ETHICAL ADJUSTING - NOT AN OXYMORON

By: Craig L. Reese

May 4, 2012

CONTENTS

INTRODUCTION

No matter what Daniel Day-Lewis's opinion may be of insurance adjusters and the job they do day in and day out,[1] your role is an important one and the way you do that job is just as important. While it may sometimes seem that the legislatures and the courts are out to get the insurance carriers and you, their goals are lofty ones. The insurance industry may be first and foremost a profit-driven business, but it is a business that impacts the lives of average Americans on a daily basis. Despite what some might believe, everyone in the industry wants the insured to be treated fairly. And you want to do your job responsibly, professionally, and ethically. You know you do.

In this paper, we will consider some of the many issues that a liability adjuster faces in his or her job. We will highlight many of the statutory provisions that govern your jobs. Additionally, we will take a look at some real world problems that can and do arise in the field of adjusting claims.

STATUTORY PROVISIONS

This paper does not purport to provide an exhaustive list of all of the statutory provisions you may encounter as you adjust claims. Further, this paper is limited to the statutory provisions in Texas. If you adjust claims in other states, be sure to educate yourself on what the law of that state is with respect to your ethical and professional responsibilities.

[1] Daniel Day-Lewis turned down a movie role late last year after spending an entire day with a claims adjuster. "It was just too much. I don't know how these people do it. I'd rather play a customer service rep than one of these poor bastards."

CHAPTER 541

A. Entitled "Unfair Methods of Competition and Unfair or Deceptive Acts or Practices"

B. Often referred to as statutory bad faith

C. Subchapter B (the laundry list of practices)

1. Section 541.060 consists of a list of "unfair settlement practices"

2. Unfair Settlement Practices defined:

(a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices with respect to a claim by an insured or beneficiary:

(1) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;

(2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:

(A) a claim with respect to which the insurer's liability has become reasonably clear;

(B) a claim with respect to which the insurer's liability has become reasonably clear in order to influence the claimant to settle an additional claim under another portion of the coverage unless payment under one portion of the coverage constitutes evidence of liability under another portion;

(3) failing to provide promptly to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or for the offer of a compromise settlement of a claim;

(4) failing within a reasonable time to:

(A) affirm or deny coverage of a claim to a policyholder; or

(B) submit a reservation or rights to a policyholder;

(5) refusing, failing, or unreasonably delaying a settlement offer under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;

(6) undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, unless the payment is a compromise settlement of a doubtful or disputed claim;

(7) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;

(8) with respect to a Texas personal automobile insurance policy, delaying or refusing settlement of a claim solely because there is other insurance of a different kind available to satisfy all or part of the loss forming the basis of that claim; or

(9) requiring a claimant as a condition of settling a claim to produce the claimant's federal income tax returns for examination or investigation by the person unless:

(A) a court orders the claimant to produce those tax returns;

(B) the claim involves a fire loss; or

(C) the claim involves lost profits or income.

CHAPTER 542

A. Concerns first party claims – includes the duty to defend

B. Initial Acknowledgment And Request For Material - Section 542.055

1. The ball moves back and forth

2. Not later than 15th **day** after receipt of notice of claim (or 30th business day if eligible surplus lines insurer)

3. Acknowledge receipt of Claim

4. Commence any investigation

5. Request from claimant all items, statements, and forms insurer reasonably believes, at that time, will be required from claimant

   a. Additional requests may be made if necessary - don't abuse
   b. Probably should be in writing
   c. Primary means to extend time to conduct investigation and make decision
   d. Deadlines don't start until all items received
   e. If no request for additional materials is made, the decision making period is advanced to the day insurer receives written notice of claim

C. Obligation To Make A Decision - Section 524.056

1. Date upon which all required items, statements, and forms are received is critical

   a. Starts deadline for acceptance/rejection of claim
   b. Must notify in writing not later than 15th **business day** after receipt of all materials
   c. If arson is suspected (reasonable basis), then given until not later than 30th day

2. Optional notice for additional time - Section 542.056(d)

   a. Allows insurer to delay decision
   b. Notify claimant within Time Specified in 1(b) or (c) above
   c. Give reasons for additional time
   d. Limited extension
   e. Absolute time period of 45 days runs from notice date given under this section

3. Payment of claims - Sections 542.057/542.058

   a. 60 day deadline from receipt of claimant's materials[2]
   b. May be modified by other statutes (e.g., pip payments must be made within 30 days)

[2] Please note that in cases involving the duty to defend, an insurer can be liable under Chapter 542 even though the insured has not submitted bills for its defense costs. *See Trammell Crow Residential Co. v. Virginia Sur. Co.*, 643 F. Supp. 2d 844, 858 (N.D. Tex. 2008) (noting that while proof of defense costs is necessary to calculate damages, it is not necessary to establish liability in the first place).

c. Must be made no later than 5th **business day** after notice that claim will be paid has been made

THE DUTY TO DEFEND

While you are all familiar with the standards for the duty to defend (especially if you have gotten a coverage opinion from someone in our firm over the last several years), it does not hurt to set them out again. Our focus then turns to some recent cases from Dallas and Houston that appear to turn these rules on their head, especially with respect to determining when bodily injury or property damage occurs for purposes of coverage. Many of these cases are pending review by the Texas Supreme Court so they may not withstand review. However, as we all remember that famous quote by the Fifth Circuit, "[w]hen in doubt, defend."[3]

GENERAL LAW ON THE DUTY TO DEFEND

The duty to defend and the duty to indemnify are two separate duties. *Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 821-22 (Tex. 1997). One may well exist without the other. *Argonaut Southwest Ins. Co. v. Maupin*, 500 S.W.2d 633, 635-36 (Tex. 1973). Thus, an insurer may have a duty to defend but, eventually, no duty to indemnify. *Farmers Tex. County Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 82 (Tex. 1997). The duty to defend is broader than the duty to indemnify. *Enserch Corp. v. Shan Morahan & Co.*, 952 F.2d 1485, 1493 (5th Cir. 1992).

In determining whether there is a duty to defend, Texas courts follow the "eight corners" rule (also called the "complaint allegations" rule). *Cluett v. Medical Protective Co.*, 829 S.W.2d 822, 829 (Tex. App.—Dallas 1993, writ denied). Under this rule, the duty to defend is determined solely by looking to the face of the pleadings, and the allegations contained therein,

[3] *Essex v. Hines*, 358 Fed. Appx. 596, 597 (5th Cir. 2010).

and the insurance policy. *National Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141 (Tex. 1997). In applying the eight corners rule, the petition is given liberal interpretation. *Id.* The insurer must examine the pleadings, in light of the policy, without reference to the truth or falsity of the allegations and without reference to any legal determination thereof. *See Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co.*, 387 S.W.2d 22, 24 (Tex. 1965); *see also Don's Bldg. Supply, Inc. v. OneBeacon Ins. Co.*, 267 S.W.3d 20, 31 (Tex. 2008) (policy imposes a duty to defend regardless of whether plaintiff has a legally meritorious claim). When it is unclear whether the petition states sufficient facts to bring the case within coverage, all doubts are resolved in favor of imposing a duty to defend. *National Union Fire Ins. Co.*, 939 S.W.2d at 141. However, courts may not read facts into the pleadings, look outside the pleadings, or imagine factual scenarios which might trigger coverage. *Id.* at 142. Courts may, and often do, however, draw inferences from the petition that may lead to a finding of a duty to defend. *Gore Design Completions, Ltd. v. Hartford Fire Ins. Co.*, 538 F. 3d 365, 369 (5th Cir. 2008); *General Star Indem. Co. v. Gulf Coast Marine Assocs.*, 252 S.W.3d 450, 456 (Tex. App.—Houston [14th Dist.] 2008, pet. denied). The focus is on the factual allegations rather than the legal theories asserted by the plaintiff in the underlying lawsuit. *Griffin*, 955 S.W.2d at 82*; see also National Union Fire Ins. Co.*, 939 S.W.2d at 141 (mere fact that negligence is alleged does not establish a duty to defend - court focuses on factual allegations, not legal theories).

If a plaintiff's petition does not allege facts within the scope of coverage, the insurer has no legal obligation to defend. *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 848

(Tex. 1994). Further, an insurer does not have a duty to defend when the petition makes allegations which, if proven, would clearly place the plaintiff's claim within the scope of an exclusion from coverage. *See Puckett v. United States Fire Ins. Co.*, 678 S.W.2d 936, 938 (Tex. 1984). Finally, an insurance company has no duty to investigate possible coverage before denying a defense if the allegations in the underlying lawsuit impose no duty to defend. *See Fidelity & Guar. Ins. Underwriters, Inc. v. McManus*, 633 S.W.2d 787, 788 (Tex. 1982) (insurer is entitled to rely on plaintiff's allegations in determining whether facts alleged are within coverage).

Where the petition alleges both covered and non-covered claims, the insurer must provide a defense against all claims. *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116, 119 (5th Cir. 1983). Further, the duty to defend is unaffected by facts ascertained before suit, by facts developed during litigation, or by the ultimate outcome of the suit. *Cowan*, 945 S.W.2d at 829.

Courts will often go out of their way to find a duty to defend. In *St. Paul Fire & Marine Ins. Co. v. Green Tree Financial Corp.-Tex.*, 249 F.3d 389 (5th Cir. 2001), the court carefully scrutinized the factual allegations supporting a claim for unfair debt collections practices to find a duty to defend. Although there would have been no duty to defend that claim, the court "discovered" that the plaintiff was actually alleging an invasion of privacy claim for which a defense was owed, even though no such claim had ever been pleaded. *Id.* at 394.

RELEVANT PLEADINGS FOR THE DUTY TO DEFEND

Courts in Texas have been consistent in holding that, in a case where the insured is added by way of third party pleadings and is not sued by the original plaintiff, in determining the duty

to defend the court will look to the allegations in the third party petition against the insured and will ignore the allegations in the complaint filed by the plaintiff against the original defendant. *See Gibson & Assocs., Inc. v. Home Ins. Co.*, 966 F. Supp. 468, 473 (N.D. Tex. 1997) (the factual background alleged in third party complaint provided pertinent frame of reference with regard to duty to defend); *see also Fox Elec. I, Ltd. v. Amerisure Ins. Co.*, 2006 U.S. Dist. LEXIS 11975, at *9 n.5 (N.D. Tex. 2006), *aff'd*, 252 Fed. Appx. 579 (5th Cir. 2007) (court refused to consider allegations in petition filed by owner against general contractor but instead looked only to allegations in third party petition brought by general against subcontractor); *but see E & R Rubalcava Constr., Inc. v. Burlington Ins. Co.*, 148 F. Supp. 2d 746, 749 n.4 (N.D. Tex. 2001) (refusing to follow *Gibson*, court held that it would consider both third party petition and original plaintiff's petition for purposes of determining duty to defend).

WHEN DOES AN INJURY OCCUR

Under Texas law, the insured has the burden of showing that the claimed damages occurred during the policy period. *Employers Cas. Co. v. Block*, 744 S.W.2d 940, 945 (Tex. 1988).

An occurrence policy has been defined as one which "covers all claims based on an event occurring during the policy period, regardless of whether the claim or occurrence itself is brought to the attention of the insured or made known to the insurer during the policy period." *Yancey v. Floyd West & Co.*, 755 S.W.2d 914, 918 (Tex. App.—Fort Worth 1988, writ denied).

The question then becomes whether an event that invokes coverage has occurred during a policy period.[4]

A. Bodily Injury.

Four primary theories of triggering coverage have evolved in the bodily injury/latent disease/continuous exposure case context. *See, e.g., Guaranty Nat'l Ins. Co. v. Azrock Indus. Inc.*, 211 F.3d 239, 251 (5th Cir. 2000), *overruled in part on other grds, OneBeacon Ins. Co. v. Don's Building Supply Inc.*, 553 F.3d 901 (5th Cir. 2008) (court finding that Texas would apply exposure theory to asbestos case - bodily injury coverage triggered upon initial exposure to injury causing agent and in every policy period in which exposure to injury causing agent occurs); *Clemtex, Inc. v. Southeastern Fidelity Ins. Co.*, 807 F.2d 1271, 1274 (5th Cir. 1987) (court found Texas would apply exposure theory to silicosis case - bodily injury includes damage upon initial inhalation and all damage incurred through subsequent exposure - coverage triggered in any policy in which exposure to cause of injury occurs); *American Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 748 F.2d 769 (2d Cir. 1984) (in exposure to medical products case, court applied "injury in fact" rule which triggers coverage at point when body's defenses are overwhelmed - when real injury occurs; injury need not be manifest, but it must exist in fact); *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12, 24-5 (1st Cit. 1982), *cert. denied*, 460 U.S. 1028 (1983) (applying relaxed manifestation rule in asbestos cases which triggers

[4] For personal injury claims, the insured must have committed the enumerated offense while the policy was in effect in order to trigger advertising injury coverage. *See American Cyanamid Co. v. American Home Assurance Co.*, 30 Cal. App. 4th 969, 981-82 (Cal. Ct. App. 1994, rev. denied). In *Two Pesos, Inc. v. Gulf Ins. Co.*, 901 S.W.2d 495 (Tex. App.—Houston [14th Dist.] 1995, no writ), the court held that since there was no allegation of an offense within the policy period, there was no duty to defend under the policy. *Id.* at 501 (advertising injury claim).

coverage in first policy period that disease becomes reasonably capable of medical diagnosis - date of manifestation is usually equated with date of diagnosis); *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034, 1044-45 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982) (in asbestosis case, court adopts continuous or triple trigger theory - policy coverage is triggered by (1) inhalation exposure, (2) exposure in residence, and (3) manifestation - exposure in residence being defined as period between initial exposure and time injury manifests itself); *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 523 F. Supp. 110, 118 (D. Mass. 1981) (applying pure or strict manifestation rule which triggers coverage upon actual discovery of injury), *aff'd as modified*, 682 F.2d 12 (1st Cit. 1982), *cert. denied*, 460 U.S. 1028 (1983). In *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994), the Texas Supreme Court recognized each of the foregoing trigger of coverage theories in a medical malpractice case involving allegations of malpractice over a period of approximately two years. Unfortunately, the court decided that the case did not require it to decide which among these theories would be appropriate in Texas. *Id.* at 853 n.20. It is interesting to note, however, that the court assumed, without deciding, that 3 occurrence policies would provide coverage. In effect, the court adopted, without expressly stating so, the exposure theory. In *Pilgrim Enterprises, Inc. v. Maryland Cas. Co.*, 24 S.W.3d 488 (Tex. App.—Houston [1st Dist.] 2000, no pet.), the court held that the *Azrock* analysis applied to both physical injury and property damage cases. *Id.* at 497-98. Therefore, although the issue of which coverage trigger theory applies in personal injury cases has never been settled by the Texas Supreme Court, it is very likely it would likewise adopt the exposure rule (or what might also be called the actual injury rule). Interestingly, in *Don's*

Bldg. Supply, Inc. v. OneBeacon Ins. Co., 267 S.W.3d 20 (Tex. 2008), wherein the Texas Supreme Court adopted the actual injury rule for property damage cases, the court refused to express any opinion on whether the coverage rules were the same for bodily injury and property damage claims. *Id.* at 28 n.31.

B. Property Damage.

In property damage cases, the Texas Supreme Court has adopted the actual injury or injury-in-fact approach. *Don's Building Supply, Inc. v. OneBeacon Ins. Co*, 267 S.W.3d 20 (Tex. 2008). Under this approach, property damage occurs when there is actual physical damage to the property, not when the damage was or could have been discovered. *Id.* at 24. For purposes of the duty to defend, the pleadings must allege property damage that occurred during the relevant policy term. *Id.* at 31. In other words, if the plaintiff alleges that any amount of physical injury to tangible properly occurred during the policy period, the duty to defend will be triggered. *Id.*; *see also OneBeacon Ins. Co. v. Don's Building Supply Inc.*, 553 F.3d 901, 903 (5th Cir. 2008) (duty to defend depends on whether pleading alleges property damage that occurred during policy period that was caused by insured's acts or omissions).

This holding is consistent with prior opinions that required some allegation of damage during the relevant policy period before invoking a duty to defend. *See, e.g., Azrock Indus. Inc.*, 211 F.3d at 251; *Allstate Ins. Co. v. Hicks*, 134 S.W.3d 304, 311-12 (Tex. App.—Amarillo 2003, no pet.).

A quick review of recent cases illustrates this point. In *Landstar Homes Dallas, Ltd. v. Mid-Continent Cas. Co.*, 2010 U.S. Dist. LEXIS 131516 (N.D. Tex. 2010), the petition alleged

that the insured designed the house foundation in 2001 and that damage occurred from faulty design work. In the amended pleading, the plaintiff added dates regarding the pouring of the foundation and the sale of the home. The carrier at issue afforded coverage from 2001 to 2007. The lawsuit was filed in 2008. Given the foregoing, the court held there was a clear duty to defend. *Id.* at *11.

In *Mid-Continent Cas. Co. v. Academy Dev., Inc.*, 2010 U.S. Dist. LEXIS 87637 (S.D. Tex. 2010), the plaintiffs sued in 2005 alleging that the lake walls of their lake front community were failing and that water was leaking into their adjacent home sites. The plaintiffs further alleged that the insured failed to disclose this information to them. While noting that the petitions were not clear as to when the lakes were damaged, the court found that the petitions were not entirely date deprived. There were allegations of letters sent in 2004 and 2005 to the plaintiffs regarding problems and a reference to a lawsuit filed several years earlier in 2002 regarding faulty construction. The petitions also alleged that at the time of the sale of one of the homes, the insured knew that the walls of the lake were leaking. The court found that these allegations were sufficient to establish that at some point prior to 2002, the lakes were constructed and began leaking and that continuous leaking caused damage to the plaintiffs. Construing the petitions liberally, the court found a duty to defend since the carrier afforded coverage between 2000 and 2005. *Id.* at *20.

Finally, in *Union Ins. Co. v. Don's Building Supply, Inc.*, 266 S.W.3d 592 (Tex. App.—Dallas 2008, pet. denied), the insured was sued for damage arising out of the installation of EIFS on a home. The petition alleged that during construction in 1991, EIFS was applied and then the

plaintiffs bought the home. The plaintiffs also alleged that injury began to occur within six months after application and was continuous through the date of filing of their lawsuit in 2004. The carrier at issue provided coverage for the years of 1996 through 1998. The court concluded that the plaintiffs necessarily alleged physical injury to tangible property during the policy periods at issue. *Id.* at 595.

C. The Rules Seem To Be Different In Dallas (and in parts of Houston).

On several occasions now, the Dallas Court of Appeals has decided cases wherein they ignore all the foregoing rules. At least one Houston Court has followed along. Several of these cases are pending review before the Texas Supreme Court and only time will tell whether Dallas is correctly forecasting a change.

In *Summit Custom Homes, Inc. v. Great Am. Lloyds Ins. Co.*, 202 S.W.3d 823 (Tex. App.—Dallas 2006, no pet.), *overruled in part on other grds, Lamar Homes, Inc. v. Mid-Continent Cas Co.*, 242 S.W.3d 1 (Tex. 2007), the court held that the carrier had the duty to establish as a matter of law that damages did not manifest during policy years. In *Gehan Homes, Ltd. v. Employers Mut. Cas. Co.*, 146 S.W.3d 833 (Tex. App.—Dallas 2004, pet. denied), the court found a duty to defend against property damage claims where the petition was filed in May of 2001 claiming past damage without identifying when damage occurred. The court found that the carrier on prior policies failed to establish as a matter of law that there was no allegation of potential occurrence within its policy coverage period.

Another example of an odd result from the Dallas Court of Appeals can be found in the case of *Vines-Herrin Custom Homes, LLC v. Great Am. Lloyds Ins. Co.*, 357 S.W.3d 166 (Tex.

App.—Dallas 2011, pet. filed). In this case, Vines-Herrin built a home in 1999. The builder had coverage under a policy issued by Great American for the period of November 1998 to November 2000. After that policy lapsed, the builder purchased coverage from Mid-Continent for the period of November 2000 to November 2002.

Cerullo purchased the home in May 2000. Shortly after moving in, he began to experience problems including water intrusion and doors not shutting properly after a rainstorm. He also discovered water gathering at several places in the house and a cracks developed in the ceiling. In November of 2000, he discovered a window in the bathroom had begun to sink into the frame of the house. In 2001, other cracks and leaks developed and by 2002, the ceiling and roof had begun to sag. Cerullo informed the builder of the problems, but no repairs were made. In January 2003, Cerullo filed suit. No defense was provided by either carrier. An arbitration ultimately resulted in an award of $2,487,507.77.

A coverage lawsuit was tried in 2008 utilizing the manifestation rule. The trial court originally ruled in favor of Cerullo, who had taken an assignment of claims from Vines-Herrin. During the pendency of post-judgment motions, the Texas Supreme Court adopted the actual injury rule for property damage cases. The trial court set aside its judgment and reopened evidence for the limited purpose of hearing evidence as to when actual damage to the house occurred. After hearing the evidence, the court entered a take-nothing judgment in favor of the carriers. In its judgment, the trial court noted the plaintiff had failed to provide expert testimony regarding the exact date on which the damages occurred. In its findings of fact and conclusions of law, the court found that (1) the residence was covered by an uninterrupted period of

insurance which began before the residence was constructed and (2) that the damages to the house manifested during the uninterrupted period of insurance coverage. In a prior finding of fact, the trial judge determined that the plaintiff suffered a continuing set of injuries and damages throughout the several policy periods and that the cause of damage to the house was defective framing. These findings were incorporated in the final judgment.

On appeal, the Dallas Court of Appeals began its analysis with the question of whether a duty to defend existed under the pleadings. In his petition, Cerullo alleged that the house was constructed in 1999, he purchased it in 2000, and by April of 2001, he noticed damage. The court concluded that these allegations were sufficient to trigger both carriers' duty to defend. The court concluded that the pleadings sufficiently alleged that the policies were in effect prior to construction and that actual damage occurred sometime during or after construction. *Id.* at 173. Turning to the duty to indemnify, the court focused on one of the findings made by the trial court to the effect that damage manifested during the second Great American policy period. The court held that since damages must occur not later than whey they manifest, coverage existed under the Great American policy. Further, since the trial judge found that the cause of damage was defective framing and that had to occur after construction began, Great American obviously owed indemnity benefits under its two policies. *Id.* The court also held that expert testimony was not required to trigger the duty to indemnify. *Id.* Finally, the court left open the question of whether Mid-Continents' policies were implicated by the doctrine of continuing injury. *Id.* at 173 n.2.

On first reading, it appears that the court is holding that any carrier that provides coverage from the date of contracting through the date of suit owes a duty to defend and potential duty to indemnify. This is not legally correct. Coverage exists only under the policy in play at the time of injury or damage, as opposed to the time of the alleged negligent conduct that caused injury. *Don's Building Supply, Inc.*, 267 S.W.3d at 27. In other words, actual injury is the controlling date, not the date of the antecedent negligence that ultimately gives rise to the injury. Second, the court was not working with a clean slate. The findings of fact played a large role in the opinion. The court also assumed, without any evidence or pleading to support same, that the home suffered injury at the time of the actual construction work. This means the court focused on the antecedent negligence, instead of when the injury occurred. It is not that a building might not suffer injury from the fact of bad construction alone, but that was not what was pleaded in the underlying lawsuit and there was no finding to that effect. In fact, the plaintiff alleged that there was injury during 2001 and 2002, which would have only invoked a duty to defend under the Mid-Continent policies. Finally, it is plainly evident that the court worked backwards in reaching its defense holding. The trial court entered a finding that the house suffered injury during 2000. This same finding was used to support both a duty to indemnify and a duty to defend (although the Dallas Court did not so state).

Most recently, in *Geico General Ins. Co. v. Austin Power, Inc.*, 357 S.W.3d 821 (Tex. App.—Houston [14th Dist.] 2012, pet. filed), the court began its analysis by noting that although there was no specific date of injury alleged, there were other indications of time of injury. The court focused on the fact that the claimants alleged that the injury occurred before the petition

was filed and they used the past tense in alleging the plaintiff had suffered injuries from exposure to asbestos. *Id.* at 825. Construing the allegations liberally in favor of the insured, the court held that the claim was potentially covered as having occurred during the policy period, so the carrier had a duty to defend. *Id.* at 826.

While the foregoing cases are anomalies and are pending review, the adjuster and the carrier should keep them in mind if determining a duty to defend, especially in cases that will be subject to review by the Dallas Court of Appeals.

THE DUTY TO INDEMNIFY - STOWERS

In this section of the paper, we will focus primarily on the *Stowers* duty. Since we are all basically familiar with this standard, the paper will not set out a lengthy analysis or background of this duty. Instead, the paper will focus on some real world situations that could be problematic.

In *G.A. Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved), the court recognized that an insurer may be liable for damages, measured by the amount of the judgment against its insured, when it negligently responds to a settlement demand within policy limits. In order to invoke the *Stowers* duty, three prerequisites must be met: (1) the claim is within the scope of coverage; (2) the demand is within policy limits; and (3) the terms of the demand are such that an ordinarily prudent insurer would accept the demand, considering the likelihood and degree of the insured's potential exposure to an excess judgment. *American Physicians Ins. Exch. v. Garcia*, 976 S.W.2d 842, 849 (Tex. 1994).

To impose a duty on an insurer when there is but a single claim, a settlement demand must propose to release the insured fully from that claim in exchange for a stated sum. 14 Couch on Insurance § 203:27 (3d ed. 2007).

In *Trinity Univ. Ins. Co. v. Bleeker*, 966 S.W.2d 489 (Tex. 1998), an intoxicated driver veered off the highway and struck a pickup truck that was stopped on the shoulder. Fourteen members of the Villarreal and Ochoa families were in the truck. One of the Villarreals was killed and all the other people were injured. The driver carrier minimum limits coverage. The treating hospital filed liens exceeding the policy limits. Shortly after the accident, an attorney representing five of the Villarreals extended several oral offers to settle. A month later, he sent a written demand that policy limits be placed into the registry of the court for the benefit of his five clients and the other nine claimants. The letter did not offer to release any claims and did not mention the hospital liens. The lawyer later came to represent all fourteen claimants. The plaintiffs obtained a multi-million dollar judgment against the insured and then sued the carrier after receiving an assignment of the insured's claims against the carrier.

The court began its analysis by assuming, without deciding, that the letter sent by the lawyer was in fact a settlement offer and that a *Stowers* demand may be made on behalf of only some of the total pool of potential plaintiffs. The court did not have to reach this question because it held that the letter did not constitute a valid *Stowers* demand because it did not meet the requirement that it offer to release the claims fully because it never mentioned the hospital liens. *Id.* at 491. Because the liens were not mentioned, the plaintiffs could not have fully settled the case. *Id.*

In *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312 (Tex. 1994), a traffic accident caused by an intoxicated driver resulted in one woman being killed and her husband and two children injured (Medina family) and another passenger being killed (Lopez). Once again, the insured carried minimum limits coverage. The carrier offered the full policy limits to the Medinas (appropriate since one death and two additional persons injured), but the offer was rejected because the plaintiffs wanted to pursue the insured's personal assets. The carrier then settled the Lopez claim (wrongful death claim brought by his parents) for $5,000 and offered the remaining $15,000 to the Medinas. They again rejected the settlement offer. The jury returned a verdict in excess of policy limits and the Medinas sued in the insured's name. The court held that when an insurer is faced with settlement demands arising out of multiple claims and inadequate proceeds, it may settle with one of several claimants even though that settlement exhausts or diminishes the insurance proceeds available to satisfy other claims. *Id.* at 315.

Finally, in *Rocor Int'l, Inc. v. National Union Fire Ins. Co.*, 77 S.W.3d 253 (Tex. 2002), the Texas Supreme Court recognized a statutory *Stowers* claim under Article 21.21. This case involved an accident where two highway patrol officers were killed. The plaintiffs purported to offer to settle only the adults' claims, but not the children's' claims, for a sum certain. This offer was orally made and there was a lot of confusion about what the terms of the offer were. The insurer thought the offer was to settle all claims. The court ultimately held that Article 21.21 had not been violated because the oral offers did not clearly state the terms of the offer nor was a release mentioned. *Id.* at 263.

WRONGFUL DEATH CLAIMS

For purposes of this scenario, we will operate under the following factual backdrop. As a result of an auto accident, several people are killed. Each of the decedents has multiple beneficiaries. One of the beneficiaries for decedent A offers to settle his portion of the wrongful death claim for the per person limits. A beneficiary for decedent B offers to settle her portion of the wrongful death claim for the balance of the policy limits. The question is whether these demands constitute valid *Stowers* demands.

Although the law is sparse, the available authority reveals that there was no valid demand. One law professor has stated that an insurer incurs no liability for failing to accept a policy limits settlement offer that does not emanate from all the persons having a stake in the particular claim being settled. Stephen S. Ashley, *Bad Faith Actions Liability & Damages* § 3:27 (2007). In support of that position, he cited several cases that involved the failure to include lien holders.

In *McNally v. Nationwide Ins. Co.*, 815 F.2d 254 (3d Cir. 1987), the court held that a settlement offer is conditional if it requires payment without providing in return a guarantee that the payment would result in a full settlement of the claim. *Id.* at 261.

There is one case that actually addresses the question presented. In *Williams v. Infinity Ins. Co.*, 745 So. 2d 573 (Fla. Dist. Ct. App. 1999), an auto accident resulted in the death of Willie Earl Williams. Mr. Williams was survived by his wife and son. He was also survived by three other children by another woman. All qualified as beneficiaries under the Florida Wrongful Death Act. Before an estate was opened, Williams' wife and one son demanded that

the two carriers pay their policy limits to settle their individual claims. The insurers refused because to do so would prejudice the claims of the other three children by exhausting policy limits. An estate was subsequently opened and a wrongful death claim was brought on behalf of the wife and all four children. The wife and son alleged that the carriers breached their duty of good faith by failing to settle with them for the policy limits.

The court began its analysis by noting that there was no authority for the imposition of an obligation on an insurer to settle with one claimant/beneficiary to the exclusion of other survivors/potential claimants. *Id.* at 575-76. The court noted that the question to be decided was not whether one beneficiary could settle, but rather whether an insurer is obligated to settle with the first beneficiary who claims insurance proceeds. *Id.* at 576.

The court turned to a discussion of the Florida Wrongful Death Act. It noted that a wrongful death claim must be brought by the personal representative for the benefit of all of the decedent's survivors and estate. *Id.* It also noted that the purpose of requiring the action to be brought in this manner was to avoid the possibility of a multiplicity of suits, a race to judgment, and preferential treatment of one or more beneficiaries. *Id.* (citations omitted).[5] The court rejected the plaintiffs' position that the carrier must settle with the first beneficiary because it simply was not the law and would not serve the purposes of the Wrongful Death Act. *Id.*

The court ultimately concluded that had the insurers settled with two of the five beneficiaries, the available limits would have been exhausted, thereby prejudicing the remaining beneficiaries in violation of Florida law. *Id.* The court also noted that such a settlement would

[5] These purposes are similar to those expressed by Texas courts in finding that a wrongful death claim is but one action for the benefit of all statutory beneficiaries.

not have resulted in the insured being released fully from the wrongful death claim. *Id.* at 577. The court also noted that the only way to fully protect the insured was to settle the entire wrongful death action for policy limits. *Id.*

In *Patterson v. Home State County Mut. Ins. Co.*, 2014 WL 1676931 (Tex. App.—Houston [1st Dist.] 2014, n.p.h.) (mem. op.), an eighteen-wheeler driven by Hitchens collided into a car, killing the driver. Her husband and children sued the driver, his employer, and the owner of the truck. Counsel for the family sent two letters to the owner's carrier proposing settlement. In the first letter, counsel proposed that the carrier pay the fully policy limits to the two children. In the second letter, counsel proposed that he carrier pay the full policy limits to the husband. The carrier declined to accept either proposal.

After several other parties claimed to have sustained damages in the same collision, the carrier filed an interpleader action, offering to deposit its policy limits into the registry of the court for distribution once the court determined the parties' respective rights to the funds. It also sought an order that it be discharged from any further liability. The family of the decedent objected on the ground that the carrier had violated its *Stowers* obligation.

The family then sent another letter to the carrier offering to settle all claims against the owner of the truck for the full policy limits. The carrier again declined, stating that any money would have to come out of the interpleader action. At trial, the family obtained a judgment against the owner for almost 6 million dollars. Throughout this process, the insured owner continued to tell the carrier not to settle.

On appeal, the court noted that neither of the first two demands offered to fully release the owner, as it would still have been potentially liable for an excess judgment in favor of the remaining wrongful death beneficiaries and the estate. The court held that the first two settlement demands did not trigger any *Stowers* duty. *Id.* at *9.

The court also concluded that the last settlement demand was not unconditional because although it offered to settle all wrongful death/survival claims against the owner, it did not include the driver. *Id.* at *10.[6]

INVOLVING THE DEFENSE COUNSEL IN *STOWERS* ISSUES

Defense counsel is often caught in the middle of cases involving policy limit demands. The *Stowers* letter is often sent to defense counsel to be forwarded to the carrier. When the adjuster receives the letter, he or she often wants to know (1) whether the demand letter actually invokes a *Stowers* duty, and (2) whether the case should be settled.

Defense counsel is not supposed to be involved in coverage questions. A *Stowers* demand often invokes coverage issues. It certainly invokes an issue with respect to the extent of coverage. The only proper action for defense counsel is to forward the demand letter without comment. That same defense counsel will have likely already provided the adjuster with his or her analysis of the case with respect to liability and potential exposure. It is then up to the adjuster and the carrier to determine whether to settle the case rather than expose it's insured to an excess judgment. Additionally, if pressed, the only other proper response by defense counsel would be to suggest that the insured does, after consultation, in fact want the case settled within policy limits.

[6] This last determination is incorrect under the analysis provided by the Texas Supreme Court in *Soriano*.

***STOWERS* AND MULTIPLE POLICIES**

There remains an open question as to whether it is even possible for a plaintiff to invoke *Stowers* against multiple primary carriers or both a primary and excess layer. Presented herein is what the courts have told us for sure. The remaining issues will have to remain problems for the plaintiffs' bar.

In *Pride Transp. v. Continental Cas. Co.*, 804 F. Supp. 2d 520 (N.D. Tex. 2011), an insurance dispute arose as a result of an auto accident. At the time of the accident, Pride was covered by a primary insurance policy of $1 million and an excess policy of $4 million. Pride's employee/driver was an insured on both policies. The primary carrier provided a defense to both insureds in the underlying lawsuit. The plaintiffs made a settlement demand against the driver for the combined limits of both policies. A week after the demand, Pride's counsel demanded that the primary carrier tender its limits to the excess carrier, which it did. The excess carrier then took over negotiations. The excess carrier ultimately settled the suit against the driver for the combined limits. Pride then sued the excess carrier when a judgment was entered against it.

Pride contended that the plaintiffs' demand was not a valid *Stowers* demand because neither insurer would have been liable for a judgment in excess of policy limits. Further, Pride alleged that the demand was not proper because it exceeded the limits of each individual policy. The court concluded:

> If Continental had not tendered its $1,000,000 policy limits to Lexington before the Hatleys' $5,000,000 settlement demand expired, the Court would agree with Pride. But, as noted above, Continental tendered its policy limits to Lexington just prior to the expiration of the Hatleys' demand. At that point, with combined

> policy proceeds equaling the amount of the Hatleys' demand, Lexington's *Stowers* duties came into play.

Id. at 529-30.

This holding is consistent with the position taken by the Texas Supreme Court in *Keck, Mahin & Cate v. National Union Fire Ins Co.*, 20 S.W.3d 692 (Tex. 2000) (*Stowers* duty does not arise for excess insurer until primary has tendered limits). Interestingly, the court offered no discussion regarding acceptance of the tender. Certainly, the excess carrier had no obligation to accept the tender.

In *Aftco Enters., Inc. v. Acceptance Indem. Ins. Co.*, 321 S.W.3d 65 (Tex. App.—Houston [1st Dist.] 2010, pet. denied), an eighteen-wheel tractor-trailer collided with several passenger vehicles stopped at an intersection. As a result of the collision, two people died and nine were injured. The driver was working for ETSI under a contract between it and the tractor owners, V.C. Enterprises and Gonzales. Performance Rental had rented the trailer to AFTCO. The policies of insurance in effect at the time of the accident included (1) a primary policy issued by Home State with remaining limits of $600,000 which named AFTCO and ETSI as insureds, (2) a primary policy issued by Southern with limits of $1 million which named Performance as the named insured and AFTCO, ETSI, and the driver as additional insureds, (3) a $1 million excess policy issued by Acceptance which named AFTCO and ETSI as insureds, and (4) a $10 million excess policy issued by Harco.

The plaintiffs that had not already settled with Home State sent a letter to all the carriers, except Harco, offering to settle all their claims against the defendants in exchange for a tender of policy limits available under the policies issued by the three carriers. The offer stated that the

plaintiffs understood that the combined policy limits were $2.6 million. Southern did not respond and Acceptance noted that it had no obligation to respond until all primary policies had been exhausted. After the trial court determined that a fact issue existed as to whether the Harco policy would afford coverage, the plaintiffs sent out another letter making a formal settlement demand for $13 million, the remaining limits of all policies in exchange for a full and final release against all defendants. Southern unilaterally tendered its policy limits to settle the case. Acceptance then tendered its limits. Harco continued to refuse to settle. The case went to trial and a judgment in excess of $20 million was entered.

AFTCO and ETSI sued the insurers alleging that the carriers violated their *Stowers* duty. On appeal, the court framed the issue as whether a settlement offer triggers an insurer's duty to settle when the plaintiff's settlement demands require funding from multiple insurers, and no single insurer can fund the settlement within the limits that apply under its particular policy. The court noted that the Texas Supreme Court has left this question unanswered. The court noted that the demands in this case had been unambiguously directed toward multiple policies and all the insurers together. The plaintiffs never offered to release their claims against the insureds under a particular policy in exchange for the limits available under that policy. *Id.* at 71. The court also noted that the initial settlement demand referred to a sum certain which was an aggregate amount that exceeded the primary carrier's limits. Therefore, the primary carrier was never faced with a valid *Stowers* demand. *Id.* As to the excess carrier, the court noted that no *Stowers* duty ever arose because the primary carrier never tendered its limits. *Id.* at 72.

CONCLUSION

Any number of questions remains with respect to *Stowers*, the duty to defend, and what constitutes ethical behavior by an adjuster. What we do know for certain is that each of you want to do your very best to be ethical. This is simply no oxymoron.

About the Author:

Craig L. Reese – Partner of the firm, Craig leads the appellate and coverage practice group. He has over 23 years practice experience including appeals at the federal and state level, insurance coverage/defense, and commercial litigation. His appellate experience includes cases before every level of the state courts of appeals and appeals to the Fifth Circuit Court of Appeals.