemnify, where the insured is or should be aware of an ongoing progressive loss or known loss at the time the policy is purchased. The doctrine has its roots in the premises that because insurance policies are designed to insure against fortuities, insuring against a certainty constitutes fraud. *See Scottsdale Ins. Co. v. Travis*, 68 S.W.3d 72, 75 (Tex.App. – Dallas 2001, petition denied); *see also, Birch v. Commonwealth Co. Mut. Ins. Co*., 450 S.W.2d 838, 840-41 (Tex. 1970) *Two Pesos, Inc. v. Gulf Insurance Company*, 901 S.W.2d 495, 501 (Tex.App.– Houston [14th Dist.] 1995, no writ); *Mason Drug Company, Inc. v. Harris*, 597 F.2d 886, 887 (5th Cir.1979); *RLI Ins. Co. v. Maxxon Southwest, Inc*. 265 F.Supp.2d 727, *730 -731 (N.D.Tex., 2003). This is so whether the policy contains known loss exclusions or not, as it is a matter of public policy.

Under the "loss in progress" or "known loss" doctrine, insurance coverage is precluded where the insured is, or should be, aware of an ongoing progressive loss or known loss at the time the policy is purchased. The "loss in progress" principle is recognized as part of standard insurance law. An insured cannot insure against something that has already begun and which is known to have begun. *Franklin v. Fugro-McClelland (Southwest), Inc*. 16 F.Supp.2d 732, *734 -735 (S.D.Tex., 1997); *Essex Ins. Co. v. Redtail Products, Inc*. 1998 WL 812394, *4 (N.D.Tex.,1998)("These aspects of the fortuity doctrine focus on the proposition that insurance coverage is precluded where the insured is, or should be aware of an ongoing progressive loss or known loss at the time the policy is purchased. The "loss in progress" principle is recognized as part of standard insurance law. *An insured cannot insure against something that has already begun and which is known to have begun*. Texas has long recognized that it is contrary to public policy for an insurance company to knowingly assume a loss occurring prior to its contract."), affirmed, 213 F.3d 636 (5th Cir.(Tex.) Apr 12, 2000) (TABLE, NO. 99-11056)

In *Cullen/Frost*, the court considered, but found inapplicable, the fortuity doctrine, because, it held:

> Insurers also urge that it is against public policy to allow bank to obtain insurance for an occurrence that already had taken place in spring 1986…. There is no allegation that the time Tompkins plaintiffs informed bank of the damage or that bank had such knowledge from any other source.

The court therefore held that public policy [fortuity] did not apply.

…insurance coverage is precluded where the insured is, or should be, aware of an ongoing progressive loss or known loss at the time the policy is purchased.

Rejection Of *Montrose*

Sometimes, plaintiffs in Texas assert that *Cullen/Frost*, and its particular interpretation of ongoing property damage/occurrences, plus California's decision in *Montrose Chemical Corp. v. Admiral Ins. Co*., 10 Cal. 4th 645, 42 Cal. Rptr. 2d 324 (1995), results in a rule that where the underlying dispute has not yet been adjudicated at the time the policy is purchased, the insured has only a "potential loss," and therefore fortuity doctrine does not apply. This stratagem has been rejected by at least one court expressly, at least where the insured knows of ongoing litigation at the time of the purchase of the policy. *Franklin v. Fugro-McClelland (Southwest), Inc*., 16 F. Supp. 2d 732, 734-737 (S.D. Tex. 1997).

Conclusion

Luckily, until recently, few courts have followed *Cullen Frost* for the unique, *Montrose*-like metaphysics it proposes. The exigencies of recent tort trends should not change the plain meaning of the policy and the law.

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2. *American Home Assur. Co. v. Unitramp Ltd*. 146 F.3d 311, *313 (C.A.5 (Tex.),1998); *Snug Harbor, Ltd. v. Zurich Ins*., 968 F.2d 538, 544 (5th Cir.1992) ("Texas courts have concluded that the time of an occurrence is when a claimant sustains actual damage – not necessarily when the act or omission causing that damage is committed."). *See, e.g., State Farm Mut. Auto. Ins. Co. v. Kelly*, 945 S.W.2d 905, 910 (Tex.App.–Austin 1997, writ denied) ("Texas courts have held that property loss occurs when the injury or damage is manifested"); *Flores v. Allstate Texas Lloyd's Co*. 278 F.Supp.2d 810, *815 (S.D.Tex.,2003)(applying analysis to mold).

3. There are other "trigger" mechanisms, as well, and others that "manifestation" have been applied by various courts, nationally, and by one court in Texas, *Pilgrim Enterprises, Inc. v. Maryland Cas. Co*., 24 S.W.3d 488, 495 (Tex.App.–Houston [1st Dist.] 2000, no pet.). In *Pilgrim*, the court set forth the following description of each:

> 1. the "pure" or "strict" manifestation rule – "triggers coverage upon actual discovery of injury";
> 2. the "relaxed" manifestation rule – "triggers coverage in first policy period during which discovery of injury is possible";
> 3. the "exposure" rule – "triggers coverage in any policy period in which exposure to cause of injury occurred";
> 4. the "injury-in-fact" rule – "sets trigger in personal injury cases at point when body's defenses are 'overwhelmed' "; and
> 5. the "multiple" or "triple-trigger" rule – "requires coverage under all policies during period of continuing exposure and manifestation." *Id*. (citations omitted).

Pilgrim Enterprises, Inc. v. Maryland Cas. Co. 24 S.W.3d 488, *495 (Tex.App.–Houston [1 Dist.],2000).

Famously, the supreme court has not ruled, and has decided not to say. *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842, 853, n. 20 (Tex.1994), discussing *Dorchester Development Corp. v. Safeco Ins. Co*., 737 S.W.2d 380 (Tex.App.–Dallas 1987, no writ) and *Cullen/Frost Bank of Dallas v. Commonwealth Lloyd's Ins. Co*., 852 S.W.2d 252 (Tex.App.–Dallas 1993, no writ.). Compare, *Allstate Ins. Co. v. Hicks*, 2003 WL 22096500, *3 (Tex.App.–Amarillo,2003), comparing these decisions with *Pilgrim*. Having said this, the more academically minded practitioner might want to note the supreme court's implicit embrace of manifestation trigger in *Employers Cas. Co. v. Block*, 744 S.W.2d 940, 944 (Tex.1988), overruled in part on other grounds by *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex.1996), in which the court held:

> As pointed out in the dissenting opinion of the court of appeals, the time of the insured's damages is a precondition to any coverage rather than an exception to general coverage. Thus, we hold that Employers Casualty's general denial placed the burden on the Blocks to prove that their house was damaged during the policy period. We hold that the Blocks met their burden of proving that the damaging event occurred during the policy period which covered August 1, 1980 – August 1, 1981.
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> *Employers Cas. Co. v. Block*, 744 S.W.2d 940, *944 (Tex.,1988).

4. For the purposes of this paper, we assume that no substantive coverage defenses, such as the work/product exclusions, apply.

5. See *Encore*, at 3: "Given that the lawsuit was filed while the policy was still in effect, this allegation is sufficient to suggest that at least one occurrence became manifest during the policy period. *See Cullen/Frost Bank*, 852 S.W.2d at 258."

6. A dubious proposition in light of later case law. *See State Farm v. Kessler*, discussed below.

7. The issue was framed this way:

> In its third point of error, Bank asserts that the trial court erred in granting summary judgment on the ground that the petition in the Tompkins suit failed to allege an occurrence. Although both parties agree that there was an occurrence, they disagree as to the number of occurrences. Bank asserts that the Tompkins plaintiffs alleged continuous or multiple occurrences that fell within the coverage periods of all five policies. Insurers argue that, in this case, there was only one occurrence in Spring 1986 when, after an inspection of the property, the Tompkins plaintiffs discovered property damage.

8. *Michigan Chem. Corp. v. American Home Assurance Co*., 728 F.2d 374 (6th Cir.1984) *Michigan Chem. Corp. v. American Home Assurance Co*., 728 F.2d 374, 379-80 (6th Cir.1984) (noting that "[t]he vast majority of courts… have concluded that… the number of occurrences for purposes of applying coverage limitations is determined by referring to the cause or causes of damage and not to the number of injuries or claims."); *Appalachian Ins. Co. v. Liberty Mut. Ins. Co*., 676 F.2d 56 (3d Cir.1982) (holding that to determine the number of occurrences "the court asks if '[t]here was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damage' "); *Interstate Fire & Cas. Co. v. Archdiocese of Portland*, 747 F. Supp. 618, 624 (D.Or.1990) (Oregon law) ("Each time this negligent supervision presented Father Laughlin with the opportunity to molest a different child, the Archdiocese was exposed to new liability."), rev'd on other grounds, 35 F.3d 1325 (9th Cir.1994).

9. Principally by Randy Paar. See, The Brief, Summer, 2001 Tort and Insurance Practice Section, "INSURANCE AND NON-FEDERAL QUESTION CLASS ACTIONS PROSECUTION AND DEFENSE STRATEGIES" 30-SUM Brief 52, *56:

> An additional key term in many occurrence definitions is the "batch" clause. A typical batch clause provides:
>
> For purposes of determining the limit of the company's liability and the retained limit, all bodily injury and property damage arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence. This provision generally is referred to as the batch clause because it combines, or batches, all related claims emanating from substantially the same conduct into a single occurrence. Under the batch clause, only one occurrence arises when the insured's conduct creates conditions leading to comparable injuries to multiple claimants.

See also, Practising Law Institute PLI Order No. F0-007N November 2000 MCLE Marathon 2000 RECOVERY IS IN THE DETAILS: HOT ISSUES IN THE ADMINISTRATION AND APPLICATION OF GENERAL LIABILITY INSURANCE POLICIES Randy Paar 86 PLI/NY 199.

Compare, HANDBOOK ON INSURANCE COVERAGE DISPUTES, Ninth Edition Barry R. Ostrager and Thomas R. Newman Chapter 9: Trigger and Scope of Occurrence-Based Coverages 9.02 SINGLE VS. MULTIPLE OCCURRENCES.

10. "Further, the damages in all of the cases arose from exposure to substantially the same general condition emanating from one source. *Michigan Chem. Corp*., 728 F.2d at 376, 382, 383 (distribution of contaminated livestock feed; injury occurred at time feed was shipped); *Appalachian Ins. Co*., 676 F.2d at 61 (injuries all resulted from one source – the insured's discriminatory employment policies; the single occurrence for purposes of policy coverage was the insured's adoption of its discriminatory policies); *Interstate Fire & Casualty Co*., 747 F. Supp. at 621, 624 (priest sexually molested child during four policy years; injury to each child occurred at the time of first molestation). In contrast, the policies at issue here do not provide that all exposure to the same condition constitutes a single occurrence. Thus, our policies do not, by their terms, prevent there being multiple occurrences. For that reason, we conclude that *Michigan Chemical Corp*., *Appalachian Insurance Co*., and *Portland Archdiocese* are not dispositive of this issue."

Comments FROM THE EDITOR

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

Our goal has been to make this publication the best publication offered by any Section of the State Bar of Texas and one of the best insurance law publications in the country. Based on the feedback we continue to receive from many people from all over the state and all over the country, we are doing well in our continuing efforts to reach that goal. The first reason for our success is the quality of our articles. This issue provides another great example of scholarly analysis and practical insight in all three of the articles. Thanks to each of the authors for their hard work and great articles.

You also probably noticed the advertisements in this issue of The Journal. The cost for printing and mailing each issue of this publication is staggering. The cost of 4 issues would exceed our total annual budget if we did not have some way to supplement our income as a Section. So, the Counsel of the Insurance Law Section voted earlier this year to begin accepting advertising revenue for our publication to help us defray the costs of graphics design, printing, and mailing. If you are interested in helping sponsor the Insurance Law Section by purchasing an ad in the next issue of The Journal, please let me know.

If you are interested in submitting an article for a future issue of this publication, we are always looking for good articles on timely topics relating to Texas Insurance Law. If you are interested in joining our editorial team, we can also use help in proofreading and editing. Finally, if you have any comments on how this publication can better serve you, please let me know that as well. We are always trying to improve and we appreciate all feedback.

Christopher W. Martin,
Martin, Disiere, Jefferson & Wisdom L.L.P.
Editor-In-Chief

Graphic design for the Journal of Texas Insurance Law is provided by Peretti Design, 713-502-6153.

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Insurance Law Section
P.O. Box 12487, Capitol Station
Austin, Texas 78711-2487

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