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This letter is intended to summarize the most significant cases impacting the insurance practice since the Spring 2007 newsletter. It is not a comprehensive digest of every case involving insurance issues during this period or of every holding in the cases discussed. This newsletter was not compiled for the purpose of offering legal advice. Any opinions expressed herein are those of the authors and do not necessarily reflect the views of Beirne, Maynard & Parsons, L.L.P.

"OCCURRENCE" – FAULTY WORKMANSHIP; ARTICLE 21.55

Lamar Homes, Inc. v. Mid-Continent Cas. Co., No. 05-0832 (Tex. Aug. 31, 2007)

The Texas Supreme Court answered the following certified questions from the Fifth Circuit:

1. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege an "accident" or "occurrence" sufficient to trigger the duty to defend or indemnify under a CGL policy?

2. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege "property damage" sufficient to trigger the duty to defend or indemnify under a CGL policy?

3. If the answers to certified questions 1 and 2 are answered in the affirmative, does Article 21.55 of the Texas Insurance Code apply to a CGL insurer's breach of the duty to defend?

The court concluded that allegations of unintended construction defects may constitute an "accident" or "occurrence" provided such defects are alleged to have resulted from the negligence of the insured and that allegations of damage to or loss of use of the home itself may constitute "property damage" for purposes of determining if there is a duty to defend. Noting that the duty to indemnify is triggered not by allegations, but by the proof at trial, the court did not reach the duty to indemnify. The court also concluded that former Article 21.55, re-codified as Sections 542.051-.061 of the Texas Insurance Code, does apply to an insurer's breach of the duty to defend.

Homebuyers sued Lamar and a subcontractor alleging that Lamar was negligent in designing and constructing their home's foundation, and that Lamar's defective workmanship caused the home's sheetrock and stone veneer to crack some time after they purchased the home. The majority rejected the carrier's arguments that:

1. A CGL policy covers only tort damages, not contract damages and despite the allegations of negligence, there was not an "occurrence" because the economic-loss rule dictates that damages arising from defective work are economic damages for breach of contract, not property damage;

2. Defective work is not an occurrence because a contractor should expect that faulty workmanship will result in damage to the property itself; and

3. Extending CGL coverage to defective work transforms liability insurance into a performance bond.

In determining that defective construction or faulty workmanship that damages only the work of the insured may be an "occurrence," the court initially rejected the notion that foreseeability is the boundary between accidental and intentional conduct. However, the majority later stated that *Mid-Century Insurance Co. v. Lindsey*, 997 S.W.2d 153, 155 (Tex. 1999), held that "a claim does not involve an accident or occurrence when either direct allegations purport that the insured intended the injury (which is presumed in cases of intentional tort) or circumstances confirm that the resulting damage was

the natural and expected result of the insured's actions, that is, was highly probable whether the insured was negligent or not." Adopting the reasoning of *Federated Mutual Insurance Co. v. Grapevine Excavation, Inc.*, 197 F.3d 720, 725 (5th Cir. 1999), the court stated that an "occurrence" includes damage that is the unexpected, unforeseen, or undesigned happening or consequence of an insured's negligent behavior, including claims for damage caused by an insured's faulty workmanship. The court also refused to distinguish between damage to the insured's work and damage to some third party's property for purposes of the "occurrence" analysis. Ultimately, the court concluded that because the underlying complaint alleged that the defective construction was the product of Lamar's negligence, it did allege an occurrence for purposes of the duty to defend.

Relying on the language of the CGL policy itself, the court also concluded that the allegations of cracking sheetrock and stone veneer alleged "physical injury" to "tangible property." In other words, the court held that the CGL policy covers what it covers and the fact that similar protection would have been available under a performance bond is not sufficient to eliminate coverage under the CGL.

While noting that the business risk exclusions will often preclude coverage for faulty workmanship, the court accepted Lamar's argument that the subcontractor exception to the "your work" exclusion restores coverage when the general contractor is liable for damage to work performed by a subcontractor or for damage to the general contractor's work arising out of the subcontractor's work.

The court further stated that the economic loss rule is not a useful tool for determining insurance coverage because the CGL policy does not distinguish between tort and contract damages. Thus, "any preconceived notion that a CGL policy is only for tort liability must yield to the policy's actual language." The duty to defend must be determined based on a comparison between the policy language and the allegations in the complaint, the eight corners rule.

Finally, the court concluded that Sections 542.051-.061 of the prompt payment statute are applicable to defense costs owed in connection with a third party claim. While acknowledging that the prompt payment statute applies to a "claim," which is defined as "a first party claim made by an insured or policyholder . . . that must be paid directly to the insured or beneficiary," the court focused on the latter part of the definition. The court concluded that whether a claim is a "first party claim" is determined based on the claimant's relationship to the loss, and because "a defense claim" relates solely to the insured's own loss, it is a first party claim. The court reasoned that whether defense costs must be paid to the insured or to defense counsel, the claim is one that is owed by the insurer directly to the insured.

In response to the contention that the prompt payment statute is unworkable in the context of defense costs, the court recognized that the statutory deadlines for accepting and paying claims do not begin to run until the insurer has "receive[d] all items, statements, and forms required by the insurer to secure final proof of loss." Accordingly, in order to "mature its rights" under the prompt payment statute, the insured must submit its legal bills to the insurance company as received. The court did not discuss the Legislature's reference to a proof of loss in connection with its determination that a claim for costs of defense of a third party claim was a first party claim within the meaning of the statute.

STOWERS **– SUBROGATION**

Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co., No. 05-0261 (Tex. Oct. 12, 2007)

The Texas Supreme Court answered certified questions presented by the Fifth Circuit in *Liberty Mutual Insurance Co. v. Mid-Continent Insurance Co.*, 405 F.3d 296 (5th Cir. 2005), holding that there is no actionable duty owed, either directly or by subrogation to the insured's rights, by one co-primary insurer to another when one co-primary insurer refuses to pay its proportionate share of a settlement.

Kinsel was the named insured on a primary policy with limits of $1 million and an excess policy with limits of $10 million by Liberty. Kinsel was also an additional insured under a $1 million primary policy issued by Mid-Continent to one of Kinsel's subcontractors. Both primary policies contained identical "other insurance" clauses that provided for equal or pro rata sharing up to the co-insurer's respective policy limits in the event the loss is covered by other primary insurance.

Kinsel was one of several defendants sued in connection with an automobile accident. Both insurers agreed that the total verdict against all defendants was likely to be $2-3 million. Initially, both carriers estimated Kinsel's percentage of fault at

between 10-15 percent. As the case progressed, Liberty increased its estimate to 60 percent. Liberty agreed at mediation to settle on behalf of Kinsel for $1.5 million (60% of an anticipated $2.5 million verdict). Liberty demanded that Mid-Continent contribute half of the settlement. Mid-Continent refused to contribute more than $150,000, half of its evaluation of the settlement value of the case. Liberty took the $150,000 offered by Mid-Continent, funded the remaining $1.35 million of the settlement, and reserved its right to seek recovery from Mid-Continent for its portion of the settlement. Mid-Continent contended that the voluntary payment and no action clauses in its policy limited its liability to the amounts it consented to pay.

In the coverage litigation, the federal district court found that Mid-Continent was objectively unreasonable in assessing Kinsel's share of liability and that Liberty was reasonable in assessing liability and accepting the settlement demand. The district court held that Liberty was entitled through subrogation to recover from Mid-Continent, relying on *General Agents Insurance Co. of America v. Home Insurance Co. of Illinois*, 21 S.W.3d 419 (Tex. App.—San Antonio 2000, pet. dism'd by agr.). On appeal, the Fifth Circuit certified questions to the Texas Supreme Court concerning whether a primary co-insurer owed any actionable duty to reimburse another co-insurer that paid more than its proportionate share of a settlement; if so, the standard for determining that duty; and whether the duty was limited to amounts paid under the excess policy.

When the Fifth Circuit certified these questions, it identified inconsistencies in the last twenty years of Texas Supreme Court precedent (from *Ranger v. Guin* to *Rocor*), that created a lack of clarity as to the exact nature or extent of a *Stowers* claim. In particular, two such open questions were as follows: 1) whether the *Stowers* duty extended to claims that the primary carrier negligently defended the claim as suggested in *Ranger v. Guin* and *American Centennial v. Canal*; and 2) whether the *Stowers* duty is triggered when a demand requires funding from multiple insurers and no single insurer can fund the entire settlement within the limits of its policy, a question left open by *APIE v. Garcia*. In answering the certified questions, the Texas Supreme Court did not address the first issue, although it appears to have resolved the second issue against the existence of any such duty.

The court confirmed that there is no direct action between insurers, whether they are primary co-insurers or an excess and a primary insurer. The court specifically disapproved of *General Agents* to the extent it would provide a recovery to an overpaying co-primary insurer.

The court further held that Kinsel had no rights against Mid-Continent to which Liberty could be subrogated. In reaching this conclusion, the court reasoned that in a subrogation action, Liberty necessarily stands in the shoes of Kinsel, the insured. Noting that both Liberty and Mid-Continent owed contractual and common law duties to their insured, including a several and independent duty to pay a pro rata share of a covered loss up to their respective policy limits, the court then construed this duty in light of the pro rata "other insurance" clauses in the policies. Relying on a California case, the court concluded that because an insured is not entitled to a double recovery, once the insured has recovered the full amount of its loss from one or more, but not all, of its carriers, the insured has no further rights against the insurers that did not contribute to its recovery. The court reasoned that because the insured would have no further right of recovery from the non-contributing carriers, the contributing carrier's would have no such rights either. In reaching this conclusion, the court apparently chose to look at whether the insured has any rights against a carrier after all the dust settles rather than at the point where one carrier fails to fulfill its duties forcing another carrier to step into the breach.

The court further held that Mid-Continent did not breach any *Stowers* duty to Kinsel because the plaintiffs' demand exceeded Mid-Continent's policy limit. Accordingly, it reasoned that Liberty cannot be equitably subrogated to any common law rights against Mid-Continent. The court seemed to distinguish this situation involving co-primary insurers from the situation in *American Centennial v. Canal*, leaving open the possibility that an excess carrier could still be able to assert an equitable subrogation action against a primary carrier that unreasonably fails to settle a case within policy limits, even if the insured's rights against the primary carrier were extinguished as a result of payment by the excess insurer.

The distinction made by the court appears to be whether the carrier asserting rights through subrogation was also "primarily liable" for the loss. When both carriers are "primarily liable," the court has now held that if an insurer pays all of a loss for which another carrier is also "primarily liable," the carrier that protected the insured and exceeded its duties destroys any right of subrogation against a carrier that refuses to contribute its pro rata share.

Cain v. Safeco Lloyds Ins. Co., No. 05-06-00487-CV (Tex. App.—Dallas Aug. 31, 2007, no pet. h.)

The Dallas Court of Appeals recently addressed one of the issues raised by the Fifth Circuit in *Liberty Mutual v. Mid-Continent* that was not addressed by the Texas Supreme Court. Relying on the Texas Supreme Court's decisions in *Maryland v. Head* and *Traver*, as well as its own decision in *Dear v. Scottsdale*, the Dallas Court of Appeals held that Texas law does not recognize a cause of action for negligent defense by an insured against his insurer.

This case arose out of an automobile accident in which Cain was severely injured. Cain was a passenger in a vehicle driven by Safeco's insured. Despite Safeco's repeated offers of policy limits, Cain sued the insured and Ford. Safeco defended its insured in the lawsuit. The case was tried and the jury found that Ford was not liable but awarded over $4 million against Safeco's insured.

The insured assigned rights to Cain, who proceeded with a lawsuit against Safeco asserting, *inter alia*, that the *Stowers* duty has been expanded by *Ranger v. Guin* to include a duty to exercise ordinary care in the investigation, preparation for defense of the lawsuit, trial, and attempts to settle. The Dallas Court of Appeals held that the lack of any such duty entitled Safeco to summary judgment as to all causes of action asserted by Cain, including causes of action for negligent defense, negligence, bad faith, and violation of the insurance code.

SUBROGATION – "MADE WHOLE" DOCTRINE

Fortis Benefits v. Cantu, No. 05-0791 (Tex. June 29, 2007)

The Texas Supreme Court held that the "made whole" doctrine did not serve to bar the insurer from recovering from the insured's settlement of the underlying suit because the insurer had a contractual, as opposed to equitable, right to subrogation.

In *Cantu*, the issue was whether the "made whole" doctrine—an equitable remedy preventing an insurer from being subrogated to an insured's medical benefits unless the insured has been "made whole"—outweighs an insurer's contractual subrogation right. The insured, after suing numerous parties for injuries that she sustained in an automobile accident, settled all of her claims for approximately $1.5 million. Prior to settlement, the insurer intervened in the lawsuit asserting contractual subrogation and reimbursement rights based on its payment of the insured's medical expenses. After settlement, the insured argued that she had not been "made whole" by the settlement because her future medical expenses were estimated to exceed the settlement amount, and, therefore, the "made whole" doctrine precluded the insurer from recovering from the settlement proceeds.

The court determined that the insurer was entitled to recover from the settlement proceeds despite the fact that the insured may not have been "made whole" by the settlement. The "made whole" doctrine only applied to a claim for *equitable* subrogation, not *contractual* subrogation. The policy provided that "'[u]pon payment of benefits, [the insurer] will be subrogated to *all* rights of recovery a Covered Person may have against *any* person or organization. . . . Such right extends to the proceeds of *any* settlement or judgment; but is limited to the amount of benefits [the insurer has] paid'" (emphasis added by the court). Accordingly, the insurer "retained an unfettered right to recover the proceeds from the settlement of the underlying suit, the only limitation being the *amount* of recovery—what [the insurer] had paid under the contract [because n]owhere does [the] provision suggest that [the insured] must first be 'made whole' for [the insurer] to recover."

CONDITIONS PRECEDENT

Caddell v. Travelers Lloyds of Tex. Ins. Co., No. 06-06-00063-CV (Tex. App.—Texarkana June 1, 2007, no pet. h.)

The Texarkana Court of Appeals affirmed the trial court's order granting the insurer's summary judgment motion because the insured failed to comply with the contractual obligation to provide the insurer with prompt written notice of loss.

After the insured suffered hail damage to her home, she called a toll-free service number provided by her insurer to make a claim for the damages but never filed a written notice of loss. After a lengthy dispute on her claim, the insured brought suit against the insurer, and the insurer filed a summary judgment motion asserting, among other grounds, that the insured failed to comply with policy provisions. The motion was granted, and the insured appealed.

The court noted that conditions precedent are stipulations that call for the performance of some

act or the occurrence of some event before an agreement is enforceable. Here, the subject policy contained several provisions that instructed the insured to give prompt written notice to the insurer as soon as is practical after a loss to covered property. The court also noted that although the insured cited authority for the proposition that her failure to comply was not fatal *unless* the insurer was unduly prejudiced, those types of cases were not controlling here because they dealt with liability policies and not casualty insurance. Finally, the court dismissed any questions as to waiver and estoppel because the insured failed to plead or pursue those theories.

Thompson v. Diamond State Ins. Co., No. 4:06-cv-154 (E.D. Tex. June 15, 2007)

The insurer was not liable on an insurance contract covering a horse because the insureds failed to disclose that the horse was lame prior to the renewal of the policy.

ARTICLE 21.55

Houston Cas. Co. v. Lexington Ins. Co., No. H-05-1804 (S.D. Tex. June 25, 2007)

In this case of first impression, the magistrate judge determined that the "reinsured's claim for indemnity by its reinsurer is not a 'first party claim' within the meaning of [former article 21.55]."

Although the court determined that the reinsurance contract at issue was a policy of insurance, former article 21.55 was inapplicable because the original insurer/reinsured's claim was not a "first party claim." The court noted that it was the original insured, not the original insurer/reinsured, that incurred the loss because it was the original insured's business that was interrupted. As between the original insured and the original insurer/reinsured, the claim was a first party claim, but as between the original insurer/reinsured and the reinsurer, the claim was a third party claim because the original insurer/reinsured was seeking reimbursement (from the reinsurer) for compensating the original insured for the original insured's loss.

SEVERANCE OF *STOWERS* CLAIM

In re Home State County Mut. Ins. Co., No. 12-07-00062-CV (Tex. App.—Tyler May 16, 2007, no pet. h.)

The court held that the severance of a *Stowers* claim from contractual and extra-contractual claims arising from the failure to settle a liability claim within policy limits was an abuse of discretion because the *Stowers* claim, as well as all of the other claims, involved the same facts and issues.

Horn was a passenger in a vehicle driven by Home's insured. The vehicle was involved in a one-car accident, resulting in the death of Home's insured, and serious injuries to Horn. Horn made a time-sensitive settlement demand within policy limits. Home sent a settlement check, which was rejected because Horn's attorney claimed that it was untimely. Horn then sued the estate of the deceased driver and recovered a judgment in excess of $10 million.

Approximately two years after recovering the judgment, Horn, as assignee of the insured's estate, sued Home for negligent failure to settle, breach of contract, breach of the duty of good faith and fair dealing, violations of the DTPA, and violations of articles 21.21 and 21.55 of the Texas Insurance Code. Horn moved for summary judgment on his *Stowers* cause of action, and, while that motion was pending, Horn also filed a motion to sever the *Stowers* claim. The district court granted both motions. Home filed a petition for writ of mandamus relating to the severance order.

In conditionally granting mandamus relief, the Tyler Court of Appeals determined that all of Horn's claims—*Stowers* or otherwise—related to Home's handling of Horn's settlement demand. As such, the main issue was whether Home's handling of Horn's settlement demand was appropriate, and, accordingly, the court held that the *Stowers* claim was so interwoven with Horn's other claims that severance was improper.

SEVERANCE AND ABATEMENT OF EXTRA-CONTRACTUAL CLAIMS

In re Allstate Ins. Co., No. 12-07-00152-CV (Tex. App.—Tyler Aug. 15, 2007, no pet. h.)

Allstate was a mandamus proceeding considering whether the trial court erred in denying a motion for severance of a contract claim from extra-contractual claims and abatement of discovery on the extra-contractual claims.

As a result of a tree falling on their recreational vehicle, Allstate's insured filed a claim

under their policy, and Allstate requested an appraisal of the damages caused by the tree. After receiving the appraisal, Allstate tendered a check to the insured that represented the appraised damages minus the insured's deductible (i.e., $917.34 - $50.00 = $867.34). The insured also obtained an appraisal by the same company used by Allstate asking that all of the damage to the RV be considered. This appraisal showed the total damages to the RV were $7,989.75. The insured filed suit against Allstate alleging breach of contract and extra-contractual claims, and Allstate filed its motion to sever and abate.

After the trial court denied Allstate's motion, Allstate offered to settle the disputed portion of the contract claim with the insured for $1,000, and filed a motion asking the court to reconsider the ruling on the motion to sever and abate. Again, the trial court denied Allstate's motion. In response, Allstate filed its petition for writ of mandamus.

In conditionally granting mandamus relief, the Tyler Court of Appeals ruled that the trial court abused its discretion by denying Allstate's motion. The court noted that if all the claims were extra-contractual claims or if the settlement offer represented only the undisputed portion of the contract claim, the trial court's denial of severance would not have been an abuse of discretion. However, because those circumstances were not present, and given the actual circumstances, the court noted that the trial court could have reached but one decision—that severance was necessary.

The court further noted that if the extra-contractual claims were not abated, both parties would incur unnecessary discovery expenses if the contract claim was ultimately decided in Allstate's favor. Despite noting that there is no bright line rule requiring abatement and that these factors, standing alone, do not necessarily require abatement, the court set forth two additional factors requiring abatement in this case: (1) premature disclosure of privileged information (i.e., information on Allstate's claims handling) and (2) the insured did not argue that if the case was severed, abatement should not be ordered.

"LEASED-IN WORKER" EXCLUSION

Yorkshire Ins. Co. v. Diatom Drilling Co., No. 07-05-0386-CV (Tex. App.—Amarillo May 2, 2007, no pet. h.)

The Amarillo Court of Appeals held that a leased-in worker exclusion, although not defined by the CGL policy, was applicable so as to bar coverage for a death claim because the parties to the policy intended to exclude liability for injury or death claims of workers who were "leased-in" by the insured.

INTENTIONAL-ACTS EXCLUSION

Tanner v. Nationwide Mut. Fire Ins. Co., No. 11-05-00371-CV (Tex. App.—Eastland Aug. 9, 2007, pet. filed)

The Eastland Court of Appeals held that the intentional-acts exclusion excluded coverage for personal injury claims brought against the insured as a result of injuries sustained during a police chase.

After being stopped by a Texas State Trooper, the insured fled, and a high-speed chase ensued. During the chase, the insured struck Greg and Maribel Tanner's vehicle, injuring them and their children. After the collision, the insured drove off, but he was ultimately caught, arrested, and charged with aggravated assault with a motor vehicle.

After the Tanners filed suit against the insured, Nationwide filed a declaratory judgment action asserting that coverage was precluded by the intentional-acts exclusion. The jury found that the insured did not intentionally cause the Tanners' damages, and Nationwide filed a motion to disregard the jury finding. The trial court granted the motion and entered a judgment declaring that Nationwide owed the insured no duty to defend or indemnify. The Tanners appealed.

The intentional-acts exclusion at issue provided that "[p]roperty damage or bodily injury caused intentionally by or at the direction of an insured, including willful acts the result of which the insured knows or ought to know will follow from the insured's conduct." The court noted that although no Texas cases have construed this precise language, Texas courts have considered similar intentional-acts exclusions. The court also stated that Texas follows the inferred intent rule, which considers a result to be intentional whenever it is the natural and probable consequence of an intentional act. Stated differently, regardless of the insured's subjective intent, intent is inferred when it is substantially certain that a particular result will follow an intentional act.

After referencing the undisputed evidence before the jury, the court stated that each of the insured's actions carried with it an undisputed and substantial risk that someone would be injured, and the risk became less hypothetical and more real the

longer the chase continued. Following the analysis in *Nationwide Mutual Insurance Co. v. Finkley*, 679 N.E.2d 1189 (Ohio Ct. App. 1996), the court held that, as a matter of law, that type of conduct fell within the policy's intentional-acts exclusion. Moreover, the court stated that while the insured's desire to avoid the police did not necessarily include a subjective intent to cause injury, by his conduct, an accident was substantially likely to occur. Accordingly, the trial court's judgment was affirmed.

"NAMED INSURED" IN EMPLOYEE INJURY EXCLUSION vs. "EACH INSURED" IN SEPARATION OF INSUREDS CLAUSE

Starwood Hotels & Resorts Worldwide, Inc. v. Century Sur. Co., No. H-06-1210 (S.D. Tex. June 5, 2007)

In this case of first impression under Texas law, the United States District Court for the Southern District of Texas determined that the term "the named insured" contained in a modified employee injury exclusion was not the same as the insured identified in the Separation of Insureds provision, namely, the "insured against whom claim is made or 'suit' is brought."

Starwood hired Absolute to install windows at one of Starwood's hotels. Absolute had a CGL policy with Century, and such policy was amended to add Starwood as an additional insured. After a worker, allegedly employed by Absolute, died at the worksite, the worker's estate and his parents filed suit against Starwood. Starwood demanded that Century assume the defense, but Century denied coverage by citing the "Action Over Exclusion" contained in an endorsement to the policy. The "Action Over Exclusion" provided, in pertinent part, as follows:

e. Employer's Liability

"Bodily injury" to:

(1) An "employee" of the named insured arising out of and in the course of:

(a) Employment by the named insured; or

(b) Performing duties related to the conduct of the named insured's business; or

(2) The spouse, child, parent, brother or sister of that "employee" as a consequence of Paragraph (1) above.

In contrast, the Separation of Insureds provision provided as follows:

7. Separation of Insureds

Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:

a. As if each Named Insured were the only Named Insured; and

b. Separately to each insured against whom claim is made or "suit" is brought.

Starwood argued that the Separation of Insureds provision prevented application of the "Action Over Exclusion" because the term "the named insured" (as used in the "Action Over Exclusion") referred only to Starwood, and because the deceased worker was not a Starwood employee, the "Action Over Exclusion" was inapplicable.

Century successfully countered this argument by contending that it had no duty to defend because the "Action Over Exclusion" was applicable due to the fact that Absolute was the only named insured and the deceased worker was allegedly employed by Absolute. Accordingly, the court held that the "Action Over Exclusion" barred coverage, and, therefore, Century had no duty to defend Starwood.

BREACH OF CONTRACT EXCLUSION

Gemini Ins. Co. v. The Andy Boyd Co. LLC, No. 06-20464 (5th Cir. June 26, 2007)

In this duty to defend case, the policy at issue contained an exclusion for personal and advertising injury "arising out of a breach of contact, except an implied contract to use another's advertising idea in your 'advertisement.'"

In the underlying lawsuit, the insured and its employee were sued because the employee allegedly

breached his non-disclosure agreement by making copies of confidential customer lists and other customer information prior to his departure from a former employer. The insured allegedly used the information to market to the former employer's customers thereby resulting in the insured obtaining business from the former employer and causing damages. In the declaratory judgment action, the insurer asserted the breach of contract exclusion as a defense, and the insured filed a counterclaim. After both sides moved for summary judgment, the district court granted the insurer's motion holding that the exclusion applied. The insured appealed.

On appeal, the insured conceded that the allegations against its employee arose from the breach of contract but argued that some of the claims did not arise from the breach of contract. The insured also argued that, pursuant to *King*, the exclusion should not apply because only the employee breached a contract, and the insurance policy contained a separation-of-insureds provision.

In affirming the district court's judgment, the Fifth Circuit first noted that Texas law states that "when an exclusion prevents coverage for injuries 'arising out of' particular conduct, '[a] claim need only bear an *incidental relationship* to the described conduct for the exclusion to apply.'" The court also noted that "arising out of" are words of much broader significance than "caused by." Furthermore, the court stated that the case was analogous to *McManus* because whether the injury arose from a breach of contract was readily determined. Citing *Reyna*, the court held that the separation-of-insureds provision did not prevent application of the exclusion. Finally, the court noted that for the exclusion to apply, the breach of contract need not have caused the injuries; instead, the breach of contract must merely have had an incidental relationship to or connection with the injuries.

POLLUTION EXCLUSION

United Nat'l Ins. Co. v. Hydro Tank, Inc., 497 F.3d 445 (5th Cir. 2007)

The Fifth Circuit determined that the pollution exclusion barred coverage for claims arising from injuries allegedly caused by exposure to "hydrogen sulfide and/or other chemicals and vapors," irrespective of whether the injuries may have only been caused by contact with sludge containing the chemicals. Furthermore, the court refused to allow the contractors limitation endorsement to neutralize explicit exclusions and create coverage when it otherwise would not exist.

The underlying suit involved two workers who were injured while removing sludge from a mixing tank owned by the insured. After the workers entered the tank, they were allegedly "overcome by fumes and fell face-first into the sludge." The workers alleged that they were exposed to "'toxic levels of hydrogen sulfide and/or other chemicals and vapors.'" Subsequent to settling the lawsuit, the insured sought indemnification from the insurer up to the $5 million umbrella policy limit. The insurer denied the claim, filed a declaratory judgment action, and obtained a declaration that the pollution exclusion contained in the policy barred the insured's indemnification claim.

On appeal, the insured argued that two separate injury scenarios were created by the underlying plaintiffs' use of the conjunction "and/or" in their pleadings. The insured contended that the workers could have been injured by hydrogen sulfide, which was a pollutant, or they could have been injured by "other chemicals and vapors," which are not necessarily pollutants. The insured contended that in the latter scenario, the workers had not alleged injury by a pollutant.

After noting that the policy excluded coverage for "'"bodily injury" . . . which would not have occurred in whole or in part but for the . . . alleged . . . release . . . of "pollutants,"'" the court explained that "if a claim alleges that injury arose at least in part from a pollutant, coverage is denied." The court reasoned that the phrase "toxic levels of hydrogen sulfide" alleged that the injuries arose, at least in part, from the workers' exposure to a pollutant.

Additionally, the court rejected the insured's argument that the workers' allegations could be read as suggesting that the injuries were actually caused by the sludge—rather than the fumes—and sludge is not a pollutant due to it being properly stored in a mix tank. Such an argument, the court held, disregards the numerous cases holding that a substance does not have to be released into the environment before it will qualify as a pollutant for purposes of the pollution exclusion clause.

The insured also asserted that the contractors limitation endorsement contained in the umbrella policy at issue provided coverage regardless of whether the pollution exclusion was applicable. In rejecting this argument, the court relied, in part, on

Fiess v. State Farm Lloyds, 202 S.W.3d 744 (Tex. 2006), which, the court stated, "reaffirmed the general interpretive maxim that a general clause permitting coverage cannot render ineffective another clause that contains a specific and unambiguous coverage exclusion." Accordingly, the court held that the endorsement could not override the explicit exclusions. Therefore, the insurer did not have a duty to indemnify the insured.

CANCELLATION – REPLACEMENT COVERAGE; FORM F ENDORSEMENT

Lancer Ins. Co. v. Shelton, No. 06-10617 (5th Cir. Aug. 7, 2007)

In 1999, Lancer issued a one-year motor carrier liability policy to Rockmore that covered bodily injury or property damage caused by an accident involving a covered vehicle owned, maintained, or used by Rockmore. The policy was renewed in 2000 and 2001, and the 2001 policy had an expiration date of July 15, 2002. On November 14, 2001, Lancer notified Rockmore that it planned to cancel the 2001 policy, effective November 25, 2001, for nonpayment of premiums. As a result, Rockmore obtained replacement coverage from another insurer that became effective on December 4, 2001.

On June 24, 2002, a bus driven by a Rockmore employee crashed, killing and injuring passengers on board. After attorneys for the passengers made settlement demands on Lancer on the basis of the 2001 policy, Lancer filed a declaratory judgment action asserting that the 2001 policy was not in effect at the time of the crash. Cross motions for summary judgment were filed, and the district court held that the 2001 policy had been cancelled as of November 25, 2001. The passengers appealed.

On appeal, the passengers asserted that the 2001 policy was in effect on June 24, 2002, despite having been cancelled by Lancer and replaced with another policy by Rockmore as of December 4, 2001. Essentially, they asserted that the policy remained in effect following Lancer's cancellation because Lancer failed to comply with various state laws governing policy cancellation.

The policy contained provisions governing cancellation and a Uniform Motor Carrier Bodily Injury and Property Damage Liability Insurance Endorsement ("Form F"), which protects third parties against the possibility that a motor carrier will be underinsured with regard to state or federal law requirements. Form F provided in part that "[t]he certification of the policy, as proof of financial responsibility under the provisions of any State motor carrier law . . . amends the policy." It also provided that "[t]his endorsement may not be cancelled without cancellation of the policy to which it is attached. Such cancellation may be effected by the company . . . giving thirty . . . days' notice in writing to the State Commission with which such Certificate has been filed . . . ."

Here, certificates were filed in several states, and the passengers claimed that because Lancer did not give notice to the states, the policy remained in effect. As the Fifth Circuit stated, they essentially contended that Form F acted as an additional set of cancellation requirements. The Fifth Circuit noted that Texas law makes clear that insurers do not need to give notice to the state to effect cancellation when replacement coverage has been purchased which complies with the language of Form F. The court further noted that nothing in Form F suggests that no other modes of policy cancellation are permissible. As such, Lancer's failure to give notice to the state was of no moment because the insured subsequently purchased replacement coverage.

Because the insured purchased replacement coverage that was effective at the time of the crash, the 2001 policy and Form F endorsement were no longer in effect. Thus, the Fifth Circuit affirmed the district court's order granting Lancer's motion for summary judgment.

MCS-90B ENDORSEMENT; RELATED AND INTERDEPENDENT DOCTRINE

Lincoln Gen. Ins. Co. v. Maria De La Luz Garcia, No. 05-20938 (5th Cir. Sept. 21, 2007)

In deciding an issue of first impression, the Fifth Circuit held that because a bus accident occurred in Mexico, the federally prescribed Endorsement for Motor Carrier Policies of Insurance for Public Liability Under Section 18 of the Bus Regulatory Reform Act of 1982 ("MCS-90B") was not applicable and did not provide coverage for the accident. The Fifth Circuit further held that, pursuant to *Reyna*, the MCS-90B endorsement did not cover the insured's liability for negligent hiring, retention, and entrustment of the insured's bus driver.

This dispute arose after one of the insured's buses was involved in a severe accident in Mexico. While the underlying suit was pending, the insurer filed this declaratory judgment action against the insured seeking a declaration that the policy did not provide coverage and, therefore, it had no duty to defend or indemnify the insured. The underlying plaintiffs intervened and requested a declaration that the policy provided coverage and that form MCS-90B applied. Cross motions for summary judgment were filed with the insurer arguing that it had no duty to defend or indemnify because the accident occurred in Mexico, outside of the policy's coverage territory, and because form MCS-90B did not expand coverage to Mexico. The intervenor plaintiffs contended that form MCS-90B trumped the territorial limitation in the policy and mandated coverage for the accident. The district court granted the insurer's motion, ultimately dismissed the case, and denied the intervenor plaintiffs' motion for reconsideration.

On appeal, the intervenor plaintiffs argued that the district court erred in determining that form MCS-90B did not cover the accident because the form read out any language in the policy, including the territorial restriction, that would limit the right of injured third parties to recover. In the alternative, they argued that the MCS-90B endorsement covered the accident, even though it occurred in Mexico, because the insured's negligent hiring, retention, and entrustment occurred in the United States.

The insured's policy covered accidents occurring within the coverage territory, which was defined as the United States, its territories, and possessions, Puerto Rico, and Canada. The policy also contained the MCS-90B endorsement, which provided, in part, that the policy was amended

> to assure compliance by the insured . . . as a for-hire motor carrier of passengers with Section 18 of the Bus Regulatory Reform Act of 1982 . . . . In consideration of the premium . . . the insurer . . . agrees judgment recovered against the insured for public liability resulting from negligence in the operation, maintenance, or use of motor vehicles subject to financial responsibility requirements of Section 18 . . . regardless of . . . whether or not such negligence occurs on any route or in any territory authorized to be served by the insured or elsewhere. . . . However, all terms, conditions and limitations in the policy to which the endorsement is attached shall remain in full force and effect as binding between the insured and the company.

The Fifth Circuit first analyzed Section 18 (now codified in 49 U.S.C. § 31138(a)), which describes the minimum level of financial responsibility required by federal law to cover liability for bodily injury or property damage for the transportation of passengers by commercial motor vehicles in the United States. The Fifth Circuit held that the form did not apply because the accident occurred in a place where the motor vehicle was not subject to the minimal financial responsibility requirements of Section 31138. The Fifth Circuit further held that the endorsement was not a private insurance contract; instead, it was mandated by federal law.

In rejecting the intervenor plaintiffs' second argument, the court noted that it was undisputed that the hiring, retention, and entrustment occurred in the United States, and that the bus driver's operational negligence occurred in Mexico. Noting that *Reyna's* analysis applied equally to the MCS-90B endorsement, the Fifth Circuit determined that the insured's liability for negligent hiring, retention, and entrustment would not exist "but for" the bus crash in Mexico, for which the court already concluded that there was no coverage.

EXEMPTION UNDER SECTION 1108.051

In re Trautman, 496 F.3d 366 (5th Cir. 2007)

After getting into financial trouble, the debtor surrendered his whole-life policy, received a check for the final cash value, and subsequently filed for bankruptcy seeking to exempt the uncashed check from the estate. In an issue of first impression, the Fifth Circuit held that the cash from a surrendered whole-life policy was not exempt under Section 1108.051 of the Texas Insurance Code.

APPLICATION OF SECTION 38.001

In re Gibbons-Markey, No. 06-51632 (5th Cir. Aug. 30, 2007)

The Fifth Circuit denied the Texas Medical Liability Trust's request to certify to the Texas Supreme Court the question of whether a trust may be subject to an award of attorneys' fees under Section 38.001 of the Texas Civil Practice and Remedies Code.

AMOUNT IN CONTROVERSY

Liberty Surplus Ins. Corp. v. Slick Willie's of Am., H-07-706 (S.D. Tex. June 21, 2007)

In this declaratory judgment action, the insurer argued that it had no duty to defend or indemnify its insureds in lawsuits filed in state courts in Texas and Oklahoma. While the insureds did not contest that the parties were completely diverse, they contested that the jurisdictional amount was satisfied, and moved to dismiss under Rule 12(b)(1).

The United States District Court for the Southern District of Texas noted that when an insurer seeks a declaratory judgment as to coverage, the "object of the litigation" is the policy and the "value of the right to be protected" is the plaintiff's potential liability under that policy. Moreover, the district court noted that in a claim for declaratory judgment to indemnify an insurer for claims against the insured, "the amount in controversy is to be measured by the policy limits or by the value of the underlying claim." If the amount at issue in the underlying claim is more than the insurance coverage, the amount in controversy is the amount of coverage, not the amount at issue in the underlying claim. However, if the insurance coverage exceeds the underlying claim, "the jurisdictional amount in controversy is measured by the value of the underlying claim – the face amount of the policy."

Despite the insureds' arguments that the subject policies' $25,000 self-insured retentions must be deducted from the amount in controversy and that the insurer asserted several exclusions that may exclude certain damages and injuries, the district court held that it was facially apparent from the underlying state court petitions, as well as additional evidence provided by the insurer, that the amount in controversy would likely exceed $75,000. As such, the insurer met its burden of showing diversity jurisdiction, and the motion to dismiss was denied.

OCCURRENCE; ECONOMIC LOSS

Charlton v. Evanston Ins. Co., No. SA-06-CA-480-H (W.D. Tex. June 29, 2007)

The United States District Court for the Western District of Texas granted the insurer's motion for summary judgment holding that the insurer had no duty to defend or indemnify the insured in an underlying lawsuit because the insured's injuries were contractual in nature and his breach of contract and warranty claims did not constitute an "occurrence" under two CGL policies.

The insured filed suit alleging that the insurer had a duty to defend and indemnify him in an underlying lawsuit under two CGL policies. The underlying lawsuit arose out of a construction contract for which the insured was to provide construction services (i.e., remolding, rebuilding, and adding onto the property) and materials to the underlying plaintiff. The underlying plaintiff alleged that he suffered damages because the insured failed to provide construction services, materials, and management at his residence. His petition alleged that the insured was negligent and breached the implied warranty that its work would be installed and provided in a good and workmanlike manner.

The district court stated that although the acts of a party may breach duties simultaneously in tort and contract, the nature of the injury determines which duty is breached. The court also stated that when the injury is only the economic loss to the subject of the contract itself, the action sounds in contract alone and that Texas law requires something other than economic loss (e.g., property damage) to trigger coverage under a CGL policy. Thus, if the factual allegations read as a contractual breach for construction defects requiring repair or replacement instead of negligence resulting in property damage, the resulting damage for economic loss does not fall within the policy's coverage.

In granting the insurer's motion, the district court stated that despite the broad negligence allegations, the gravamen of the petition was breach of contract and warranty. In a nutshell, the plaintiff's "injury was that the house [he was] promised and paid for was not the house [he] received." Because the conclusory allegations of negligence in the petition could not serve to overcome the specific facts upon which his claim was based, the insurer owed no duty to defend or indemnify the insured in the underlying lawsuit. Note that this decision was issued prior to the Texas Supreme Court's decision in *Lamar Homes*.